Region 4
Town Hall Meeting

August 29, 2019

Agenda

01	Welcome and Northeast Health Partners Update	02	Client Over Utilization Program (COUP)
03	Data Analytics Portal (DAP)	04	C-PAC Program
05	Health First Colorado Revalidation 2020	06	Provider Relations Resources
07	Q & A		

Chapter

01

Welcome And Health Colorado Inc. Updates

Chapter

02

Client Over Utilization Program (COUP)

For PCPs

Client Overutilization Program (COUP)

COUP **aligns with the goals of the Accountable Care Collaborative**:

- Improve health
- Reduce costs

COUP is a **collaborative effort** between the Department and:

- RAEs
- Department's utilization management vendor
- Department's fiscal agent
- Department's pharmacy benefit management system
- Pharmacies enrolled in Colorado Medicaid
- PCMPs and behavioral health providers contracted with the RAE

The RAE's COUP responsibilities:

- **Monitor for inappropriate utilization** of health care services

- **Reach out to clients** who inappropriately use services:
  - assess their needs
  - help them better manage medical/behavioral conditions

- **If inappropriate overutilization persists, consider locking in** to one pharmacy, one PCMP and specialist(s) as needed

- **Identify and support PCMPs and pharmacies** who have the resources to provide supports and interventions

- The **Department has authority** under 42 CFR 440.230 (d) to implement utilization control procedures and will prevent payment for services not delivered by or referred by the designated lock-in providers.

Criteria for Inappropriate Utilization

- **Any** of the following categories **within a three-month period:**
  - Client meets **all** the following prescription criteria:
    - Use of **6 or more high-risk prescriptions**; and
    - Filled prescriptions from **3 or more different pharmacies**; and
    - Filled prescriptions from **3 or more different prescribers**
  - Client had **4 or more visits to the emergency department**
  - Client meets criteria for **both #1** (prescriptions) **and #2** (emergency department)
  - Client has been **identified by a RAE or PCMP** based on a referral or care analysis indicating client's overutilization of services

- **High-risk prescription categories:**
  - Opioids
  - Controlled non-opioid analgesics
  - Controlled muscle relaxants
  - Benzodiazepines
  - Controlled non-benzodiazepine sedative hypnotics
  - Barbiturates

(Exclusions from COUP prescription review: cancer diagnosis, receiving palliative care, part D dual eligible or clients determined by the RAE to be inappropriate)

COUP Process

- The **Department creates a client list** and sends to the RAE every quarter
- Each **client also receives a letter** recommending they contact PCP/RAE for care coordination support
- **RAE outreaches clients** to improve utilization
- **RAE reports back** to the Department every quarter
- As needed, **RAEs and their providers perform a clinical review** to determine which clients would benefit from being locked in to a single PCMP and pharmacy

Lock-In Process

- RAEs **work with clients' PCMPs** to determine whether PCMP is able/willing to serve as the **client's COUP Lock-In provider**
- **RAEs submit client list to the Department** with **provider names** and **billing IDs** of **PCMP**, **pharmacy**, and **specialist** (if appropriate) who have agreed to serve the client
- **Department updates** Colorado interChange client record (starting fall 2019)
- A **formal letter is sent to notify client** of their status and rights
- **RAEs and provider network educate Lock-In client** about the program and what it means for their health care services
- **RAEs and network providers deliver care coordination**/other interventions to Lock-In clients for 12 months/until client is stabilized and appropriately utilizing services
- **When client appropriately utilizes services for at least one quarter**, the RAE can request the Department to remove the client from Lock-In
- **The Department removes client's Lock-in Assignment plan** and updates PCMP and RAE enrollment start reason codes

Specialty Care

- COUP Lock-In assignment providers **may refer clients to a physician specialist for consultation or short-term episodes of care.**

- **To receive reimbursement, the specialist** will need to enter the referring Lock-In provider's name and billing ID in the Referring Physician block on the claim.

- For **ongoing specialist treatment**, the RAE may request that the specialist be added to the client's COUP Lock-In assignment plan.

- **Providers are able to view** whether or not a client is in COUP Lock-In through the **Eligibility Verification response on the Provider Portal**.

- **The Lock-In Details panel** will identify the client's Lock-In assignments, including PCMP, physician specialist, and pharmacy.

- **Providers not named on Lock-In assignment plan or referred** by a provider on the COUP Lock-In assignment plan **will not receive payment for any non-emergency services** provided.

Client's Right to Appeal

- **Clients must ask for a hearing** with an Administrative Law Judge by submitting an appeal to the Office of Administrative Courts

- **Information on how** a client can submit an appeal is on the **back of the COUP Lock-In letter**

- **RAEs can assist clients in the appeals process**

Chapter

03

Data Analytics Portal (DAP, Truven, IBM Watson)

Truven DAP

- Intended for PCMP practice use.
- Practices may apply for fob or access by passcode.
- From KPI dashboards and tables there is ability to drill down into member-specific lists which then can be downloaded as CSV files.
- Multiple filters for sorting.
- Drill down content is by ***practice location***.
- Member-specific Patient Health Record (PHR) highly valuable for helping to close care coordination information gaps.

C-PAC and *RxSolve*

Presented by

Elizabeth Richards, MSW, LCSW

C-PAC Program Supervisor

RxSolve Project Coordinator

What is C-PAC?

Real time psychiatric & behavioral health supports for primary care clinics

1. Free telephonic psychiatric consultation with a board certified psychiatrist
2. Free care coordination to arrange out-patient behavioral health treatment
3. Free onsite psychiatric and behavioral health trainings

C-PAC Video

C-PAC
Colorado Psychiatric Access & Consultation for Adults and Kids
www.cpack.org

https://www.youtube.com/watch?v=NNgo5pBGicE

Who Are the C-PAC Teleconsultants?

Dr. Fred Michel

Adult, Adolescent &
Child Psychiatrist

Dr. Andrew Halpern

Adult, Adolescent &
Child Psychiatrist

Dr. Ronald Rabin

Adult, Adolescent &
Child Psychiatrist

Dr. Cristi Bundukamara

Psychiatric Nurse
Practitioner

Primary Care Practices enrolled in C-PAC

- **Pueblo & Pueblo West:**
  - Care for The Family
  - Rocky Mountain Primary Care
  - Small World Pediatrics
  - Stepping Stones Pediatrics

- **Walsenburg, La Veta & Trinidad:**
  - Spanish Peaks Regional Health Center Clinics
  - Salud Family Health Center

- **Holly, Lamar, La Junta, Rocky Ford, Springfield:**
  - Arkansas Valley Family Practice
  - High Plains Family Health Center
  - Rocky Ford Family Health Center
  - Ryon Medical
  - Southeast Colorado Medical Clinic
  - Valley-Wide

- **Eads & Walsh**
  - Eads Medical Clinic
  - Walsh Medical Clinic

- **Canon City:**
  - Button Family Practice
  - Canon Family Medicine

- **Salida & Leadville:**
  - First Street Family Health
  - Rocky Mountain Family Practice
  - St. Vincent Medical Center

- **Alamosa, Monte Vista, Moffat, Del Norte, Creede, Antonito, Moffat, San Luis:**
  - Rio Grande Hospital Clinics
  - San Luis Valley Health
  - Valley-Wide

➢ **Total of 41 Clinics**

C-PAC Trainings Provided since July 2018

PTSD & Suicide Prevention

- Care for the Family (Pueblo)
- Button Family Practice (Canon City)

Behavioral Health Screening Tools & Suicide Prevention

- Small World Pediatrics (Pueblo West)
- Rocky Mountain Family Practice & St. Vincent Medical Clinic (Leadville)
- Valley-Wide (Canon City)

Suicide Prevention

- Salud Family Health Center (Trinidad)

Psychopharmacology & Suicide Prevention

- Eads Medical Clinic (Eads)

Treating ADHD in Primary Care

- Eads Medical Clinic (Eads)

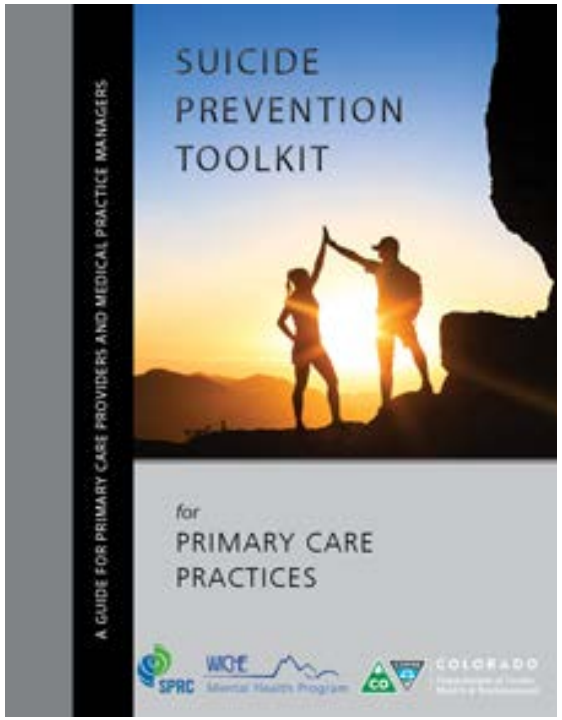
Treating Depression and Anxiety in Primary Care & Suicide Prevention

- Spanish Peaks Family Clinic (Walsenburg)
- La Veta Family Clinic (La Veta)

Suicide Prevention for Primary Care Clinics

WICHE
(Western Interstate Commission on Higher Education)

https://www.wiche.edu/mentalHealth/suicide-prevention-toolkits



Zero Suicide

https://zerosuicide.sprc.org/

END THE SILENCE END SUICIDE

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

beacon | Health COLORADO

How to contact C-PAC

Enrolled Clinics Call

1-855-758-9747

For a psychiatric consult or behavioral health referral assistance

To enroll in C-PAC contact:

Elizabeth.Richards@beaconhealthoptions.com

719-579-7897 (office)

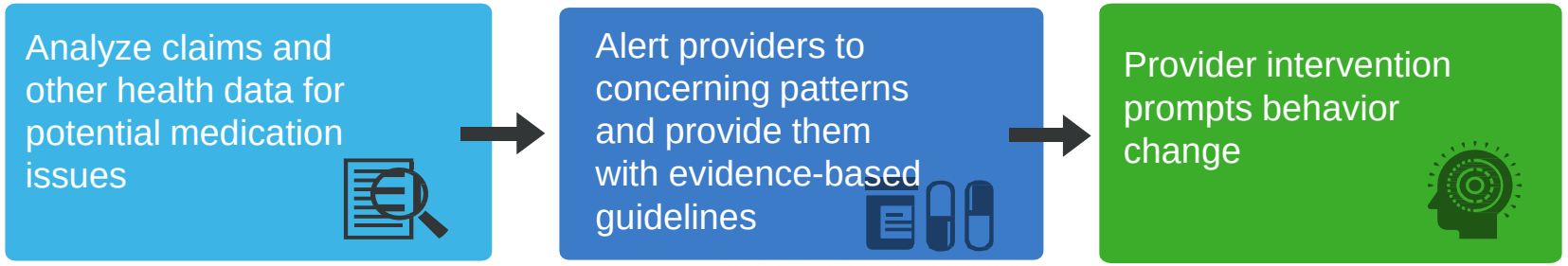
719-367-7164 (cell)

www.cpack.org

@CPACprogram (Facebook)

RxSolve

RxSolve Overview



RxSolve targets common and complex medication challenges such as:

- Polypharmacy
- Non-adherence
- Dosing efficacy
- Substance use disorder management
- Opioid use disorder
- Gaps in care & coordination of care between prescribers

RxSolve Analyzes:

- Psychotropics (adult, elderly and child)
- Benzodiazepines
- Opiates

RxSolve has sent 4 rounds of intervention letters to providers as of July 31st:

- Adult psychotropic: 1,061 letters
  - Including Elderly psychotropics
- Child psychotropic: 157 letters
- Opioid: 171 letters

- **Total of 1,389 letters sent**

RxSolve Monthly & Quarterly Provider Information Packets

- **Prescriber Summary Report** provides a list of patients who were flagged for Quality Indicators (QIs), helping prescribers see which practices fall outside the standard of care

- **Patient Profile Report** includes member-specific prescription claims history with flags for associated Quality Indicators, so providers can shape individual treatment

- **Clinical Considerations** are included for every flagged Quality Indicator, giving providers an educational overview of clinical issues and the evidence base

RxSolve Monthly & Quarterly Report Example

Opioid Prescription Intervention™

Patient Profile Report

02/22/2010

Patient Name: SMITH, JUDY
Patient DOB: 06/20/1965
Prescriber Name: John Jones, M.D.

Patient ID: 11122233
Patient Age: 43.8
Prescriber ID: 33322211

THREE MONTH PERIOD ENDING: March 2009

QUALITY INDICATOR™ SUMMARY - This patient has been flagged for the Quality Indicators™ listed below. Attached to this document are the Clinical Considerations™ for the relevant Quality Indicators™ which may be helpful in your treatment of this patient:

886 Multiple prescribers of Opioids without a malignant cancer diagnosis

RELEVANT DIAGNOSES – no relevant data

OPIOID, MUSCLE RELAXANT AND BENZODIAZEPINE MEDICATIONS DISPENSED OVER THE LAST 3 MONTHS:

RX Number	Prescriber	Label/Strength	Date Filled	Days	Qnty	Pharmacy Information	Associated Quality Indicators
4070449	John Jones, M.D.	HYDROCODONE BT-IBUPROFEN TAB	03/30/2009	20	40	CLIFTON PHARMACY 838-777-4949	
4561199	Frank Green	HYDROCODONE-APAP 5-325 TABLET	03/28/2009	2	12	CITY HOSPITAL 111-555-9999	
4561138	Michael White	HYDROCODONE-APAP 7.5-325 TAB	03/26/2009	3	16	CITY HOSPITAL 111-555-9999	
4070242	John Jones, M.D.	HYDROCODONE-APAP 5-500 TABLET	03/09/2009	20	40	CLIFTON PHARMACY 838-777-4949	
4448974	John Jones, M.D.	HYDROCODONE-APAP 5-325 TABLET	03/02/2009	20	40	GENERAL PHARMACY 699-353-5000	886
4070111	John Jones, M.D.	PROPOXYPHEN-APAP 100-650 MG TB	02/25/2009	15	30	CLIFTON PHARMACY 838-777-4949	
4070035	John Jones, M.D.	HYDROCODONE BT-IBUPROFEN TAB	02/18/2009	30	60	CLIFTON PHARMACY 838-777-4949	

RxSolve Clinical Consideration Letter Example

Use of an Opioid and a Muscle Relaxant for 60 or More Days

CLINICAL ISSUE

- Given that opioids are useful in the short term for most conditions, but not necessarily in the longer term, and that the same is true for muscle relaxants, the long-term use of both together may be a signal of possible abuse by patients.
- Muscle relaxants have some utility in the short-term. However, evidence to support chronic use is lacking. "The lack of high-quality evidence regarding this class of medications is concerning given their wide use" (Chou, 2004).
- Existing evidence suggests that analgesic efficacy, although initially good, is not always sustained during continuous and long-term opioid therapy (months to years)" (Ballantyne & Shin 2008).

The Table below lists the medications considered skeletal muscle relaxants for purposes of this Quality Indicator™. (Brand names are provided for ease of identification only and do not reflect a preference for one formulation over another.)

Generic Name	Brand Name
Baclofen	Lioresal®
Carisoprodol	Soma®
Chlorzoxazone	Parafon®
Cyclobenzaprine	Flexeril®
Dantrolene	Dantrium®
Metaxalone *	Skelaxin®
Methocarbamol	Robaxin®
Orphenadrine	Norflex®
Tizanidine	Zanaflex®

* - Not available as generic (all others in table are)

CLINICAL CONSIDERATIONS

- If you haven't already, please consider whether your patient needs to be on a muscle relaxant, Muscle relaxants have a limited, short-term role in pain management, and may be subject to abuse by patients.
- If your patient has neuropathic pain (such as diabetic neuropathy or multiple sclerosis), if you haven't already, please consider (Jackman 2008):
  - Non-pharmacologic options (such as cognitive behavioral therapy, exercise, physical therapy, relaxation)
  - Initial pharmacologic treatment with topical lidocaine, topical capsaicin, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors (venlafaxine, duloxetine), gabapentin or pregabalin;
  - proceeding to opioids if the preceding measures are insufficient.
- If your patient has musculoskeletal, inflammatory pain or pain from mechanical compression, if you haven't already, please consider (Jackman 2008):
  - Non-pharmacologic options (such as cognitive behavioral therapy, exercise, physical therapy, relaxation);
  - Initial pharmacologic treatment with non-opioid analgesics (acetaminophen, NSAIDs, salicylates);
  - proceeding to opioids if the preceding measures are insufficient.

REFERENCES

- Ballantyne JC, Shin NS: Efficacy of opioids for chronic pain – a review of the evidence. *Clin J Pain* 2008; 24(6):469-478.
- Chou R, Peterson K, Helfand M: Comparative efficacy and safety of skeletal muscle relaxants for spasticity and musculo-skeletal conditions: a systematic review. *J Pain Symptom Management* 2004; 28(2):140-175.
- See S, Ginzburg R: Skeletal Muscle Relaxants. *Pharmacotherapy* 2008; 28(2): 207-213.
- See S, Ginzburg R: Choosing a Skeletal Muscle Relaxant. *Am Fam Physician* 2008; 78(3):365-370.
- Chou R, Peterson K: *Drug Class Review on Skeletal Muscle Relaxants.* Oregon Evidence-based Practice Center, 2005: accessed at http://derp.ohsu.edu/final/SMR_Final_Report_Update%2023.pdf
- Jackman RP, Purvis JM, Mallett BS: Chronic nonmalignant pain in primary care. *Am Fam Physician* 2008; 78(10):1155-1162.

RxSolve Support for Providers who receive Information Packets

RxSolve Support for Providers who receive Information Packets

RxSolve clinical team consists of pharmacists, nurses, other clinical staff and a medical director who will provide clinical support via phone or email to a provider. This can include:

- Review of patient medications and current treatment plan
- Education on best clinical practices & evidenced based interventions
- Increased coordination of care with other prescribers

How to Contact RxSolve

1-877-591-2978 during the hours of 8 a.m. ET and 5 p.m. ET

RxSolve@beaconhealthoptions.com

Chapter

05

Health First Colorado Revalidation 2020

Revalidation 2020

Actions for Success:

Please log into the portal and *review/update:*

- Email address for point of contact/ provider is still correct
- Please start as early as you can once you receive an email announcing that it is your window to revalidate. Notification emails will go out in stages, so that not everyone is trying to revalidate at the same time.
  - This will help with getting an issues that come up resolved prior to time running out

- This process will be much easier than the previous revalidation process.

More to come from the Colorado Department of Health Care Policy & Financing (HCPF) in the fall of 2019

Chapter

06

Provider Relations Resources for Providers

Questions?

Thank You

Contact Us

888-502-4185

www.beaconhealthoptions.com | www.healthcoloradorae.com

healthcolorado@beaconhealthoptions.com

coproviderrelations@beaconhealthoptions.com

REGION 4 TOWN HALL- AUGUST 29, 2019

RESOURCE DOCUMENTS

Client Overutilization Program (COUP)

- **Fact Sheet**

Data Analytics Portal

- **Frequently Asked Questions**

https://www.colorado.gov/pacific/hcpf/health-first-colorado-data-analytics-portal-dap

C-PAC

- **Flyer**
- **Meet the C-PAC Administrative Staff**
- **Meet the C-PAC Psychiatric Consultants**

Join Us:

- **Training ~ Claims Overview**
- **Next Town Hall ~ October 24, 2019 in Pueblo**
- **Program Improvement Advisory Committee**

From Department of Health Care Policy and Financing (HCPF):

https://www.colorado.gov/hcpf/interchange-resources

- **Provider Web Portal Quick Guide- Verifying Member Eligibility and Co-Pay**

- **Provider Web Portal Quick Guide- Web Portal Registration**
- **Provider Maintenance-Provider Web Port Quick Guide:**

  Individual within a Group Provider Maintenance

  Group Provider Maintenance
- **Health First Colorado and CHP+ Provider Revalidation and Implementation of Colorado NPI Law**

COLORADO
Department of Health Care Policy & Financing

Client Overutilization Program

Accountable Care Collaborative Phase II May 31, 2019

Background

The goals of the Accountable Care Collaborative (ACC) are to improve client health and to reduce costs. To achieve these goals, the Regional Accountable Entities (RAEs) are expected to follow standard managed care practices, such as using data to monitor their clients' utilization of health care services and identifying opportunities for interventions.

Two populations that provide a clear opportunity for intervention are clients who have over/inappropriate utilization of the Emergency Department and/or pharmaceuticals. These use patterns are signals of individuals who may be struggling to properly manage their medical conditions and who could benefit from care coordination and other interventions. These patterns also can be indicators of individuals who are inappropriately utilizing health services and shopping for prescriptions such as opioids. Implementing interventions to support members in utilizing outpatient primary care and behavioral health services is a primary responsibility of the RAEs and can result in significant health improvements, lead to reduction in costs, and ensure appropriate provision of services.

For individuals who do not respond to interventions to reduce the inappropriate or over utilization of Pharmacy or Emergency Department services, the Department has authority under 42 CFR 440.230 (d) to implement utilization control procedures. The Client Overutilization Program (COUP) and COUP Lock-In are part of the Department's utilization control procedures.

Client Overutilization Program (COUP) Overview

The Client Overutilization Program (COUP) is a collaborative effort between the Department, the Regional Accountable Entities (RAEs), the Department's Utilization Management (UM) vendor, the Department's fiscal agent (Colorado interChange), the Department's Pharmacy Benefit Management System, Pharmacies enrolled in Colorado Medicaid, and the RAEs' contracted network of Primary Care Medical Providers (PCMPs) and behavioral health providers. Together they work to identify, outreach, and intervene with members who meet the Department's criteria for inappropriate

overutilization of health care services.

Following identification by the Department and initial communication by the UM vendor, the RAEs and their provider networks are responsible for reaching out to identified clients to assess the clients' needs, determine whether the client is inappropriately utilizing services, and to provide additional interventions, supports and/or restrictions to effectively manage the client's health and reduce unnecessary utilization of services. Clients who are determined by the RAE and the client's providers to have not demonstrated a positive change in utilization can be locked-in by the Department to one designated pharmacy, one PCMP, and a physician specialist. This is referred to as COUP Lock-In and prevents payment for services not delivered by or referred by the designated lock-in providers.

Criteria for Inappropriate Overutilization

COUP is designed for clients who fit within any of the following categories within a three-month period:

1. Client meets all the following criteria:
    - Use of six (6) or more high-risk prescriptions; and
    - Filled prescriptions from three (3) or more different pharmacies; and
    - Filled prescriptions from three (3) or more different prescribers.
2. Client had four (4) or more visits to the emergency department;
3. Client meets utilization criteria for **both** #1 (prescriptions) and #2 (emergency department).
4. Client has been identified by a RAE or PCMP based on a referral or care analysis indicating client's overutilization of services.

For COUP, the high-risk prescription categories are:

1. Opioids
2. Controlled non-opioid analgesics
3. Controlled muscle relaxants
4. Benzodiazepines
5. Controlled non-benzodiazepine sedative hypnotics
6. Barbiturates

Clients who meet any of the following conditions are excluded from the COUP prescription review as these conditions frequently warrant higher utilization of prescription therapies:

- Clients with a cancer diagnosis
- Client receiving palliative care (ICD-10 Z51.5)
- Part D dual eligible clients
- Other clients identified by the RAE as not being appropriate for this program

The RAEs are still expected to work with clients who meet any of the above conditions to maximize care coordination and medical management; however, these members should not be considered for COUP Lock-In.

COUP Operational Process

1. Each quarter, the Department's Data Analytics Section (DAS) performs claims analysis utilizing the COUP criteria to identify a list of clients who may be inappropriately utilizing services for at least one quarter. (NOTE: the Department is working to transition this analysis to the UM vendor.)

2. Department staff review the COUP client list and send a specified client file to each RAE by the end of the second full week of each state fiscal quarter.

3. At the same time, the list of COUP clients is sent to the UM vendor who distributes letters to the clients recommending they contact their PCMP and RAE for care coordination support to help reduce their utilization. The PCMP and RAE contact information is included in the letter.

4. Each RAE receives a quarterly client list and collaborates with their provider network to perform the following during the activity period;

    a. Outreach clients on the list or ensure that the RAE or the RAE's provider network already have appropriate supports and care plans in place for the client.

    b. Work with client to identify and implement individualized interventions.

    c. Support providers in delivering interventions for clients.

    d. Monitor client engagement in interventions and utilization of services.

    e. Assess whether clients are actively engaging in interventions and more appropriate types of care.

    f. Assess whether interventions being utilized are producing the desired results and reducing inappropriate utilization of services.

5. RAE submits to the Department the quarterly COUP Report describing the previous quarter's activities.

6. RAEs and their providers perform a clinical review to determine which clients have not been effectively engaging in care and would benefit from being locked-in to a single PCMP and single pharmacy.

a. For clients determined for COUP Lock-In:

i. RAEs work with the clients' PCMPs to determine whether they are able and willing to serve as the client's COUP Lock-In provider.

ii. If a PCMP is not able or willing to serve as a COUP Lock-In provider for one of their clients, the RAE will work with their PCMP network to find an appropriate PCMP who is able to serve the client in this function.

iii. RAEs develop a list of clients they want to request for the COUP Lock-In program, along with provider names and billing IDs for the PCMP, pharmacy, and physician specialist (if appropriate) that have agreed to serve as the client's COUP Lock-In providers.

7. RAEs submit list to the Department of clients they have determined would benefit from COUP Lock-In and the provider names and billing IDs of the PCMP, pharmacy, and physician specialist (if appropriate) who have agreed to serve the client.

8. Department updates Colorado interChange client record:

a. PCMP and RAE Enrollment

i. Department will end date any current enrollment spans for the member and create a new PCMP and RAE enrollment span using the enrollment start reason code of "COUP."

ii. New COUP Lock-In enrollments will be communicated to the RAE's through:

1. List from ACC staff of processed enrollments

2. Client enrollment start reason codes, including the "COUP" reason code, are scheduled to be transmitted on the daily and monthly 834 files beginning in the fall of 2019.

b. COUP Lock-In Assignment

i. The client's record is modified to reflect inclusion in a Lock-In medical and/or pharmacy assignment plan. This will restrict the client's ability to access outpatient services and prescriptions from any provider other than those identified within the Lock-in Assignment.

9. ACC COUP Specialist sends information on clients enrolled into COUP Lock-In to

the UM vendor for mailing formal letter to the client notifying the client of their status and rights.

10. RAEs provide support to COUP Lock-In PCMPs and Pharmacies as required to support successful client care and prevent overburdening of providers.

11. RAEs, in collaboration with their provider network, engage COUP Lock-In clients to educate them about the program and what it means for their health care services.

12. RAEs and their network providers deliver care coordination and other interventions to COUP Lock-In clients for a period of 12 months or until such time as the client is stabilized and is determined to be appropriately utilizing services over a few months.

13. RAEs and PCMPs monitor COUP Lock-In clients' ongoing utilization and modify interventions to help achieve more appropriate service utilization patterns.

14. When a client is determined to be stable and appropriately utilizing services for at least one quarter or longer, the RAE can request the Department to remove the client from COUP Lock-In.

15. Upon request from the RAE to remove a client from COUP Lock-In, the Department will remove the client's Lock-in Assignment plan and update the client's PCMP and RAE enrollment start reason codes to no longer reflect COUP Lock-in enrollment.

16. ACC COUP Specialist sends information on clients disenrolled from COUP Lock-In to the UM vendor for mailing a letter to the client notifying them that they are no longer in COUP Lock-In.

17. RAEs will continue to monitor utilization for client's removed from COUP Lock-In on a regular basis in order to identify those who show signs of increases in inappropriate utilization.

    a. RAEs and their provider network will provide ongoing care coordination and interventions to prevent clients from being re-enrolled into COUP Lock-In.

Lock-In PCMP and Pharmacy

A Lock-In PCMP and Pharmacy will serve as the primary source of outpatient care for the client. RAEs and the Lock-In PCMP can also identify additional physician specialists who are regularly involved in a client's care for inclusion in the client's COUP Lock-In assignment plan. For any non-emergency services, clients will be restricted to receiving

care and filling prescriptions from only those providers and pharmacies identified in the COUP Lock-In assignment plan within Colorado interChange and Pharmacy Benefit Management System.

COUP Lock-In assignment providers may refer clients to a physician specialist for consultation or short-term episodes of care. For the new physician to receive reimbursement, the physician will need to enter the referring Lock-In provider's name and billing ID in the Referring Physician block on the claim. If a physician specialist will be providing ongoing treatment for the client, the RAE may consider requesting that the physician specialist be added to the client's COUP Lock-In assignment plan.

Providers not named on the COUP Lock-In assignment plan or referred by a provider on the COUP Lock-In assignment plan will not receive payment for any non-emergency services provided.

The RAEs are responsible for identifying PCMPs and pharmacies within their region who have the resources to provide supports and interventions for complex clients who are inappropriately utilizing pharmaceuticals and/or the emergency department. A PCMP and a pharmacy both need to be willing to work with complex clients who may actively resist having any restrictions placed on how they access services.

The RAEs are expected to provide additional supports to PCMPs and pharmacies that agree to serve as a Lock-In provider for a client. These additional supports could include additional utilization data, data analytics training, programmatic interventions, care coordination assistance, and even additional financial support to manage the complex needs of many of these clients. The RAEs have the flexibility to design their program in a way most likely to improve member health and reduce inappropriate utilization.

Client Appeals Rights

Clients who are placed in COUP Lock-In have the right to appeal the decision to be locked into one PCMP and pharmacy. Clients must ask for a hearing with an Administrative Law Judge by submitting an appeal to the Office of Administrative Courts. Information on how a client can submit an appeal is included on the back of the COUP Lock-In letter that is sent by the UM vendor to the client. The RAEs shall assist clients in completing forms and other procedural steps in the appeals process.

How to Identify Clients in COUP Lock-In

Providers are able to view whether or not a client is in COUP Lock-In through the Eligibility Verification response on the Provider Portal. If a client has been placed in COUP Lock-In, the Lock-In Details panel will identify the client's Lock-In assignments, including PCMP, physician specialist, and pharmacy. For instructions on performing

eligibility verification and accessing the Lock-In Details panel, see the Verifying Member Eligibility and Co-Pay Quick Guide.

Frequently Asked Questions

What is the criteria for members who are appropriate for COUP Lock-In?

Clients who meet the Department's criteria for inappropriate utilization for two (2) consecutive quarters and are not responsive to efforts by the RAE and/or PCMP to engage in care coordination and medical management.

Who ultimately determines whether a client will be locked-in to a provider and/or pharmacy?

Each RAE determines which clients will be referred to the Department to be locked-in to a medical or pharmacy provider.

If a client is determined for COUP Lock-In, but their current PCMP is not a Lock-In provider, will HCPF reattribute those members?

The Department expects that each RAE will identify a Lock-In provider that can meet the needs of the client. A RAE should attempt to contract the client's PCMP as a Lock-In Provider to ensure continuity of care. If the client's PCMP does not want to become a Lock-In provider, then the RAE should find another appropriate and willing Lock-In provider for that member.

Will COUP Lock-In restrict a client's access to other services?

COUP Lock-In is designed to help clients identify and utilize their care team appropriately. The RAEs and the Lock-In PCMP can also identify additional physician specialists who are regularly involved in a client's care for inclusion in the client's COUP Lock-In assignment plan.

COUP Lock-In assignment providers may refer clients to a physician specialist for consultation or short-term episodes of care. For the new physician to receive reimbursement, the physician will need to enter the referring Lock-In provider's name and billing ID in the Referring Physician block on the claim. If a physician specialist will be providing ongoing treatment for the client, the RAE should request that the physician specialist be added to the client's COUP Lock-In assignment plan.

Providers not named on the COUP Lock-In assignment plan or referred by a provider on the COUP Lock-In assignment plan will not receive payment for any non-emergency services provided.

COLORADO
Department of Health Care Policy & Financing

Health First Colorado Data Analytics Portal Frequently Asked Questions

Revised: March 2019

What is the purpose of the Data Analytics Portal?

To support the Accountable Care Collaborative's (ACC's) goal of improving member health and reducing costs, the Department has contracted with IBM Watson Health (formerly Truven) to host the Data Analytics Portal (DAP), which replaces the former Statewide Data and Analytics Contractor (SDAC). This data analytics tool for Primary Care Medical Providers (PCMPs) and Regional Accountable Entities (RAEs) includes population and performance information. The portal allows for drill downs and drill ups, data exports, and provider-level comparisons.

Can PCMPs look at their whole organization in aggregate?

This not currently a function of the Data Analytics Portal; however, the Department recognizes that this could prove a useful tool for providers and is prioritizing this work. First priority, is to get the Data Analytics Portal enhancements completed. The Department's next step will be to identify a test group and work out the details to use this function and then roll it out to other providers.

How does the My Members report in the Data Analytics Portal compare with the other reports PCMPs might receive from their RAE?

The My Members report is updated the second Tuesday of each month. The RAE roster report is updated by the 6th of each month. The monthly 834 report is generated on the last business day of the month and delivered within two business days of generation. The RAEs will have the most current and accurate snapshot from what they get through interChange (DXC Technology) throughout the month.

The My Members report provides a comprehensive and user-friendly way to filter, sort, and drill down to Member specific information.

How do PCMPs get their attribution?

The My Members report gives users a snapshot of Members at beginning of the month. Providers can work with their RAEs to get more up to date and current information throughout the month.

What is the timing of Key Performance Indicators (KPIs)?

KPIs run on a monthly basis looking at utilization for the past 12 months. Because KPIs also require three (3) months of claims run out, they are presented in the portal four (4) months after the last service dates. This run out period is very important to gain accurate data and ensure that KPI measures are correct. More information about the KPI methodology is available on the Department's Public Reporting website.

What trainings are offered?

The following DAP enhancements trainings are live for March.

Friday 3/8 9AM-RAE/12PM-PCMP
Monday 3/11 9AM-RAE/12PM-PCMP (repeat)
Monday 3/18 9AM-RAE/12PM-PCMP (repeat)
Monday 3/25 9AM-RAE/12PM-PCMP (repeat)

Join your chosen training session using the following information:
Webinar link: https://ibm.webex.com/join/joseph.tedder
Join by phone: 1-669-234-1178
Access code: 927 651 015

The user guide and .pdf of training materials will be available under the file sharing tab of the provider portal once it is live on 3/12/19. A copy can also be requested by email. Please contact Sara Haynes at Sara.Haynes@state.co.us with any questions or if you would like a copy.

IBM offers two different person-led training sessions, one for RAEs and one for PCMPs, once a month. IBM runs a query every month to identify any users that were newly provisioned since the last training session. These newly provisioned users will be invited to future training sessions.

IBM will be providing an E-learning training session available to RAEs and PCMPs for ongoing training sometime in early April.

Why does data differ from the Data Analytics Portal and a practice's Electronic Health Record (EHR)?

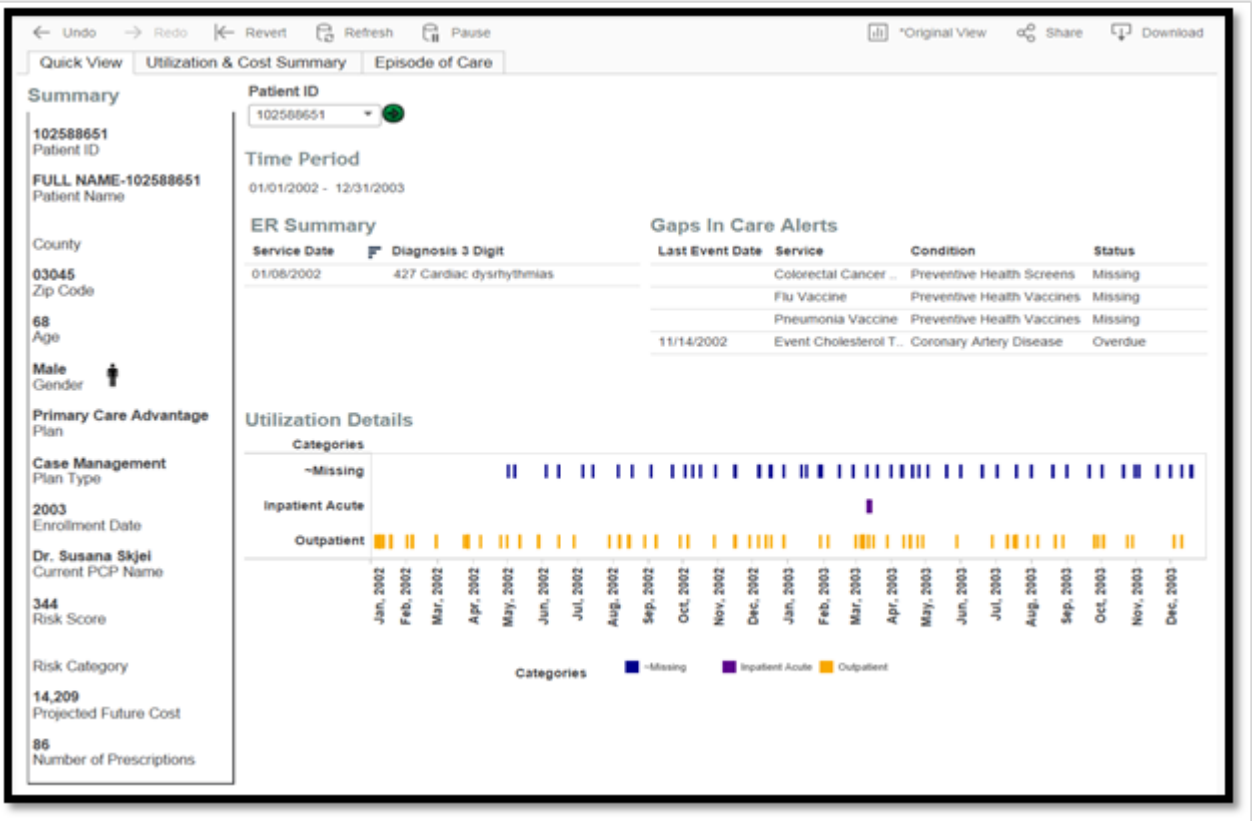
The Data Analytics Portal and practice EHRs will never reconcile. They work with different populations and systems which prevents the data from matching up. The Data Analytics Portal looks only at the Medicaid population, and calculates KPIs using claims from the past 12 months, allowing for a three (3) month lookback. EHRs are entered in real-time by providers, and captures records from patients across all payers.

When is the Data Analytics Portal refreshed?

The portal is refreshed by the 12th of each month (usually by the second Tuesday of the month).

What is the Patient Health Record?

The Patient Health Record provides the user with Member-specific information, including quick view (quick summary view), utilization & cost summary, and episode of care. Please refer to the screenshot below for more detail. It does not show lab results at this time.



Will the Alternative Payment Model (APM) be included in the Data Analytics Portal?

The portal does not currently include APM.

How does ER summary connect with ADT Feed?

There is no connection between the ER summary and the ADT Feed.

DXC is allowing a longer period to enter claims. Will this affect KPI incentives?

Although DXC is allowing a longer period to entire claims, providers will still need to enter claims in a timely manner to meet the requirements to receive incentives.

According to KPI Methodology:
“Incentive Payments are a central component of the ACC Pay-for-Performance. Since the initiation of the ACC Program, the Department has made incentive payments for performance on identified Key Performance Indicators (KPIs) to signal program-level goals and objectives; encourage improved

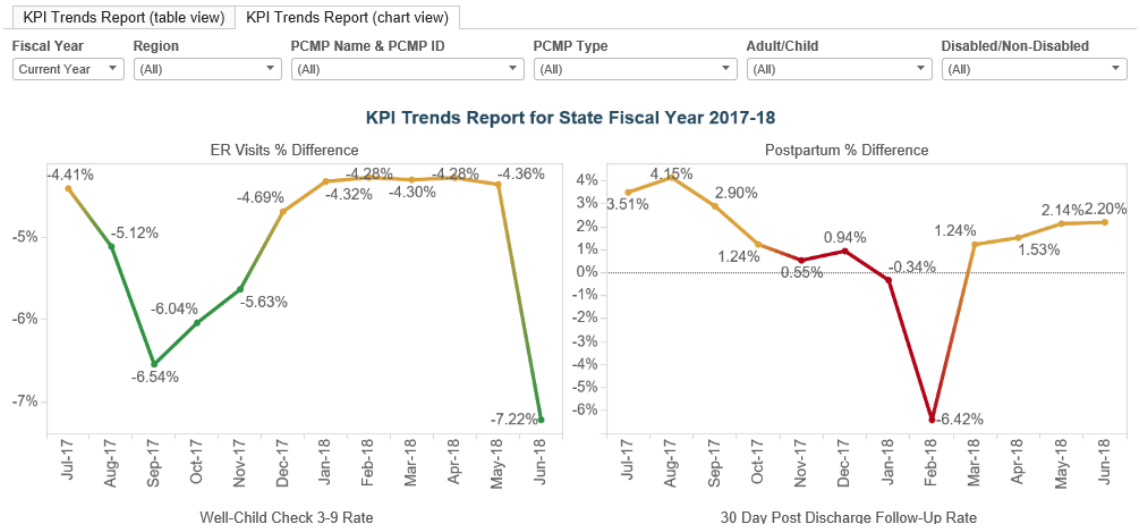
performance at the PCMP and regional level; and reward managed care entities and PCMPs for meeting certain levels of performance. Incentive Payments are a central component of the ACC Pay-for-Performance."

Is there an option to filter data by provider type and region to compare performance?

Yes, users can filter data by provider type and region. There are currently eight filters that users can apply to drill down to specific populations and the update will add Member County, Member Zip, Aggregated Diagnostic Cost Grouper (ADCG) Category, Concurrent Relative Risk Score, ER Visits, Eligible for Well-Child Check, Well-Child Checks, and dual Medicaid/Medicare (MMP) Enrolled. After downloading the report, users will have access to 34 fields. More filters will be added in the next design rollout.

Can users look at past months of data?

Results are for the 12-month evaluation period. There is the capability to review the previous fiscal year. The KPI trends report, shown in the screenshot below, is a useful tool to view past data.

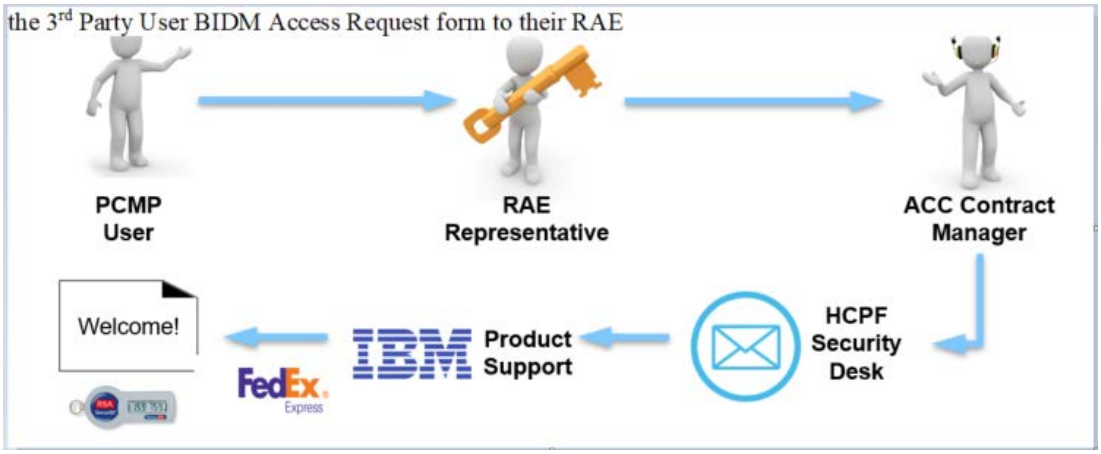


How is the risk score calculated?

The risk score is calculated using IBM/Truven's Diagnostic Cost Groups (DCG). Like all risk scores, the exact methodology is proprietary to the vendor. Please refer to the KPI Methodology specifications document for more information.

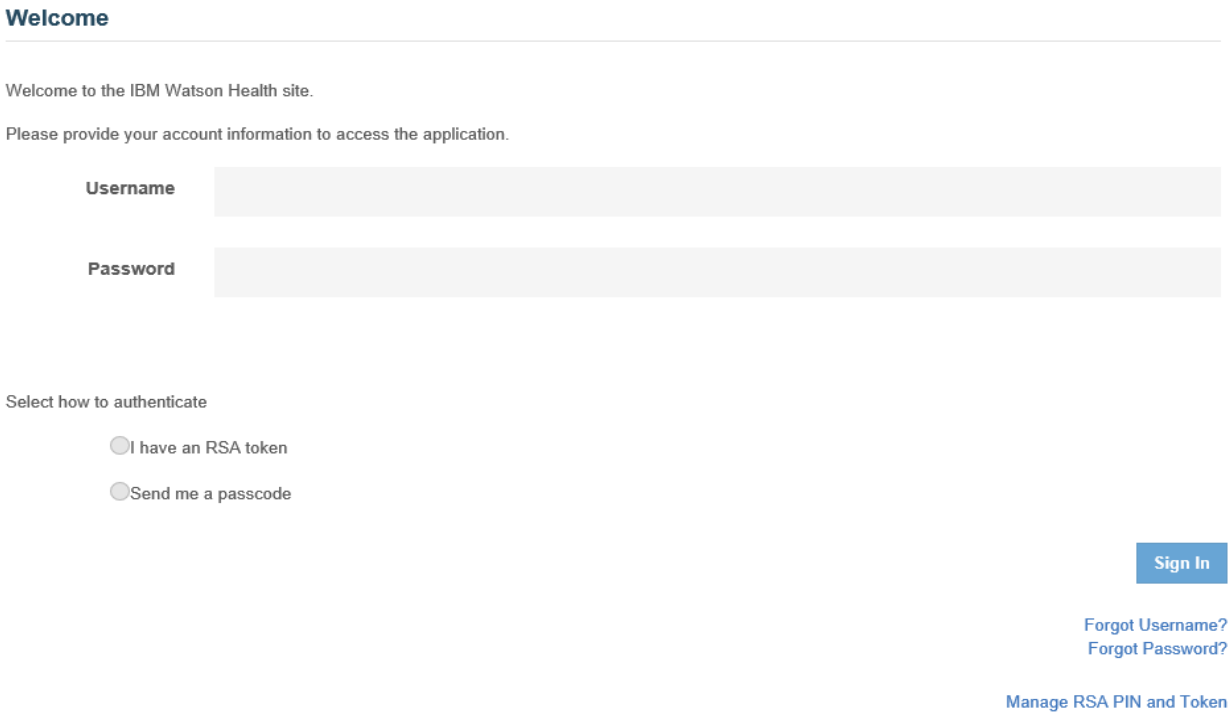
What is the process and status for provisioning (gaining access)?

To ensure the security of our members, the provisioning process is approved by several State authorities before going to IBM for final approval. The process for PCMP provisioning is shown below. The process is the same for the RAEs except they do not have to do the first step.



- PCMP requests the 3rd Party User BIDM Access Request form from RAE.
- PCMP completes form in its entirety. Failure to do so could cause delays in the provisioning process.
- PCMP user submits the completed 3rd Party User BIDM Access Request form back to their RAE.
- RAE approving authority signs the form where appropriate and sends it to HCPF program staff.
- Program staff reviews the form, signs it, and then submits it to HCPF Information Security.
- HCPF Information Security creates a ticket with IBM to create or modify access.

IBM product support analysts grant access and send the fob, used for two-factor authentication, as needed. Additionally, PCMPs now have the option to have a passcode sent instead of using the fob. This functionality is not yet available to RAE or Department users. Provisioning should not take more than two (2) weeks. Please contact your RAE if you have not been provisioned in a timely manner. IBM and the Department meet weekly to review outstanding tickets and issues to ensure these tickets are expeditated.



C-PAC

Colorado Psychiatric Access & Consultation for Adults and Kids

www.cpack.org

Colorado Psychiatric Access & Consultation

For a FREE non-crisis psychiatric consult

(Monday-Friday, 8am-5pm)

or for

Behavioral Health Referral/Care Coordination Assistance

Please call

1-855-758-9747

****Phone number is for PCP's (and clinic staff) only. Please do not give to patients/families****

C-PAC will facilitate your phone consult with a Psychiatric Consultant in approximately 30 minutes or less

***For ALL patients regardless of age or payer source/insurance**

***Call with ANY question regarding psychiatric medication, side effects, dosing, diagnosis review and/or for treatment recommendations**

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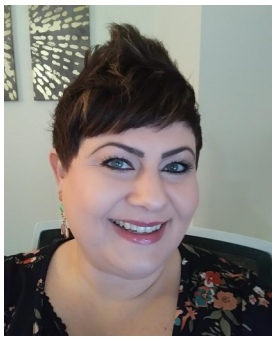
Meet the C-PAC Administrative Staff



Elizabeth Richards, MSW, LCSW, C-PAC Program Supervisor

Elizabeth is a Licensed Clinical Social Worker with 17+ years of experience in healthcare and behavioral health treatment for children and adults. She is a graduate of Colorado State University with a Master's Degree in Social Work. Elizabeth has provided leadership to various medical and behavioral health programs in Southern Colorado in addition to providing clinical services in out-patient and crisis settings. Elizabeth has special interests in human rights and healthcare reform. She is passionate about suicide prevention and is the *Zero Suicide* program champion and team leader at Beacon Health Options. Elizabeth is committed to serving the residents of Colorado, reducing the stigma related to behavioral health treatment and increasing access to care.

Amy Annett, MA, Registered Psychotherapist, C-PAC Care Manager

Amy has worked in the field of behavioral health and substance abuse for over 20 years as a care manager, utilization review manager, and a behavioral health coach. She moved from New Mexico to Colorado a few years ago and loves exploring the state. Amy graduated from Webster University with a Master's Degree in Counseling and is working on completing her Ph.D. in Industrial & Organization Psychology. She enjoys spending time with her husband, son, and fur babies. Amy is committed to helping the residents of Colorado achieve their fullest potential through improved access to services.

Stacey Crowl, C-PAC Program Clinical Assistant

Stacey has provided invaluable administrative support to the C-PAC team since 2016. She prides herself on providing excellent customer service to her team, customers, PCP offices and patients. She believes in Beacon Health's mission to help individuals live their lives to their fullest potential. Stacey is a native of Colorado and enjoys its beauty and the many adventures it has to offer.

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For more info on how to enroll in C-PAC, call (719) 579-7897 or send an email to: CPAC@beaconhealthoptions.com

C-PAC

Colorado Psychiatric Access & Consultation for Adults and Kids

www.cpack.org

Meet the C-PAC Psychiatric Consultants

Dr. Fred Michel, M.D. is dually board certified in Adult and Child/Adolescent Psychiatry. He is the Chief Medical Officer for Summitstone Health Partners in Ft. Collins and provides corporate leadership direction, clinical oversight as well as a variety of direct consultation, evaluation, and psychopharmacological management services to adult and child patients. Dr. Michel presents nationally on child and adolescent mental health issues and has special interests in healthcare reform, integrated care strategies, emerging healthcare technologies, meaningful use and EMR optimization for behavioral health settings.

Dr. Andrew A. Halpern, D.O. is a Child & Adult Psychiatrist and Diplomate of the American Board of Psychiatry and Neurology, Inc. Dr. Halpern currently serves as a staff psychiatrist at Centennial Mental Health Center providing much needed support to northeast Colorado. In addition, he provides consultation and on-call psychiatric services for *The Jefferson Center for Mental Health* and *Rite of Passage*. Dr. Halpern formerly served as a Staff Child & Adult Psychiatrist at *Highlands Behavioral Health, The Medical Center of Aurora*, *New Vistas/Jefferson Hills*, *Community Reach Center*, and *North Range Behavioral Health* and has provided school-based psychiatric services for the *Adams 12* school district.

Dr. Ronald Rabin, M.D. received his medical school and psychiatric residency training at the University of Cincinnati. After serving two years in the army, at Fitzsimmons Army Medical Center, he went on to direct the psychiatric inpatient unit at *Children's Hospital*. Later he served as medical director of the children's and adolescent programs at Bethesda Hospital. Currently, Dr. Rabin is in private practice and serves on the clinical faculty of the division of Child and Adolescent Psychiatry at CU Denver.

Dr. Cristi Bundukamara, Ed.D, PMHNP-BC, is a board certified psychiatric nurse practitioner with over 20 years of experience in treating acute and chronic mental illness across the lifespan. She is well versed in neuropsychiatry, developmental disorders, children with special needs and alternative medicine. Dr. Bundukamara is an officer in the United States Naval Reserves and has extensive experience in treating active duty service members and veterans with PTSD. She is a clinical Professor with the University of Colorado, Regis University, Colorado State University and a former Associate Senior Professor at Miami Dade College. Dr. Bundukamara is a published author and developer of a copyrighted cognitive behavioral technique which she uses in her private practice.

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JOIN US FOR A TRAINING ~ CLAIMS OVERVIEW

Friday

September 13, 2019

12:00 pm -1:00 pm

Via Zoom

Join Zoom Meeting

https://beaconhealthoptions.zoom.us/j/212167604

669-900-6833

Meeting ID 212 167 604

Region 4: Town Hall Meeting

Thursday • October 24, 2019

Pueblo City-County Public Library- Rawlings (Main Branch)

Rawlings Ryals Special Events Room -4th Floor

100 E. Abriendo Ave., Pueblo CO 81004

All Providers (PCP and Behavioral Health)
11:00 am – 1:00 pm

Provider Relations invites you to the Town Hall Meeting. Light refreshments will be available.

Please RSVP so we know who many of our providers will be attending.

https://www.surveymonkey.com/r/Region4TownHallOct242019

For your convenience, you can also join via Zoom, on the day of the Town Hall, please click the link below to join the Town Hall live on-line.

https://beaconhealthoptions.zoom.us/j/7138548191

If you have questions about how to register, please call 800-804-5008 or email: coproviderrelations@beaconhealthoptions.com

COLORADO
Department of Health Care Policy & Financing

Provider Maintenance - Provider Web Portal Quick Guide:

Individual within a Group Provider Maintenance – Provider Web Portal Quick Guide

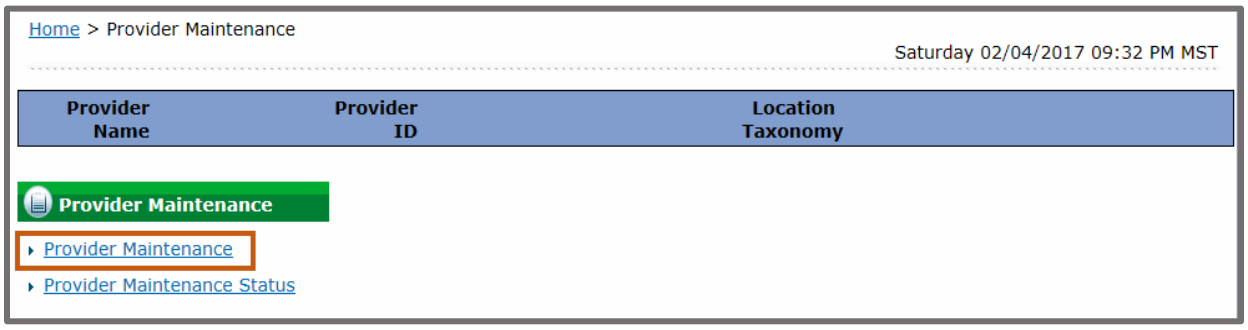
Provider Maintenance is where a provider updates information, including:

- **Provider affiliations**
- Provider Specialty and additional taxonomies
- **Contact information (including who gets the emails for a provider)**
- **Opt-out of the Provider Directory**
- License and board certification information and updates
- Insurance information
- Network Participation
- Disclosure information
- ACC opt-in changes

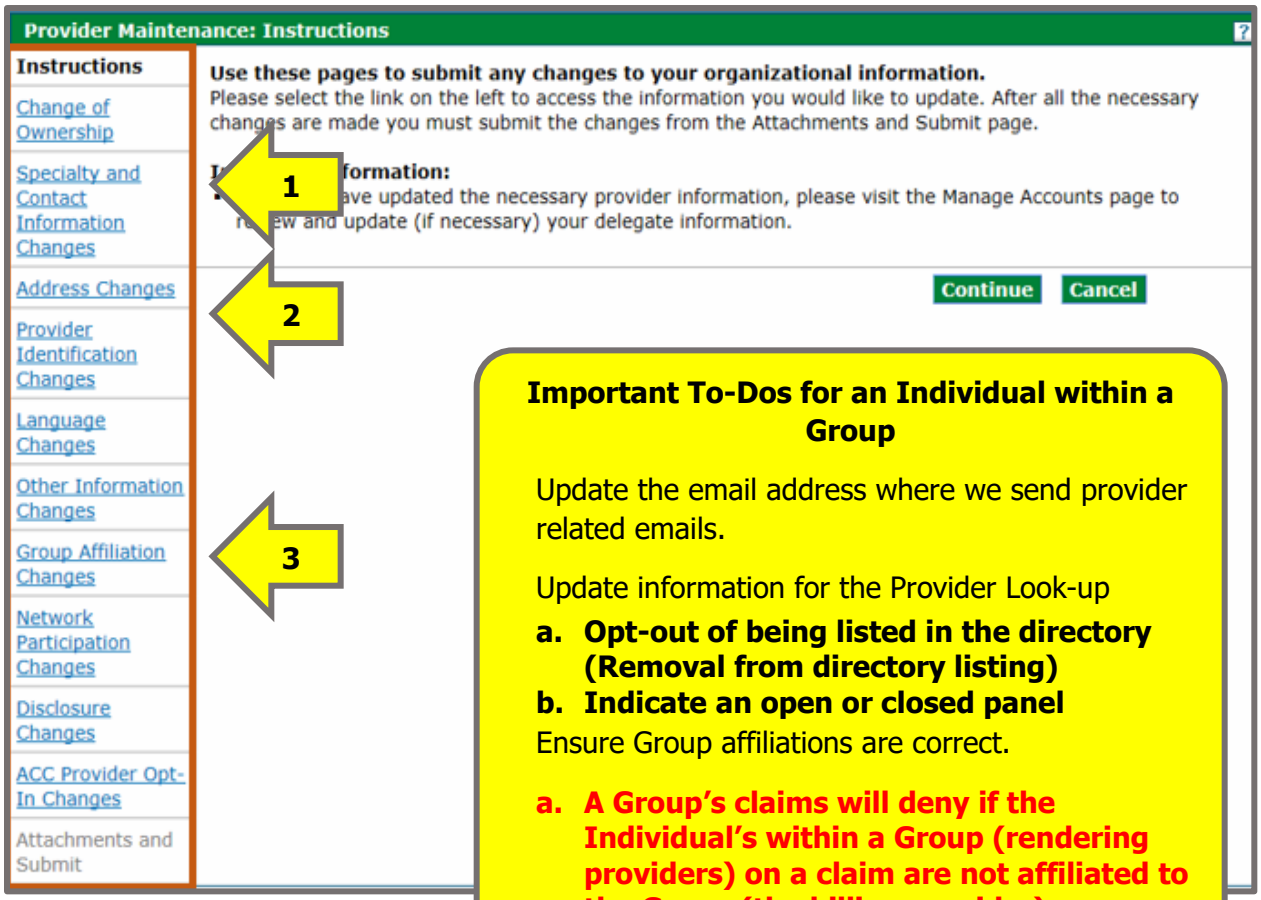
1. Login to Provider Web Portal

2. Click Provider Maintenance

3. Click Provider Maintenance again



4. Click the links on the left-hand side of the screen to jump to that area, or just click Continue



Important To-Dos for an Individual within a Group

Update the email address where we send provider related emails.

Update information for the Provider Look-up

a. **Opt-out of being listed in the directory (Removal from directory listing)**
b. **Indicate an open or closed panel**

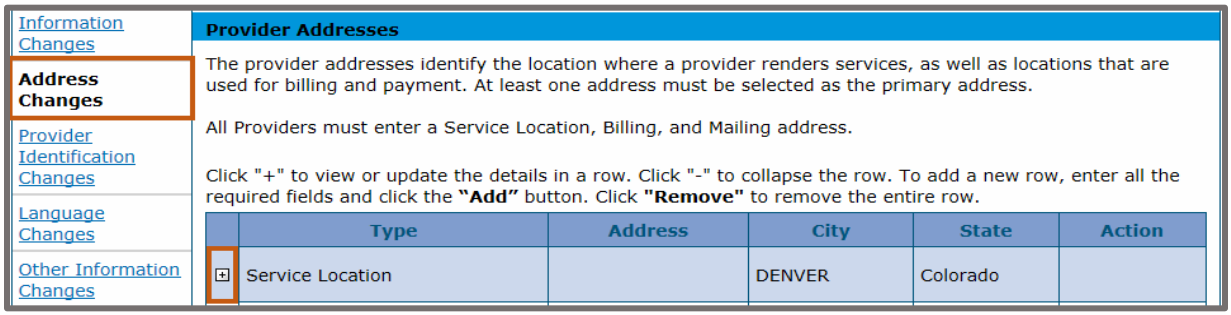
Ensure Group affiliations are correct.

a. **A Group's claims will deny if the Individual's within a Group (rendering providers) on a claim are not affiliated to the Group (the billing provider).**
b. **If the Group Affiliation Changes link does not show, updated affiliation information is not required.**

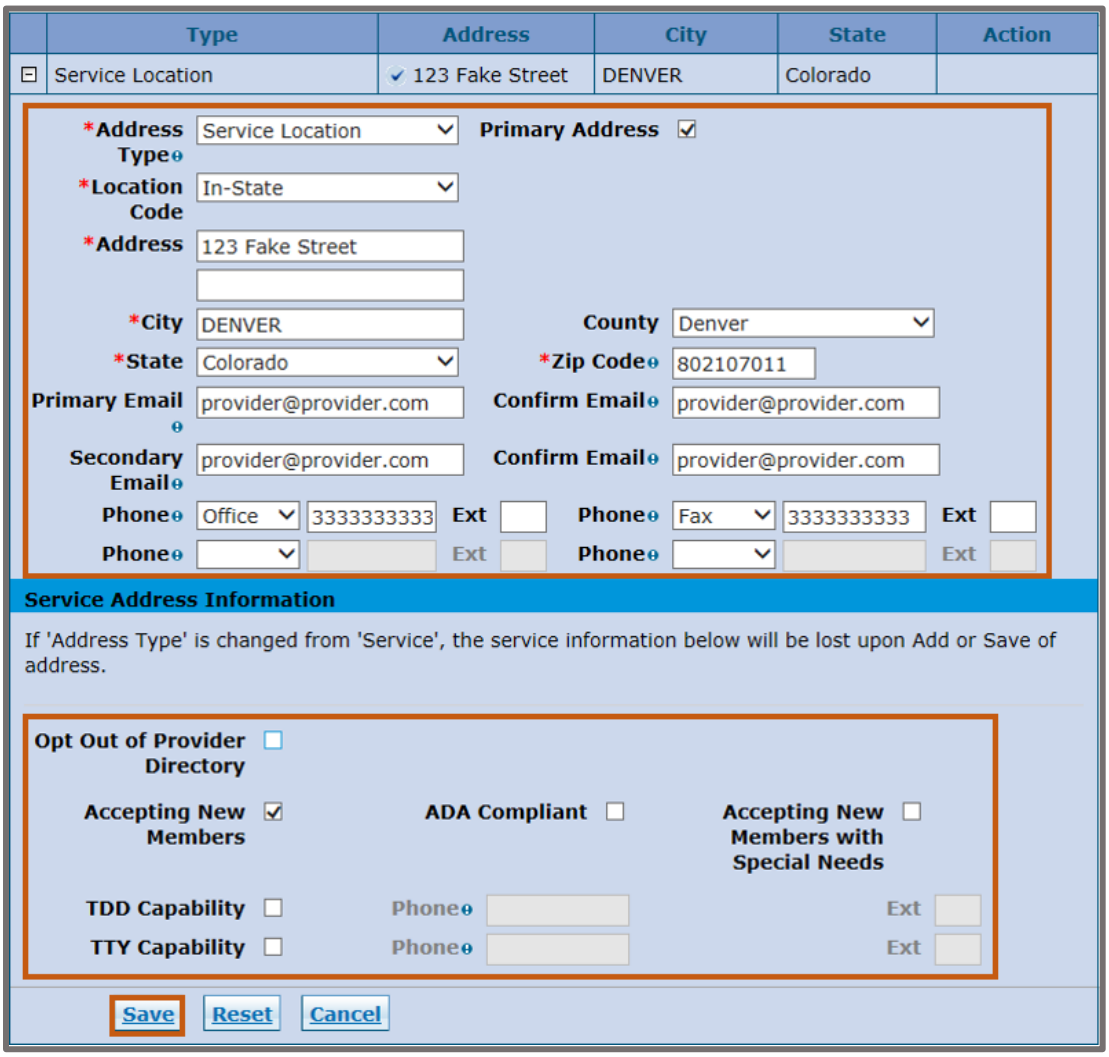
5. Changing an address, opting-out of being listed in the Provider Directory, or to indicate an open/closed panel

Click Address Changes, then click on the + next to the address being changed.

Opt-out of Provider Directory & changing the panel can only be done in the Service Location.



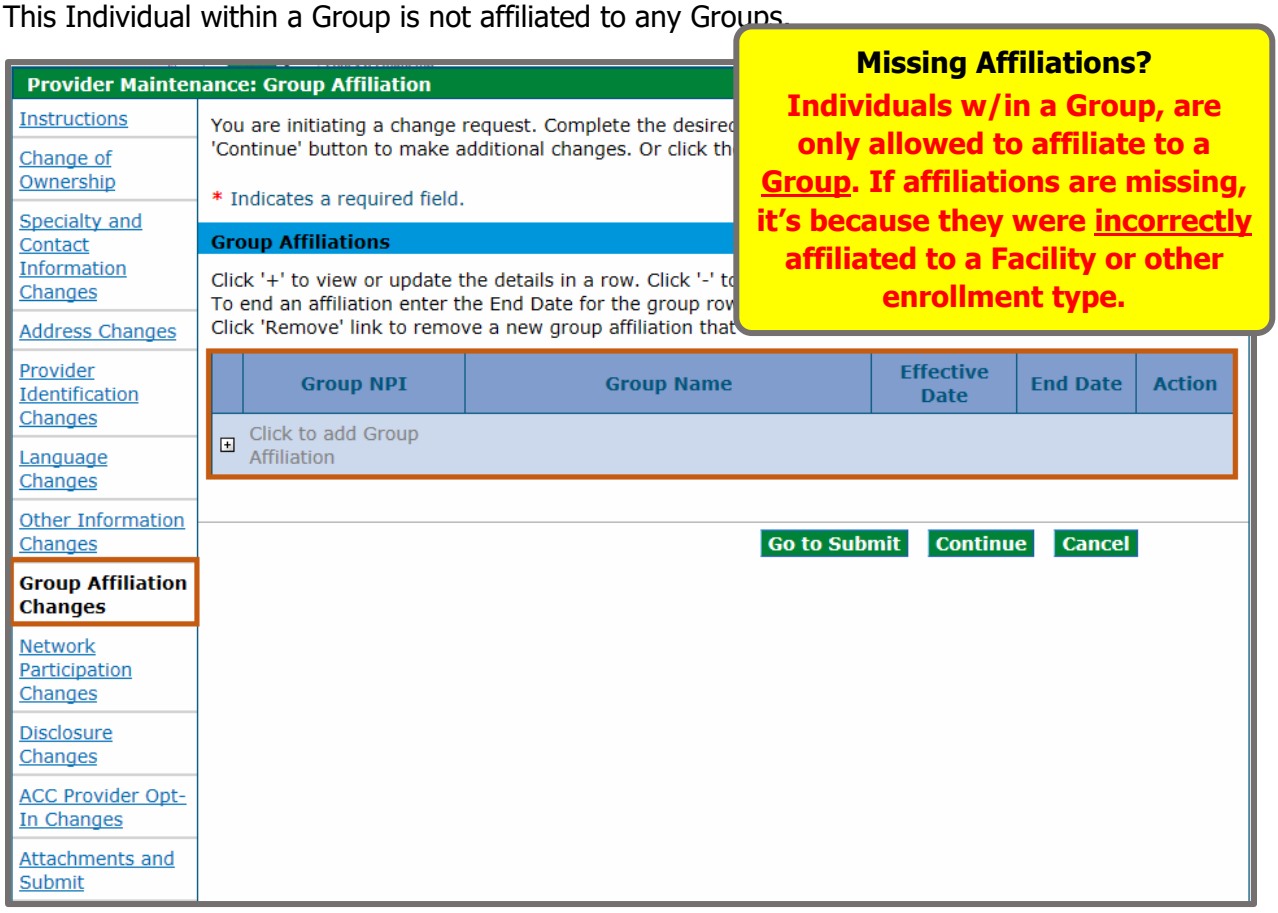
Edit the address information, check or uncheck the applicable checkboxes, & click Save.



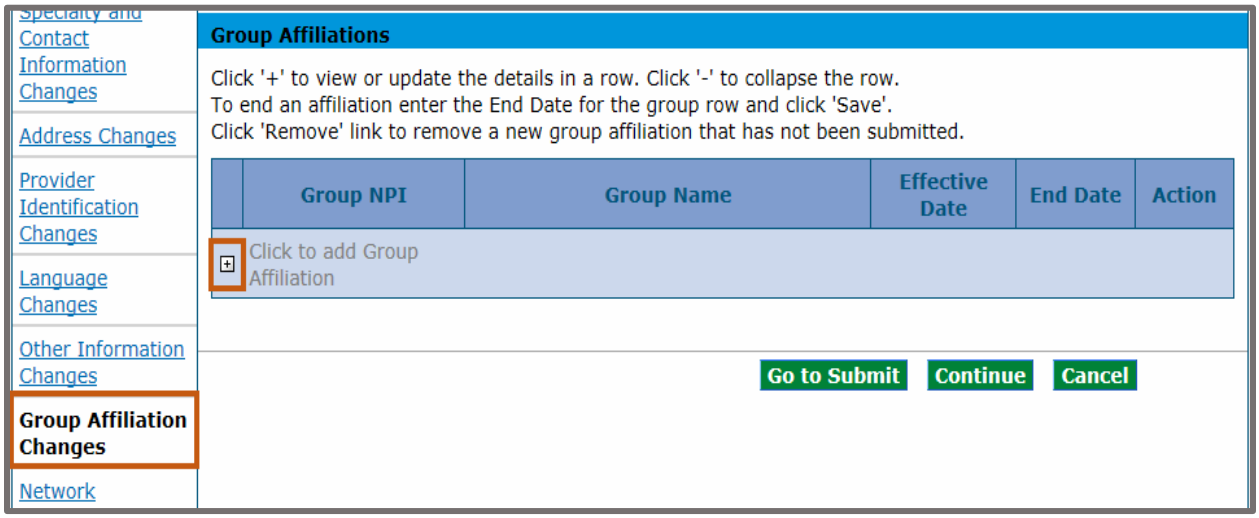
6. See all of the Groups an individual is affiliated to

Click Group Affiliation Changes

This Individual within a Group is not affiliated to any Groups

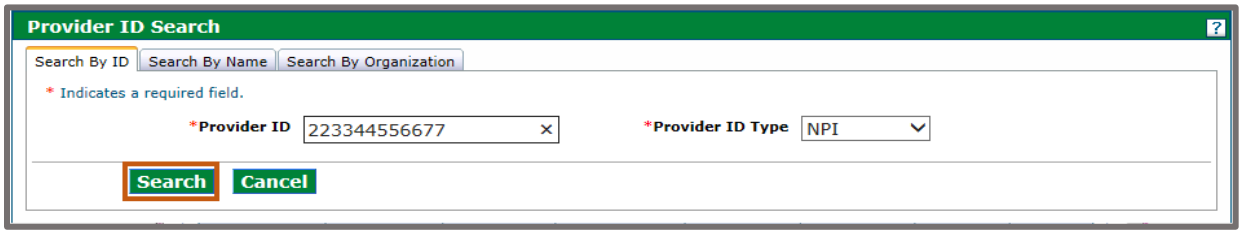


To add a Group affiliation, click the + next to Click to add Group Affiliation

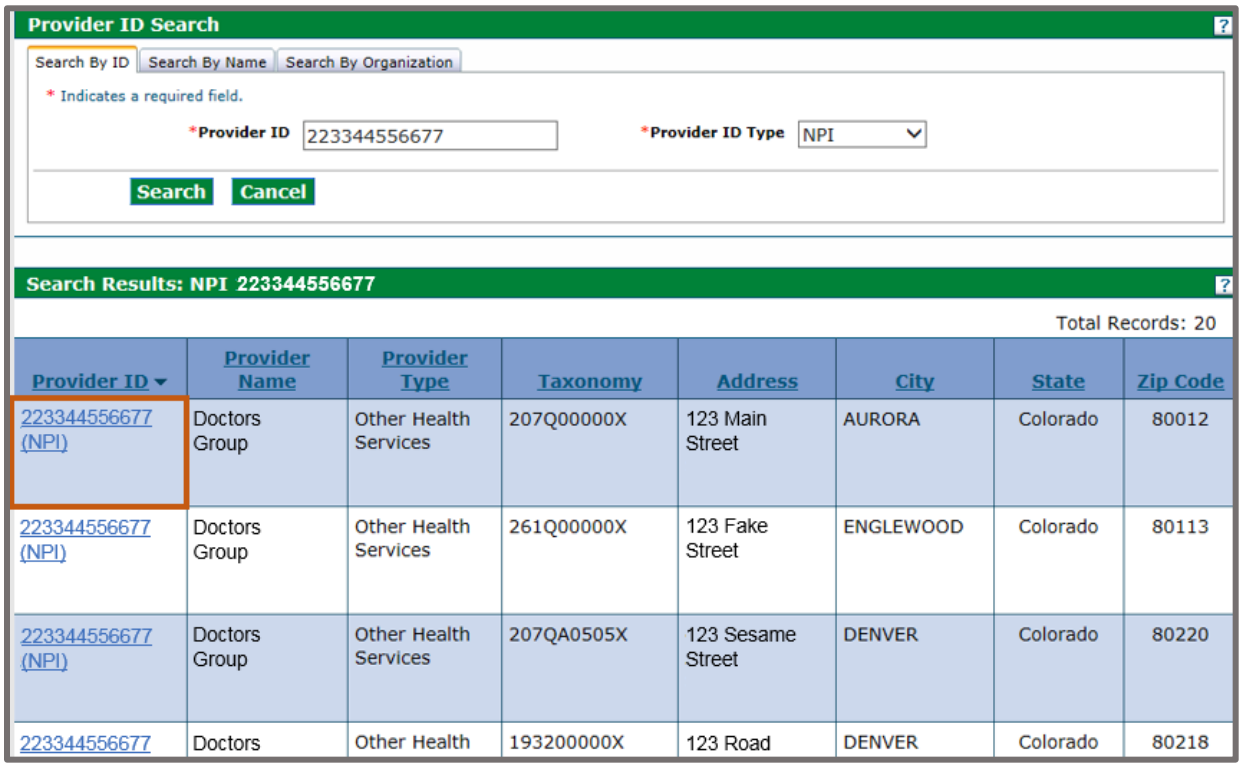


Click the magnifying glass to search for a provider Group

Search for the provider Group to affiliate to by NPI, Provider ID, Name, or Organization.

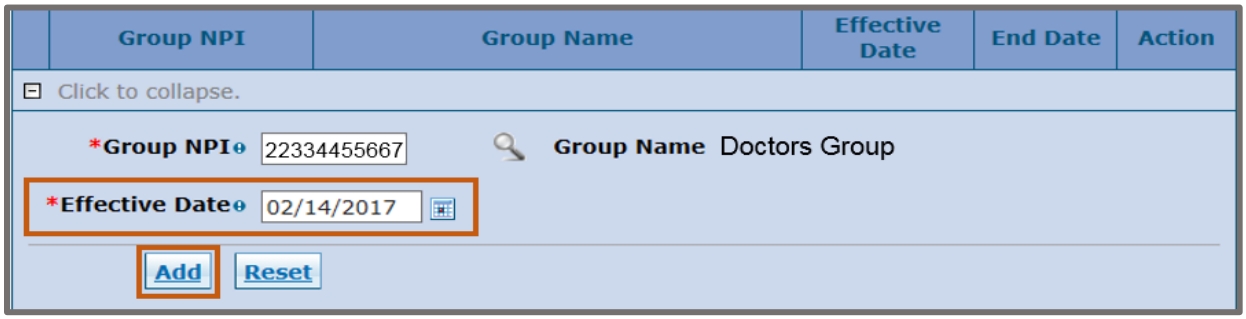


Click on the Provider ID for the provider Group to affiliate to; make sure it's the correct location.

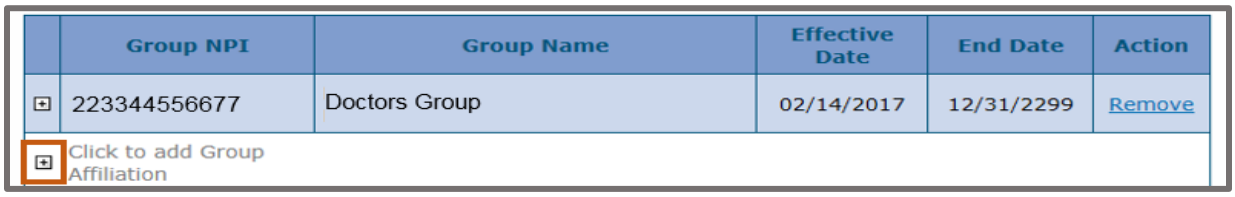


Provider ID	Provider Name	Provider Type	Taxonomy	Address	City	State	Zip Code
223344556677 (NPI)	Doctors Group	Other Health Services	207Q00000X	123 Main Street	AURORA	Colorado	80012
223344556677 (NPI)	Doctors Group	Other Health Services	261Q00000X	123 Fake Street	ENGLEWOOD	Colorado	80113
223344556677 (NPI)	Doctors Group	Other Health Services	207QA0505X	123 Sesame Street	DENVER	Colorado	80220
223344556677	Doctors	Other Health	193200000X	123 Road	DENVER	Colorado	80218

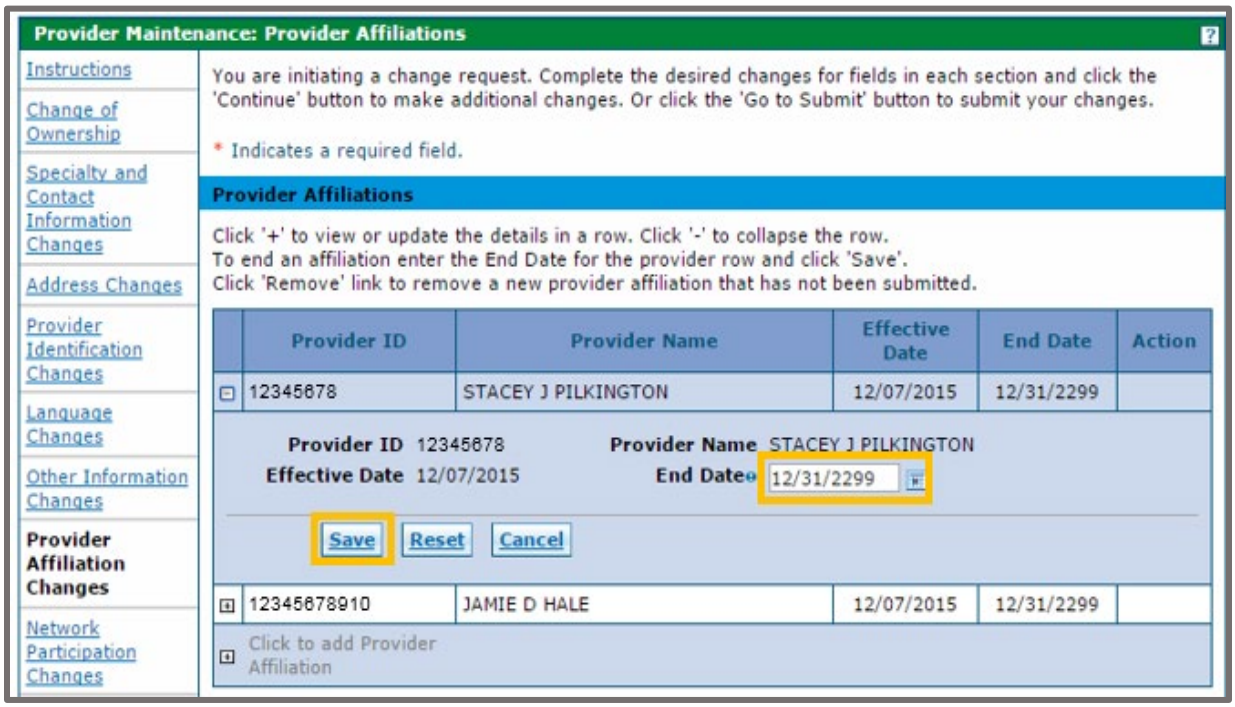
Choose the effective date for the affiliation, and then click Add



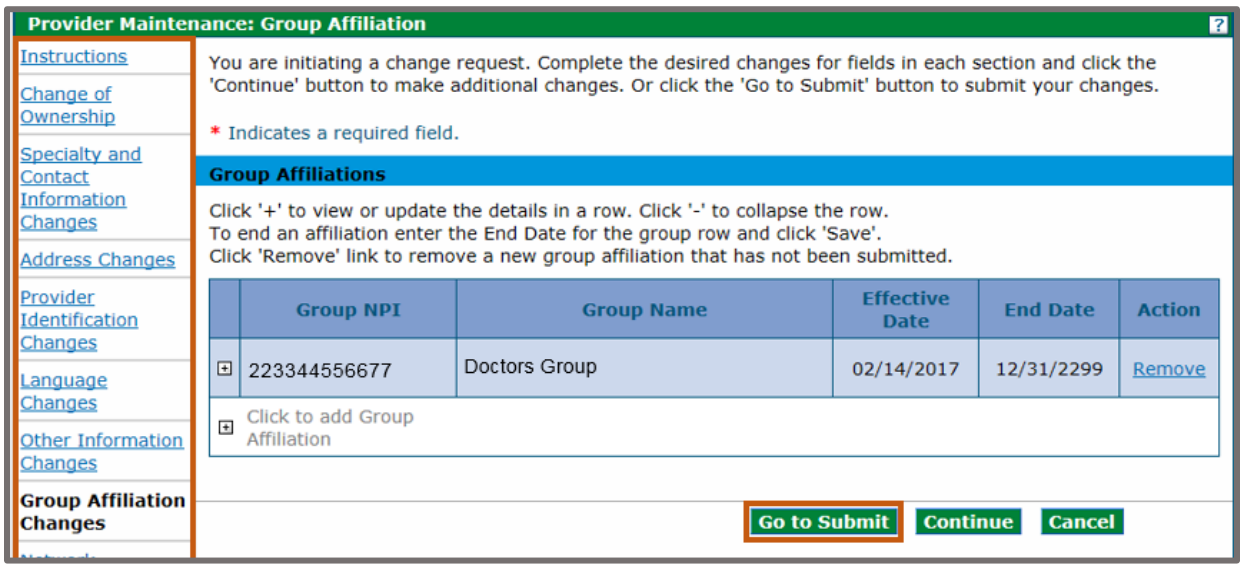
Continue to add additional Group affiliations as needed.



7. To remove an affiliation, simply fill in the end date of the affiliation and Save.

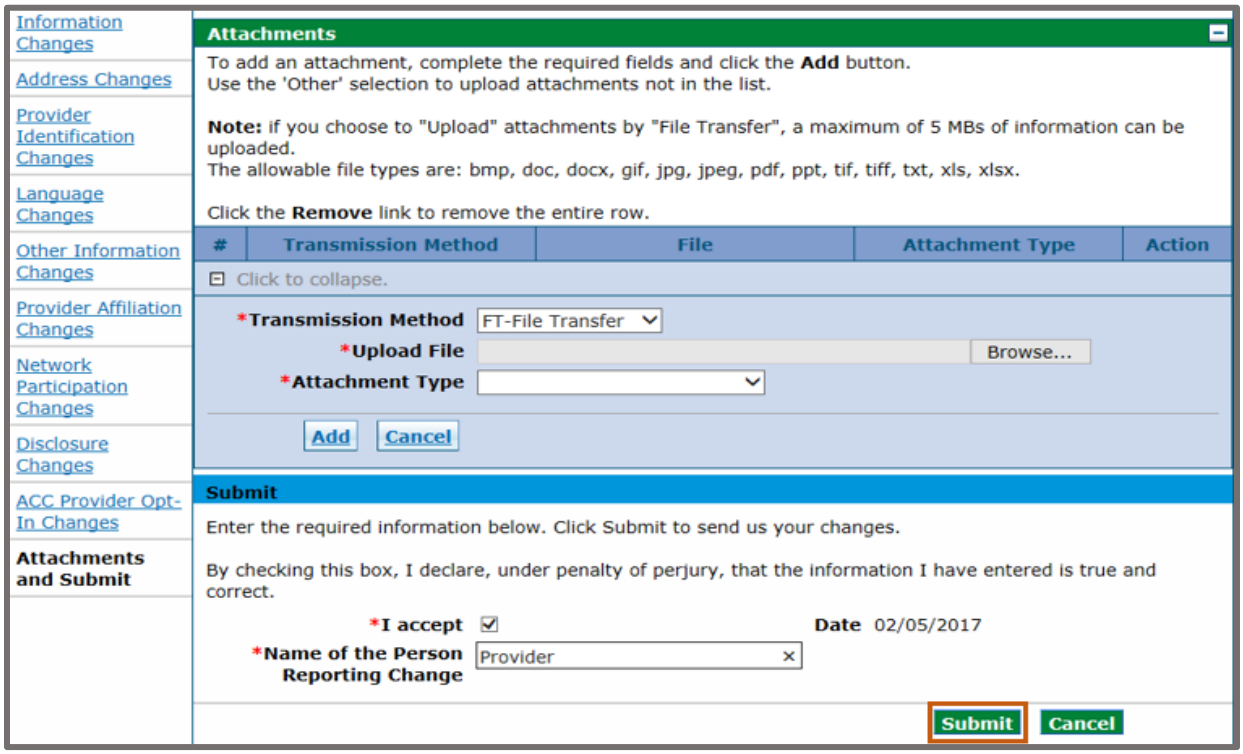


8. Click the links on the left-hand side to edit other pieces of provider information, or click Go to Submit to submit all changes made

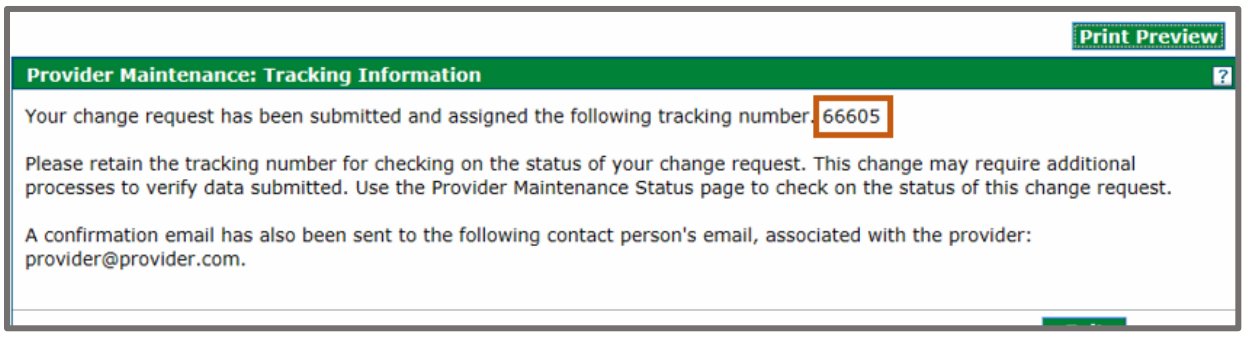


9. Submit Changes

Attach any supporting documentation (if applicable), complete required fields, and click Submit.

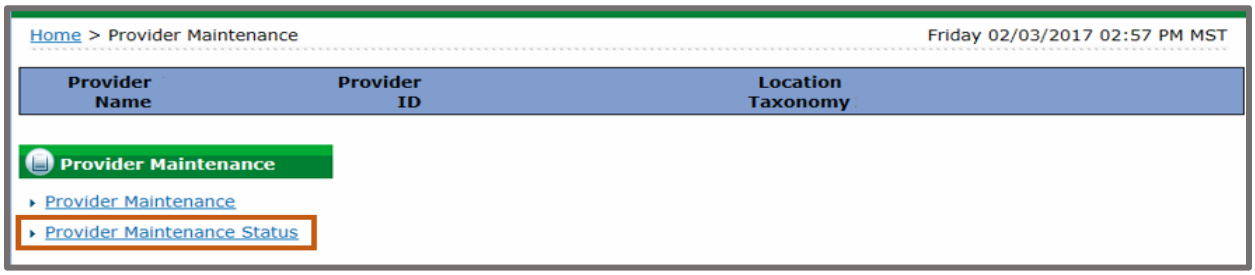


10. Retain tracking number

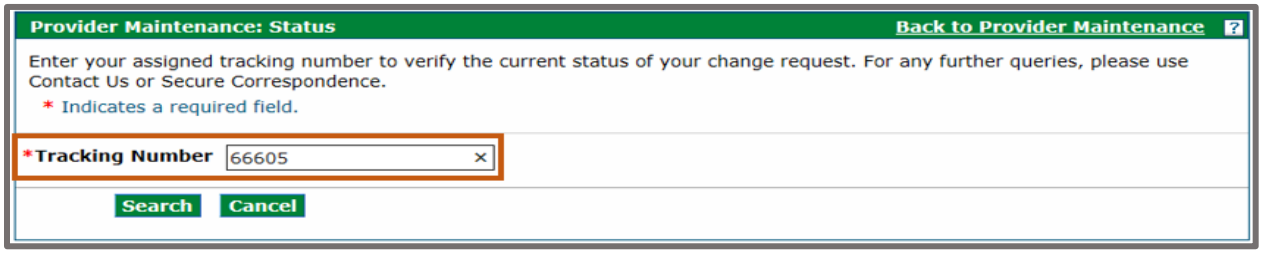


11. Check the status of an update request

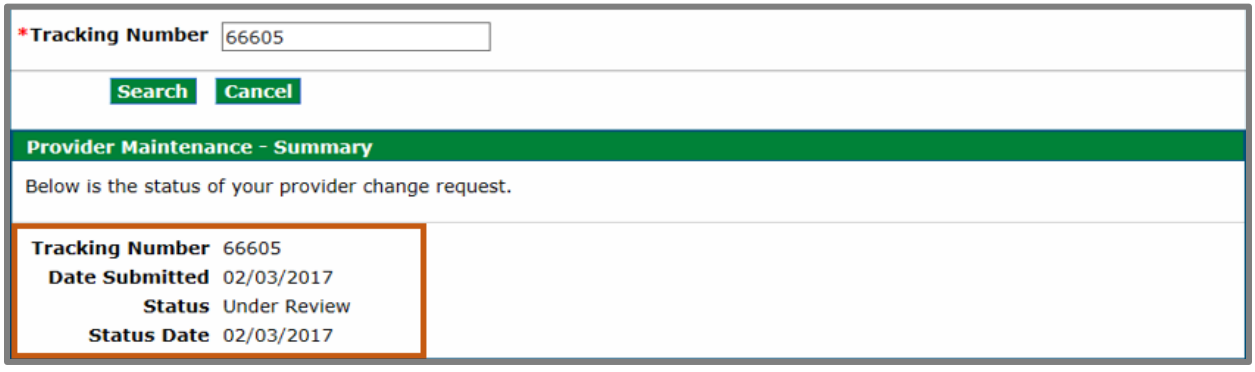
Click the Provider Maintenance Status link.



Enter the Tracking Number for the update request, and click Search.



View Status details



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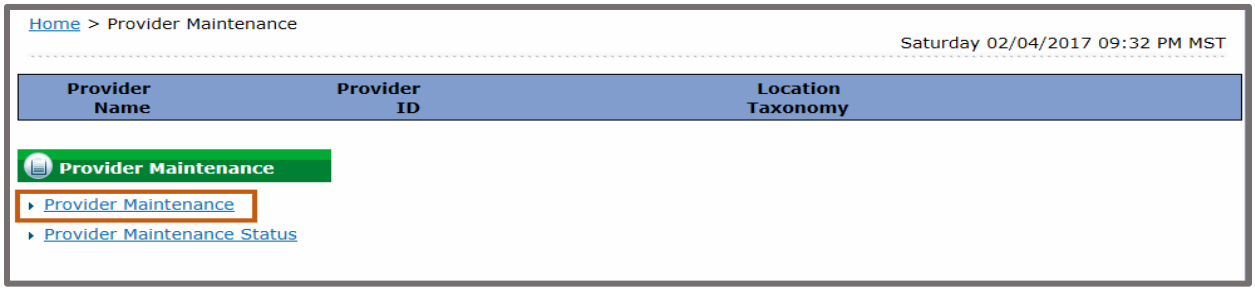
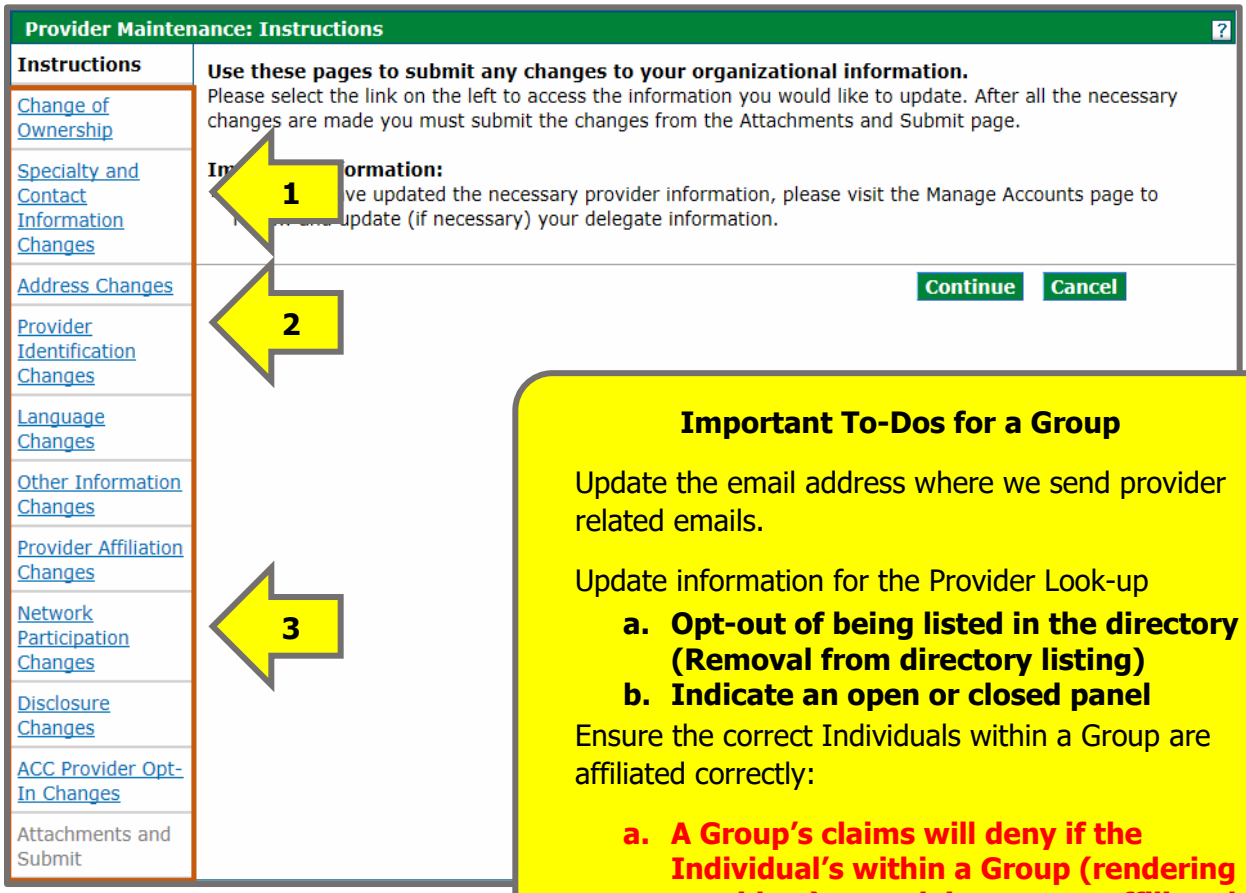


4. Click the links on the left-hand side of the screen to jump to that area, or just click Continue



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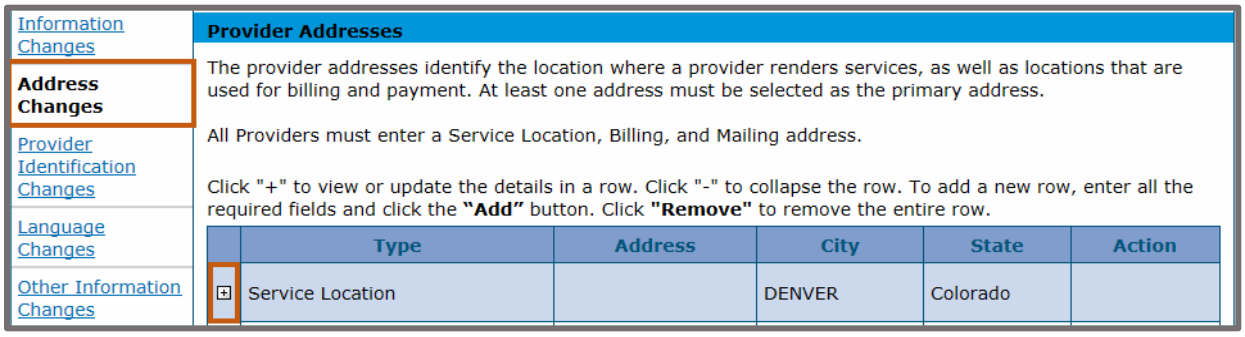
a. **A Group's claims will deny if the Individual's within a Group (rendering providers) on a claim are not affiliated to the Group (the billing provider).**
b. **If the Provider Affiliation Changes link does not show, updated affiliation information is not required.**

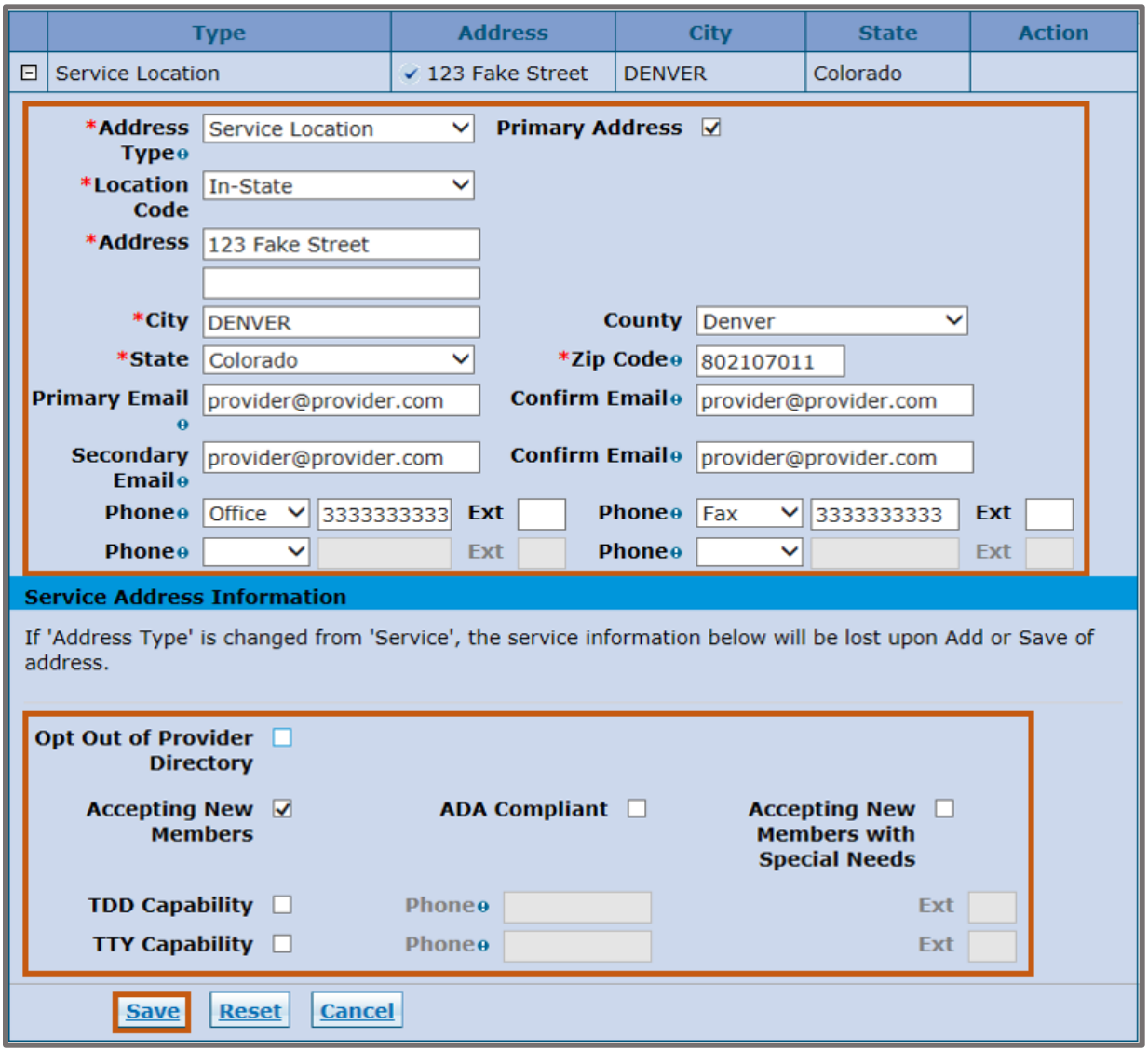
5. To change address, opt-out of being listed in the Provider Directory, or to indicate an open/closed panel

Click Address Changes, then click on the + next to the address to change.

Opt-out of Provider Directory & changing the panel can only be done in the Service Location.



Edit address information, check or uncheck the applicable checkboxes, & click Save.

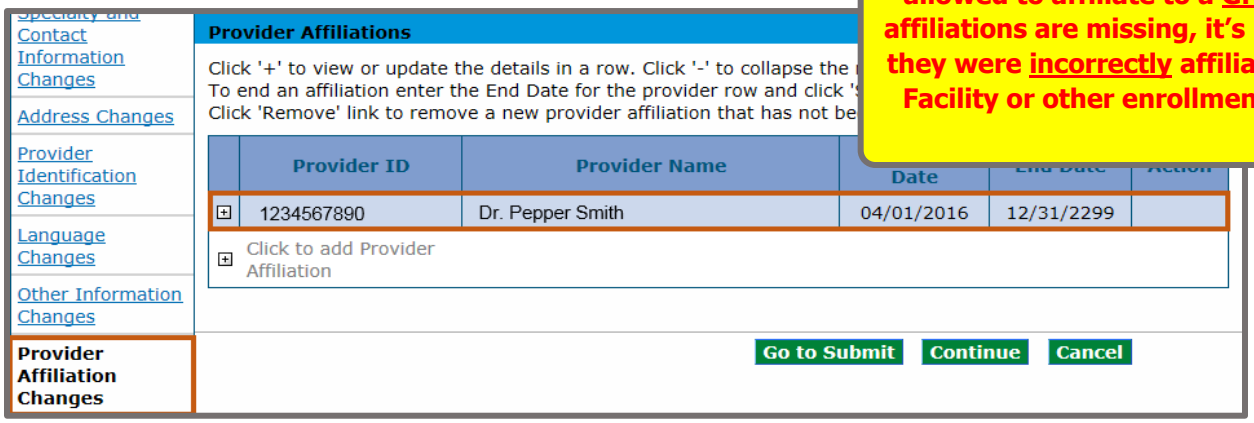


6. To see all the providers affiliated to a Group

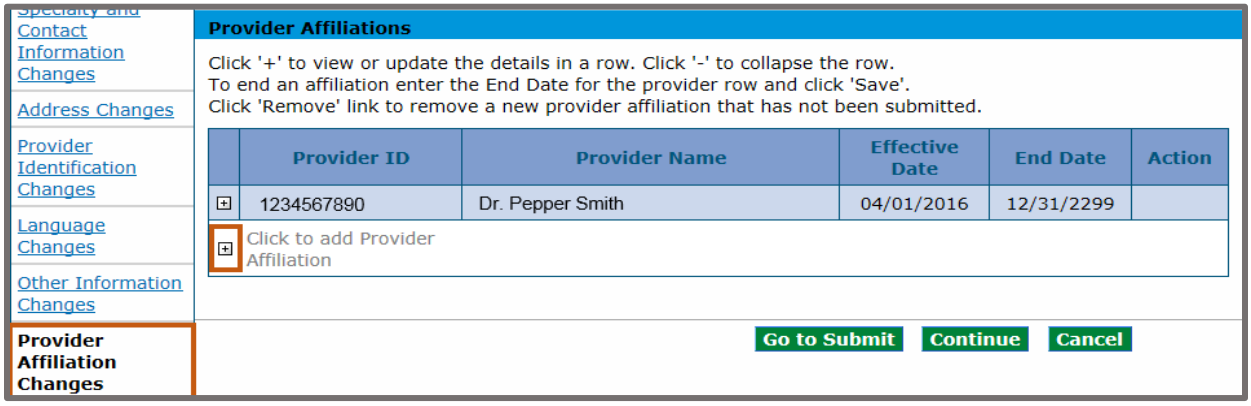
Click Provider Affiliation Changes

This Group only has one provider affiliated to it, Dr. Pepper Smith.

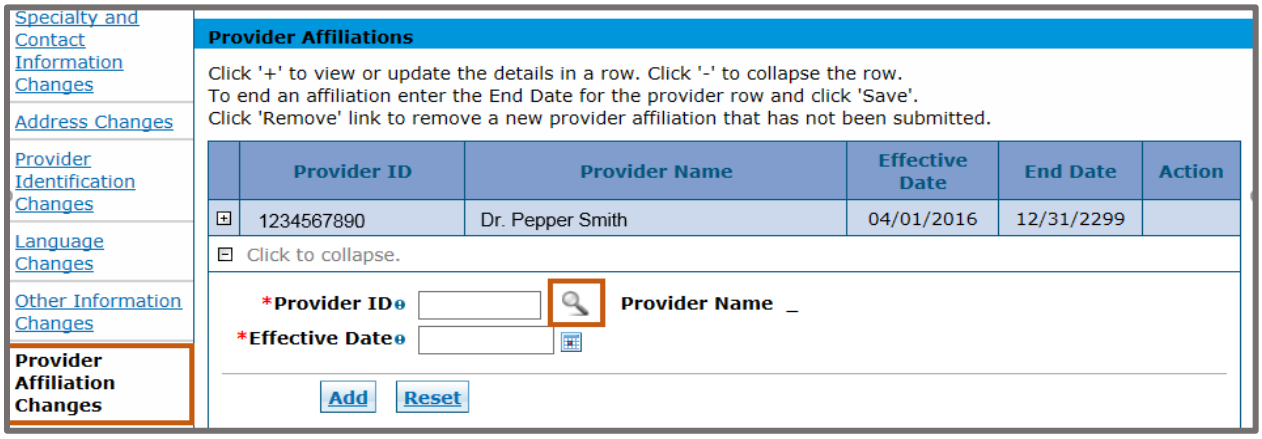
Missing Affiliations?
Individuals w/in a Group, are only allowed to affiliate to a Group. If affiliations are missing, it's because they were incorrectly affiliated to a Facility or other enrollment type.



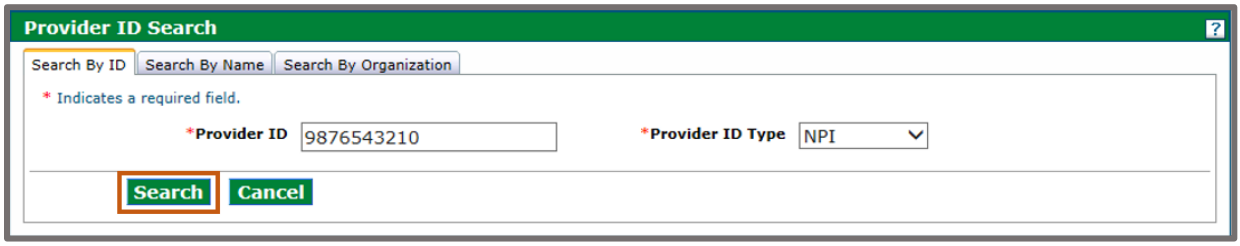
To add additional affiliations, click the + next to Click to add Provider Affiliation



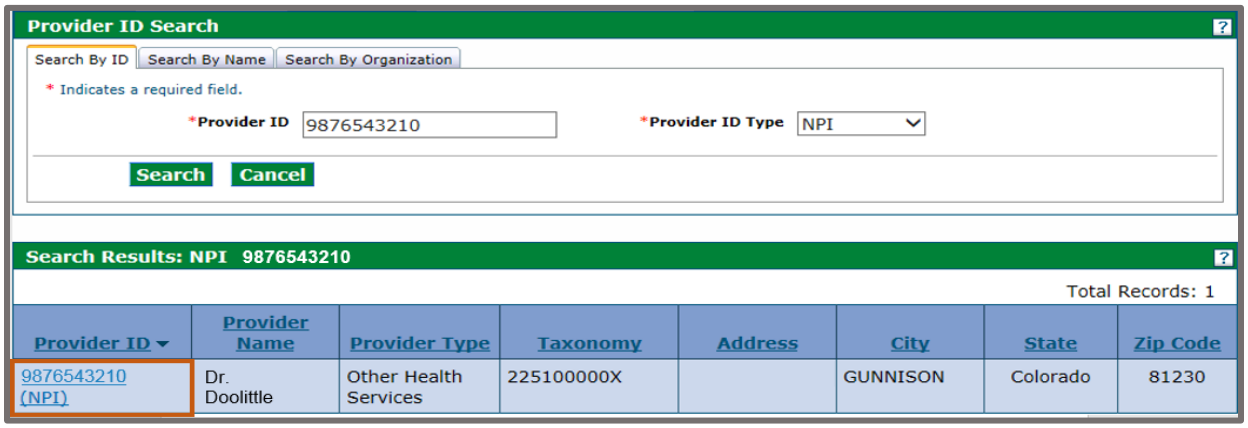
Click the magnifying glass to search for a provider



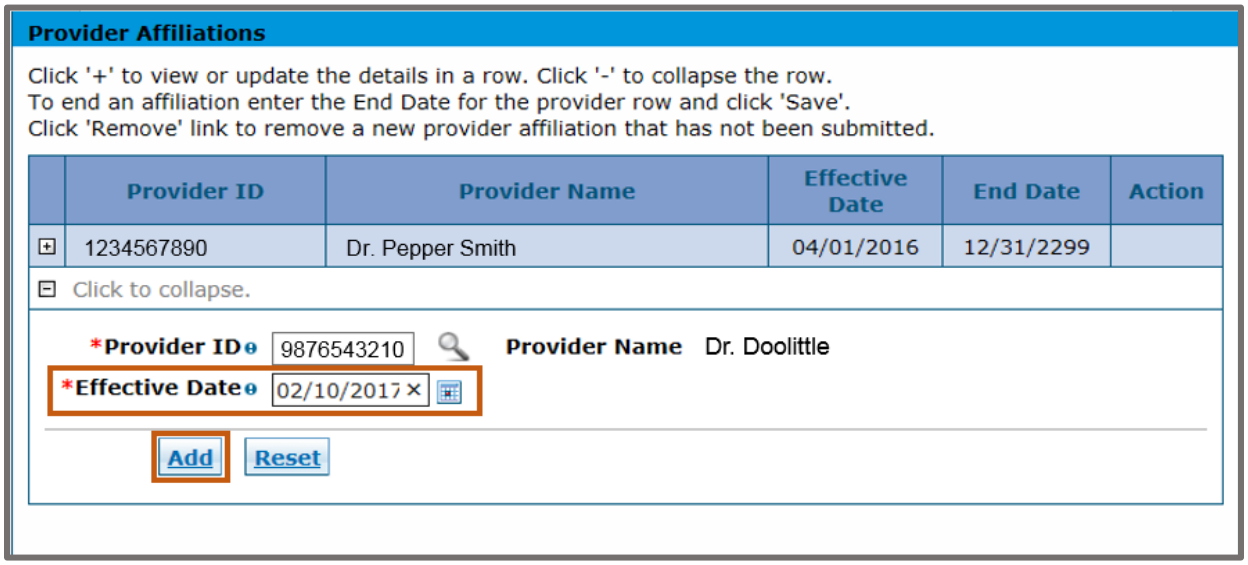
Search for the provider to affiliate by NPI, Provider ID, Name, or Organization



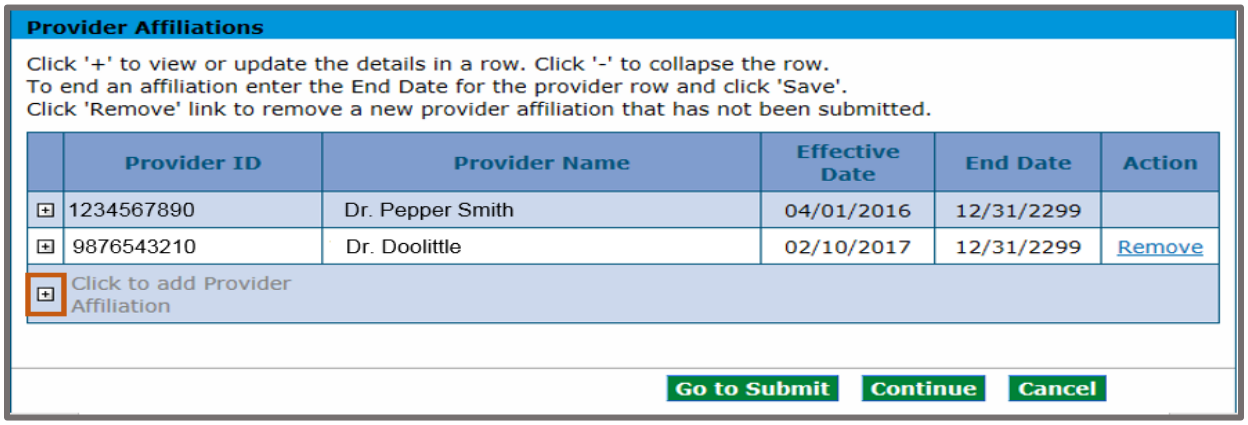
Click on the Provider ID for the provider to affiliate



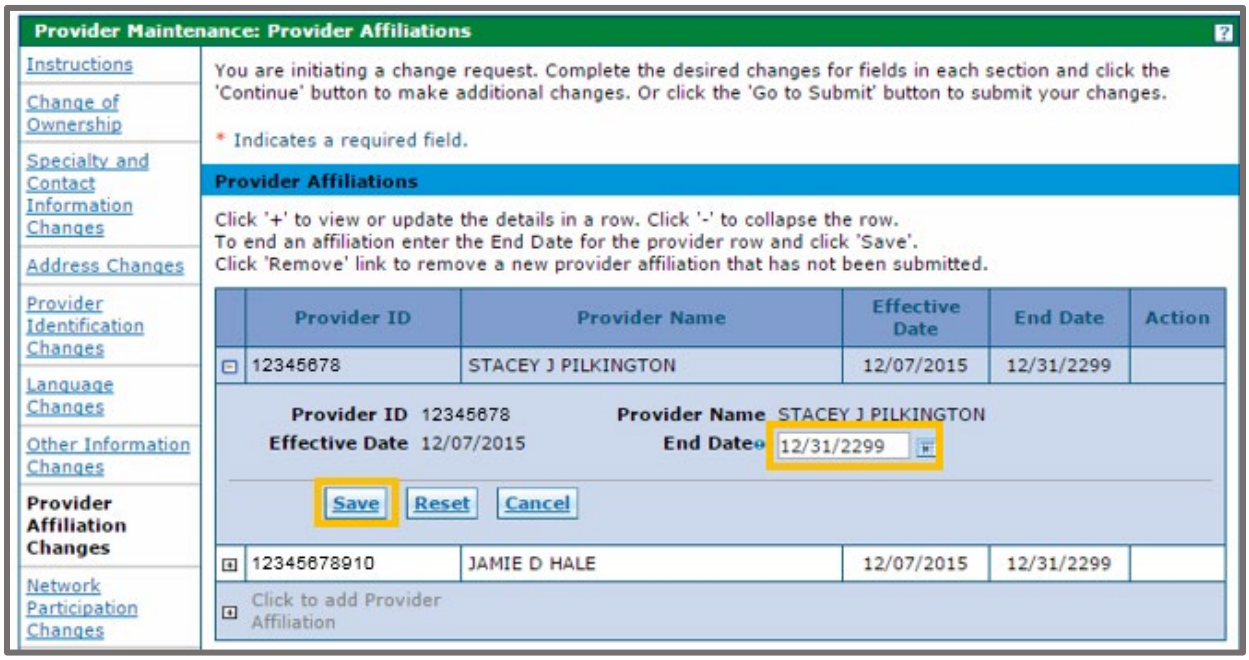
Choose the effective date for the affiliation, and then click Add



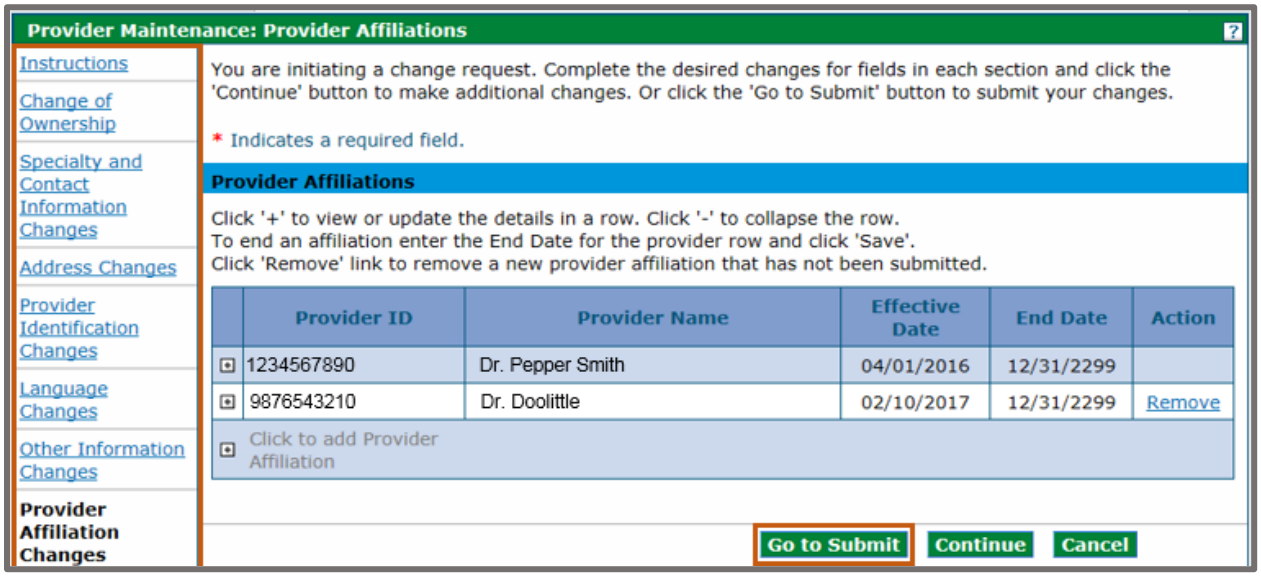
Continue to add additional affiliations as needed.



7. To remove an affiliation, simply enter the end date of the affiliation and Save.

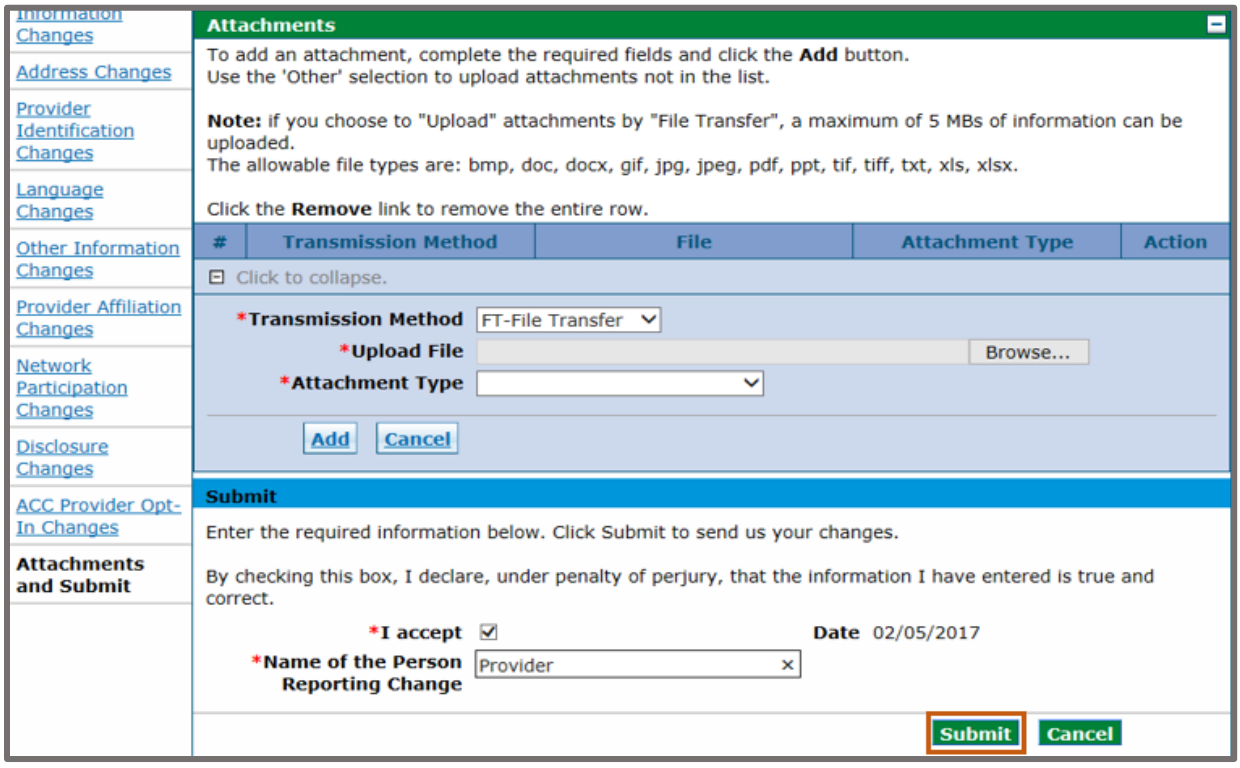


8. Click the links on the left-hand side to edit other pieces of provider information, or click Go to Submit to submit all changes made

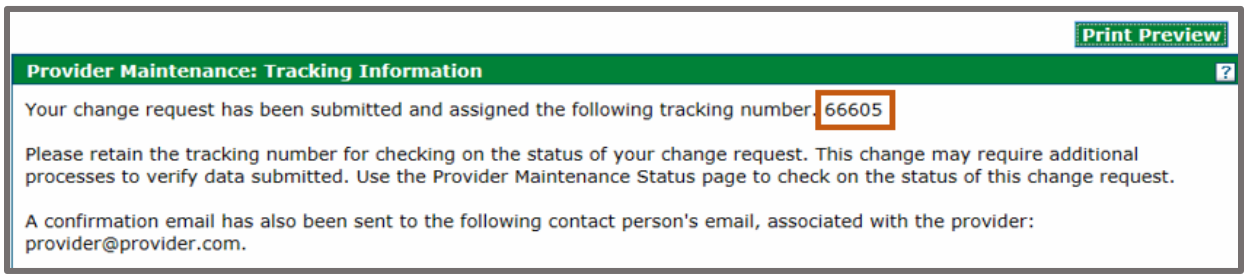


9. Submit Changes

Attach any supporting documentation (if applicable), sign by entering the name and click Submit.

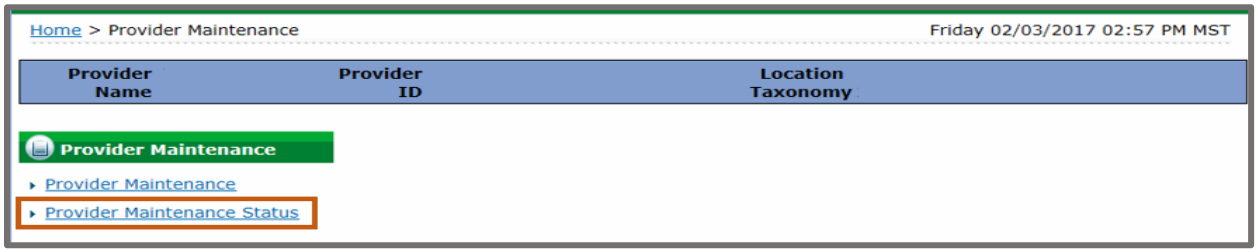


10. Retain tracking number

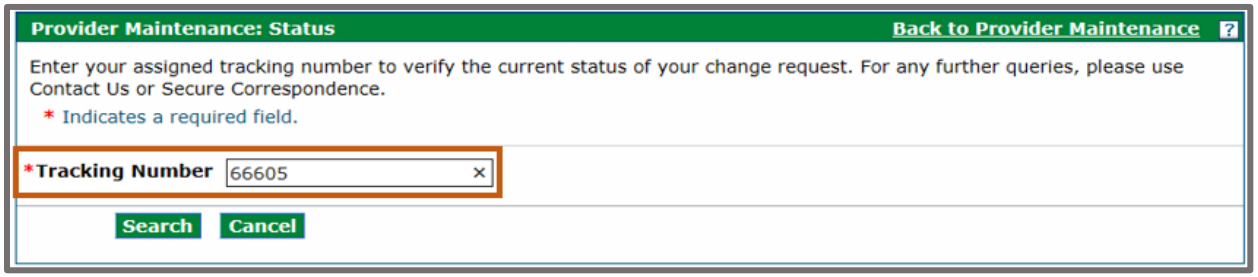


11. Check the status of an update request

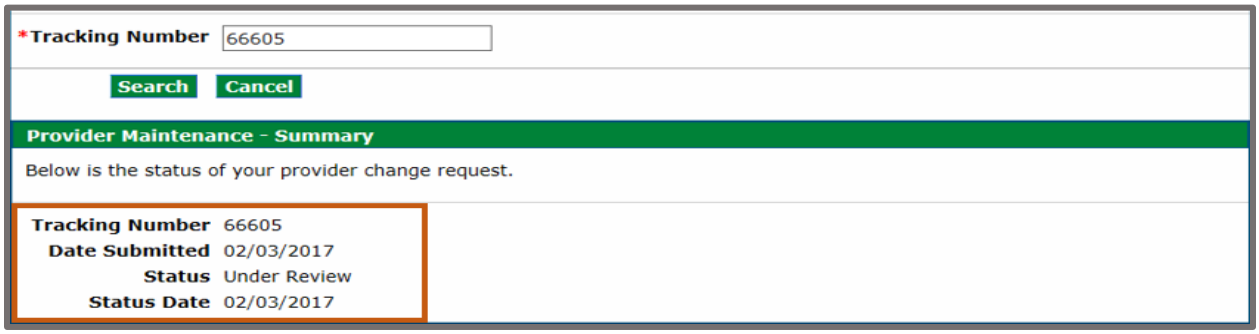
Click the Provider Maintenance Status link.



Enter the Tracking Number for the update request, and click Search.



View Status details



Need More Help?

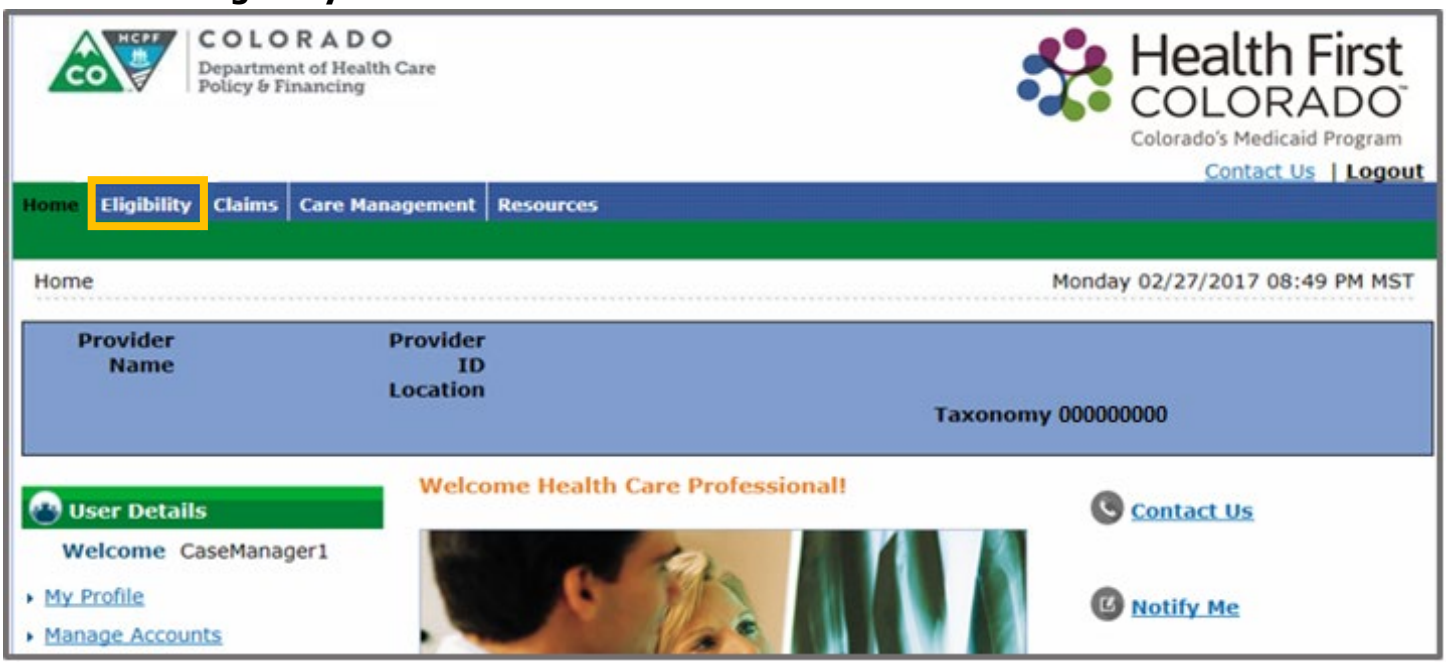
Please visit the Quick Guides and Webinars web page to find all the Provider Web Portal Quick Guides.

COLORADO
Department of Health Care Policy & Financing

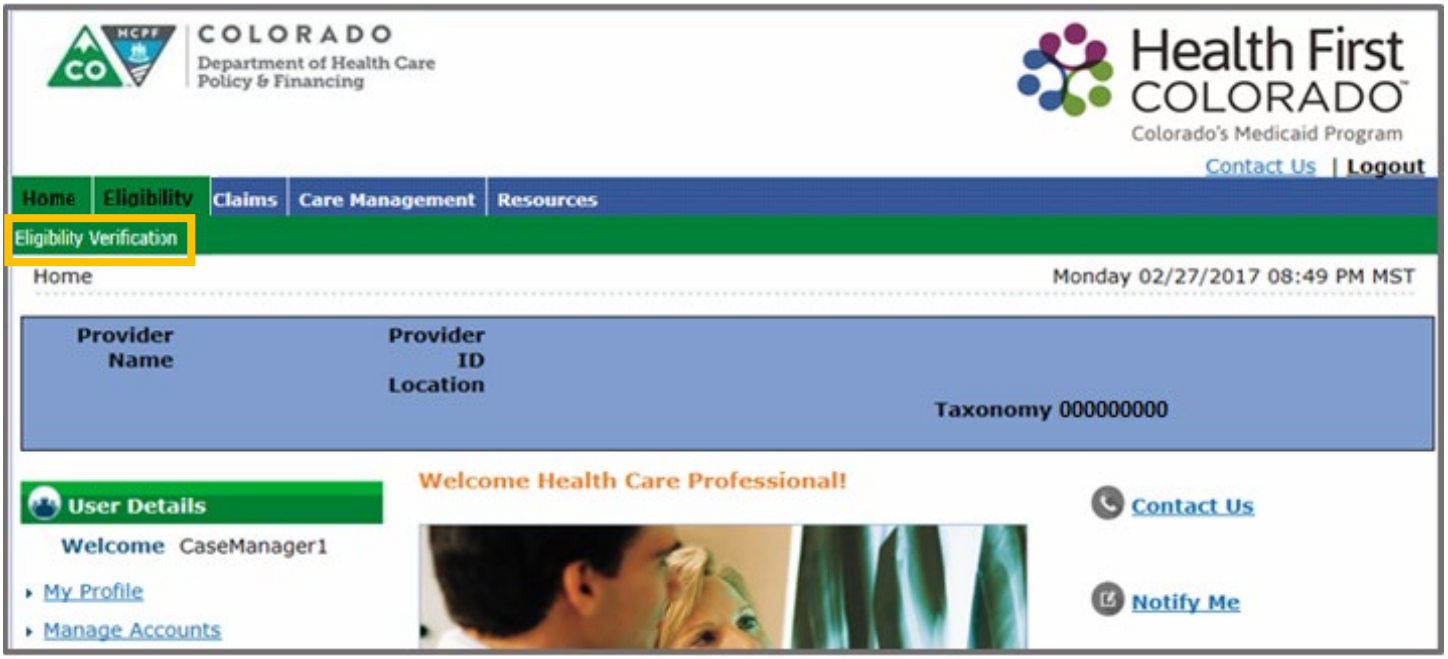
Provider Web Portal Quick Guide - Verifying Member Eligibility (Including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay

Verifying Member Eligibility

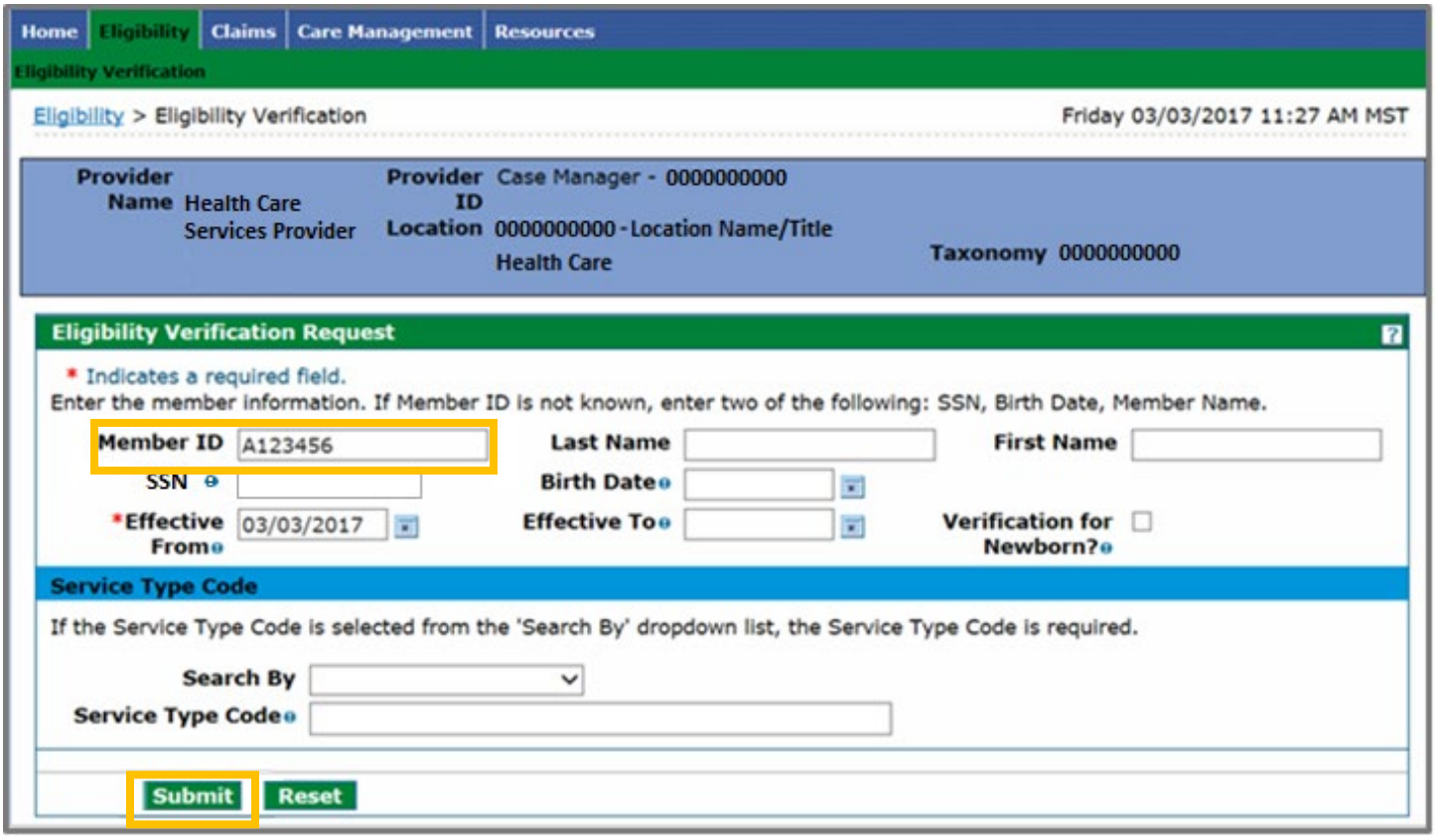
1. Log in to the Provider Web Portal.
2. Click the Eligibility tab.



3. Click the Eligibility Verification link.



4. Enter search criteria, then click "Submit."



5. Click "Expand All" to view Benefit Details, Coverage, Co-pays and Review the search results.

Member ID	Birth Date	Gender Female	
Coverage		**Effective Date**	**End Date**
Medicaid State Plan		01/01/2018	12/31/2299
Behavioral Health Benefits		01/01/2018	12/31/2299
Specified Low-income Medicare Beneficiary		02/01/2018	05/15/2019
Specified Low-income Medicare Beneficiary		05/20/2019	12/31/2019
Other Insurance Detail Information			

6. Managed Care Assignment Details.

The screenshot below shows Coverage Details, Benefit Details and Managed Care Assignment Details:

Coverage Details Back to Eligibility Verification

Coverage Details for Member ID 0000000 - Member Name

Eligibility Verification Response Guarantee Number 0000000000

Expand All Collapse All

Demographic and Copay Details

Mailing Address 123 Main Street
Apt 1234

City DENVER **State** Colorado **Zip Code** 00000 - 0000

Copay Status Copay Due

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
−	TXIX	Medicaid State Plan - H3	06/20/2019	06/20/2019

Coverage	Coverage Code Description	Copay Amount
TXIX	Health Benefit Plan Coverage	
TXIX	Medical Care	$0.00
TXIX	Dental Care	$0.00
TXIX	Hospital	$0.00
TXIX	Hospital - Inpatient	$10.00
TXIX	Hospital - Outpatient	$4.00
TXIX	Emergency Services	$0.00
TXIX	Pharmacy	Covered
TXIX	Brand Name Prescription Drug	$3.00
TXIX	Generic Prescription Drug	$3.00
TXIX	Professional (Physician) Visit - Office	$2.00
TXIX	Vision (Optometry)	$2.00
TXIX	Mental Health	$0.00
TXIX	Urgent Care	$2.00
TXIX	Chiropractic	Non-Covered

⊟	BHO+B	Behavioral Health Benefits - H3	06/20/2019	06/20/2019

Coverage	Coverage Code Description	Copay Amount
BHO+B	Health Benefit Plan Coverage	
BHO+B	Hospital	$0.00
BHO+B	Hospital - Inpatient	$10.00
BHO+B	Hospital - Outpatient	$4.00
BHO+B	Emergency Services	$0.00
BHO+B	Professional (Physician) Visit - Office	$2.00
BHO+B	Mental Health	$0.00
BHO+B	Medical Care	Non-Covered
BHO+B	Chiropractic	Non-Covered
BHO+B	Dental Care	Non-Covered
BHO+B	Pharmacy	Non-Covered
BHO+B	Brand Name Prescription Drug	Non-Covered
BHO+B	Generic Prescription Drug	Non-Covered
BHO+B	Vision (Optometry)	Non-Covered
BHO+B	Urgent Care	Non-Covered

Managed Care Assignment Details ⊟

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 1234567890	Child Health Plan Plus	ROCKY MOUNTAIN HEALTH PLANS	05/01/2019	05/31/2019
None/ 1234567890	Child Health Plan Plus - Dental	DELTA DENTAL PLAN OF COLORADO	05/01/2019	05/31/2019

Lock-In Details ⊟

NPI/MCD	Lock-in Plan	Lock-in Provider	Effective Date	End Date
1234567890	COUP Lock-in - Controlled Drugs	COLORADO TREATMENT SERVICES	05/05/2019	05/31/2019

Provider Phone: 1-999-999-9999

Level of Care Details ⊟

NPI/MCD	Level of Care Plan	Provider Name	Effective Date	End Date
1234567890	Nursing Facility/Hospital 300% institutionalized	KINDRED NURSING REHAB AURORA	05/01/2019	05/31/2019

Verifying Co-Pay Amount

7. Verify member co-pay requirements by referring to the "Copay Amount" column under the Benefit Details section.

Benefit Details

	Coverage	Description	Effective Date	End Date
⊟	TXIX	Medicaid State Plan - H3	06/20/2019	06/20/2019

Coverage	Coverage Code Description	Copay Amount
TXIX	Health Benefit Plan Coverage	
TXIX	Medical Care	$0.00
TXIX	Dental Care	$0.00
TXIX	Hospital	$0.00
TXIX	Hospital - Inpatient	$10.00
TXIX	Hospital - Outpatient	$4.00
TXIX	Emergency Services	$0.00
TXIX	Pharmacy	Covered
TXIX	Brand Name Prescription Drug	$3.00
TXIX	Generic Prescription Drug	$3.00
TXIX	Professional (Physician) Visit - Office	$2.00

Members may not be required to pay a co-pay for every visit, so it is important that providers check the co-pay amount every time they see a Health First Colorado member.

If a member has already reached their 5% co-pay maximum for a given month, the **Copay Amount** field will display $0 for a member when they are max-met or exempt, the base co-pay amount when a co-pay is due, and 'Non-Covered' when the coverage code is inactive for the member's associated coverage during the benefit plan effective dates.

The Pharmacy Coverage Code Description (CCD) will be used in conjunction with the 'Brand Name Prescription Drug' and 'Generic Prescription Drug' CCD's. If a value of 'Covered' for Pharmacy services is received the base copay due will reside in values next to 'Brand Name Prescription Drug' and/or 'Generic Prescription Drug'.

Scroll to the bottom of the page to see Managed Care Assignment Details.

Verifying Remaining Service Units – PT/OT

8. If applicable, check the member's available units of physical/occupational therapy (PT/OT) services under the Limit Details section.

Benefit Details

Coverage	Description	Effective Date	End Date
QMB	Qualified Medicare Beneficiary - F4	08/16/2018	08/16/2018
EBD	HCBS Elderly, Blind, & Disabled Waiver - M8	08/16/2018	08/16/2018
TXIX	Medicaid State Plan - M8	08/16/2018	08/16/2018
BHO+B	Behavioral Health Benefits - M8	08/16/2018	08/16/2018

Coverage	Copayments	Amount
QMB	Medical Care	$0.00
QMB	Chiropractic	$0.00
QMB	Dental Care	$0.00

Limit Details

		Limit	Used
Individual	5500 PT & OT SVC LIMITS = 48/YR	48	6

Managed Care Assignment Details

Current MCO	Benefit Plan
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

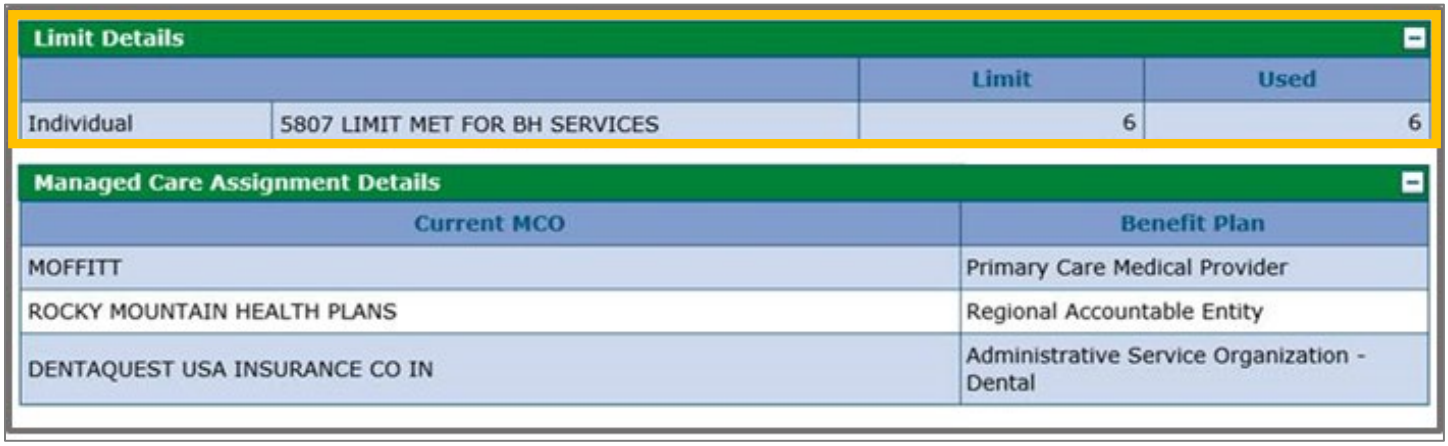
This remaining benefit amount is calculated by counting all the paid units of service for PT/OT a member has incurred in the previous rolling 365 days. Once the soft limit of 48 units has been reached, an approved Prior Authorization Request (PAR) is required to exceed it.

The counting function will calculate PT/OT units regardless of whether they were paid with a PAR on file. This means that after a PAR for PT/OT is exhausted members will not automatically have another 48 units of PT/OT available without a PAR. A full 365 days must elapse before the member has another 48 units of PT/OT available without requiring a PAR.

Refer to the Benefit Limitation Frequently Asked Questions, located on the Outpatient PT/OT Benefits web page, for more information.

Verifying Remaining Service Units – Behavioral Health

9. If applicable, check the member's available units of short-term behavioral health services under the Limit Details section.



Limit Details

		Limit	Used
Individual	5807 LIMIT MET FOR BH SERVICES	6	6

Managed Care Assignment Details

Current MCO	Benefit Plan
MOFFITT	Primary Care Medical Provider
ROCKY MOUNTAIN HEALTH PLANS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

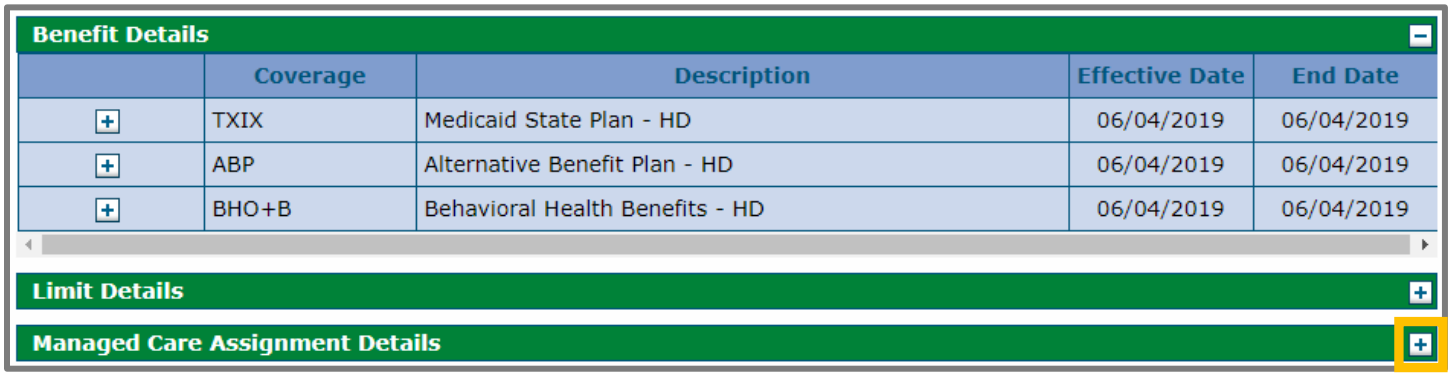
"5807 LIMIT MET FOR BH SERVICES" references the system audit that will post when the service unit limit is exceeded.

This used benefit amount is calculated by subtracting all the paid units of service for short-term behavioral health a member has incurred within the current state fiscal year from the limit. Once the unit limit has been reached for the state fiscal year, a PAR **cannot** be used to exceed it.

Additional visits beyond the unit limit during a state fiscal year may be eligible for reimbursement by the Regional Accountable Entity in accordance with their provider credentialing and utilization management policies and procedures. At the beginning of the next state fiscal year, the total units for that fiscal year will be available.

10. Scroll to the Managed Care Assignment Details section, then click the [+] sign.

Click the plus [+] sign next to Managed Care Assignment Details.



Benefit Details

	Coverage	Description	Effective Date	End Date
[+]	TXIX	Medicaid State Plan - HD	06/04/2019	06/04/2019
[+]	ABP	Alternative Benefit Plan - HD	06/04/2019	06/04/2019
[+]	BHO+B	Behavioral Health Benefits - HD	06/04/2019	06/04/2019

Limit Details [+]

Managed Care Assignment Details [+]

The coverage information will include the name or type of coverage and the **Effective** and **End dates** of that coverage. Additional information returned in the eligibility response may display the following details panels:

- **Managed Care Details** displayed when the member is assigned to a managed care plan and shows all of the plans the member is assigned to including their effective dates of coverage.
- **Lock-in Details** displayed when a member is locked-in or restricted to a specific provider known as a 'lock-in plan'. To authorize services delivered for a member by a provider other than the designated Lock-in Plan Provider, claims must include the referring provider's National Provider Identifier (NPI). The Lock-in Details panel provides the Lock-in Provider's DBA Name and Provider Phone information.
- **Level of Care Details** displayed when a member resides in a nursing home and reports their level of care within that facility.

Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 2222222222	Child Health Plan Plus	KAISER FOUNDATION HEALTH PLAN	12/01/2018	12/31/2018
1111111111/ 2222222222	Child Health Plan Plus - Dental	COLORADO DENTAL SERVICE INC	12/01/2018	12/15/2018

Lock-in Details

NPI/MCD	Lock-in Plan	Lock-in Provider	Effective Date	End Date
None/ 2222222222	COUP Lock-in - Medical	Doing Business As Name	12/01/2018	12/31/2018
Provider Phone: 123-456-7890				

Level of Care Details

NPI/MCD	Level of Care Plan	Provider Name	Effective Date	End Date
1111111111/ 2222222222	Nursing Facility/Hospital 300% institutionalized	Doing Business As Name	12/01/2018	12/31/2018

Benefit Plans and Billing Instructions

See the table below for a complete list of all possible benefit plans along with billing instructions and co-pay notes.

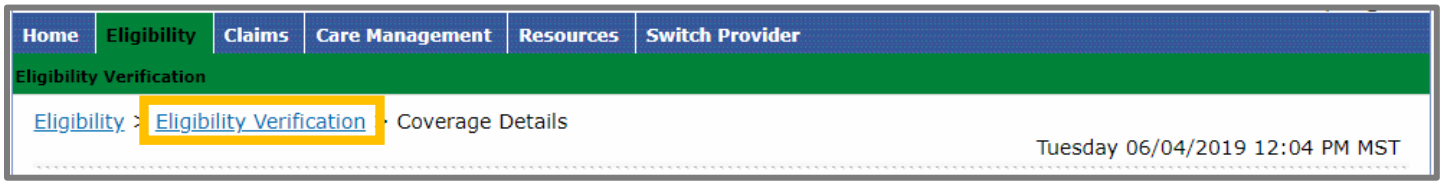
Benefit plans for which providers should bill DXC directly are marked in green below. Benefit plans for which providers should bill the listed Managed Care Organization are marked in purple below.

MC Benefit Plan	Billing	Co-pay
Denver Health Medicaid Choice (PIHP)	Providers should bill Denver Health directly, **not** DXC for medical claims. Mental health is billed to the RAE. Span must show "Active."	Most services, such as office visits, medications and hospital stays have co-pays. Services for pregnant women, children 18 and under, American Indians and Alaska Natives do not require a co-pay.
Denver Health and Hospital Authority - Primary Care Medical Provider	Providers should **not** bill the PCMP and instead should bill DXC directly for medical claims. Mental health is billed to the RAE.	Not applicable
Rocky Mountain Health Plans	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly.	..
Rocky Mountain Health Plans Prime	Providers should bill Rocky Mountain Health Plans Prime directly, **not** DXC. Mental health should be billed to the RAE.	Contact Rocky Mountain Health Plans Prime for co-pay details.
Accountable Care Collaborative	Providers should **not** bill the ACC, PCMP or RCCO and instead should bill DXC Technology (DXC) directly (unless the services are for mental health). **Note:** ACC will only appear for dates of service prior to 7/1/18.	Not applicable
Administrative Service Organization - Dental	Providers should bill DentaQuest directly, **not** DXC.	Contact DentaQuest for co-pay details.
Child Health Plan *Plus* or **Child Health Plan *Plus* - Dental** or **State Managed Care Network - CHP+**	Providers should bill Child Health Plan *Plus* (CHP+) directly, **not** DXC.	Some CHP+ clients may also have to pay co-pays to their health care provider at the time of service. There are no co-pays for preventative care, such as prenatal care and check-ups. Other services may require co-pays based on member income. Native Americans and Alaskan Natives do not have to pay co-pays.
Primary Care Medical Provider	Providers should **not** bill the RAE or PCMP and instead should bill DXC directly for medical claims. Mental health should be billed to the RAE.	Not applicable
Program For All-Inclusive Care For The Elderly	Providers should bill the Program of All-Inclusive Care for the Elderly (PACE) directly, **not** DXC.	There are no co-payments or out-of-pocket expenses for services covered under this program.

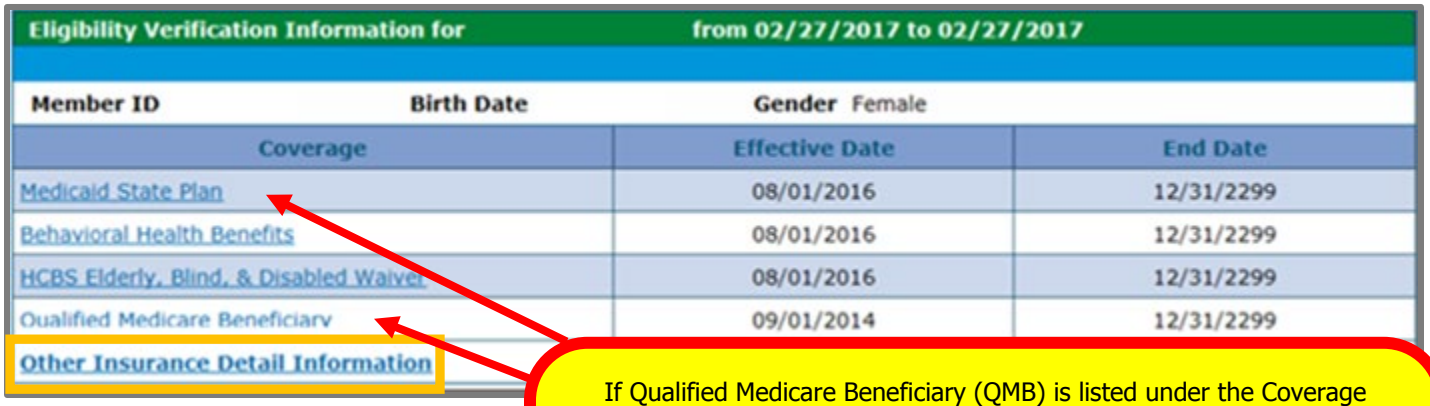
Regional Accountable Entity *[formerly known as Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs)]*	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly, unless they have Denver Health PHIP or Rocky Mountain Prime.	There are no co-pays for Health First Colorado behavioral health services. However, if the member has other insurance, they must use that insurance first before using Health First Colorado benefits.

Verifying Third-Party Liability Coverage

11. To see Third Party Liability (TPL) coverage (including Medicare), return to the Eligibility Verification page.



Scroll to bottom of page and click **Other Insurance Detail Information**.

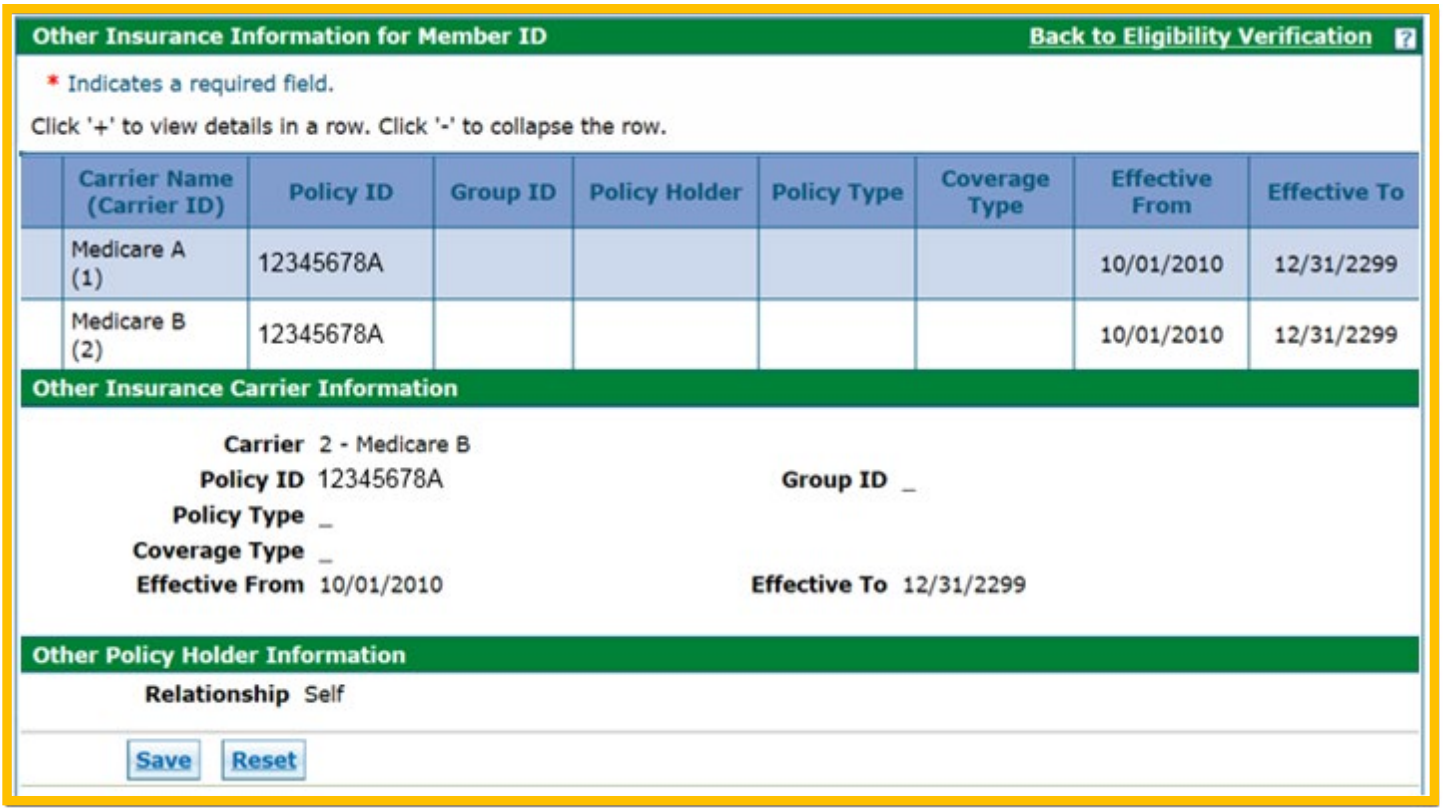


If Qualified Medicare Beneficiary (QMB) is listed under the Coverage column, this means the member has Medicare coverage.

If a member has QMB coverage but does not have Medicaid State Plan (TXIX) coverage, Health First Colorado will not provide payment unless Medicare pays first.

If a member has QMB and Medicaid State Plan (TXIX) coverage, then Health First Colorado is the secondary payor.

This is where other insurance coverage (including Medicare coverage) is displayed:



Other Insurance Information for Member ID Back to Eligibility Verification

* Indicates a required field.

Click '+' to view details in a row. Click '-' to collapse the row.

Carrier Name (Carrier ID)	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Effective From	Effective To
Medicare A (1)	12345678A					10/01/2010	12/31/2299
Medicare B (2)	12345678A					10/01/2010	12/31/2299

Other Insurance Carrier Information

Carrier 2 - Medicare B
Policy ID 12345678A **Group ID** _
Policy Type _
Coverage Type _
Effective From 10/01/2010 **Effective To** 12/31/2299

Other Policy Holder Information

Relationship Self

Save Reset

Add additional TPL information as needed.

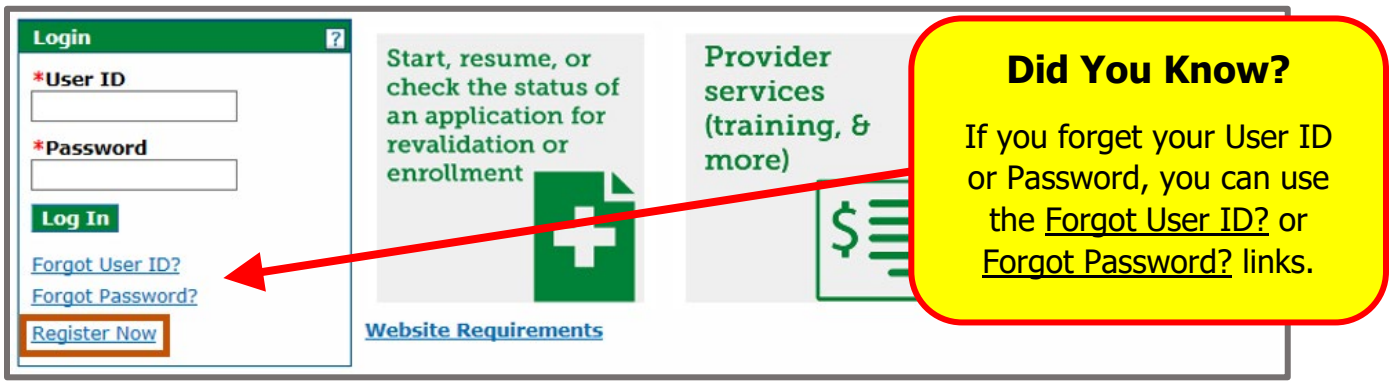
Refer to the Updating Additional TPL Information Provider Web Portal Quick Guide for step-by-step instructions on how to add TPL information for a member with TPL coverage that isn't already listed.

Need More Help?

Please visit the Quick Guides and Webinars web page to find all the Provider Web Portal Quick Guides.

Provider Web Portal Quick Guide – Web Portal Registration

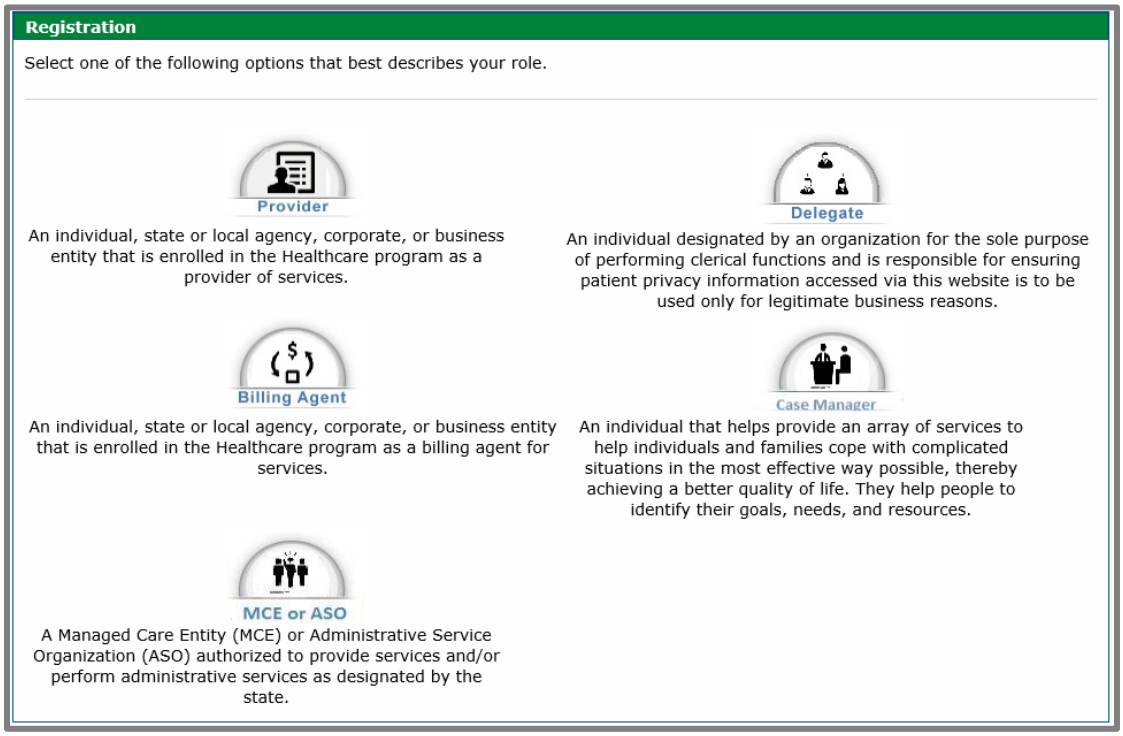
1. From the Provider Web Portal Home page, click Register Now



2. Choose the most appropriate option

If enrolled as more than one provider type, choose the option most appropriate for the Provider ID used for the creation of a Web Portal account.

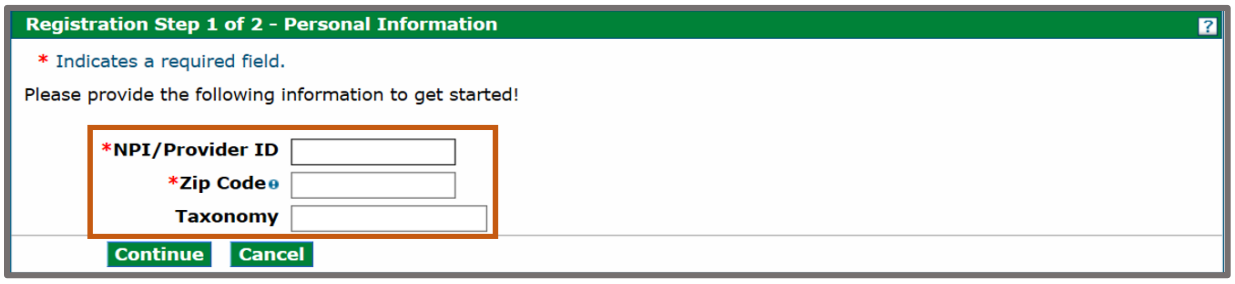
Example: many case managers (provider type 11) are also enrolled as HCBS providers (provider type 36). In this example, the case manager would need to create two Web Portal accounts. They would select the "Case Manager" option to register their case manager Provider ID; they would register their HCBS Provider ID as a "Provider".



3. Enter information.

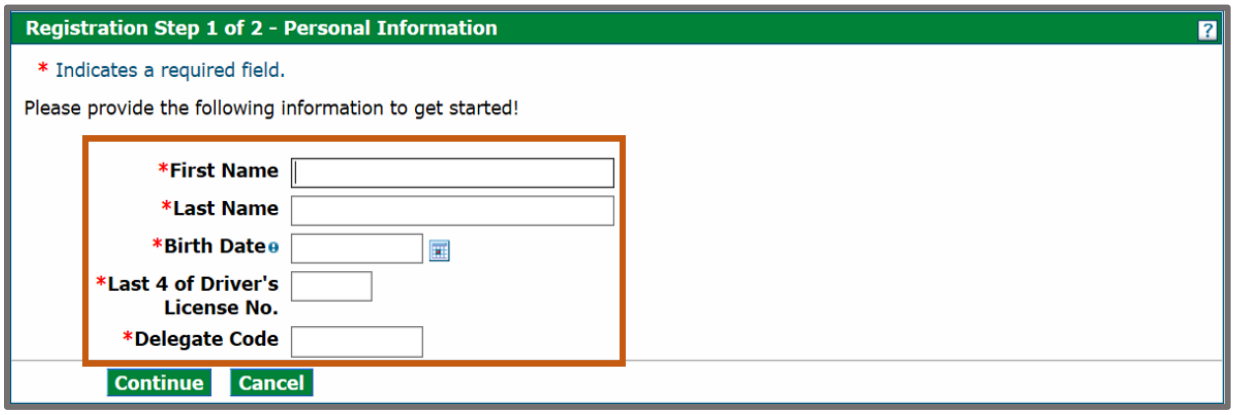
For registration as a "Provider", "Case Manager", or "MCO or ASO"

If the NPI is tied to more than one location or provider type, it is highly recommended to use the Provider ID (instead of the NPI) to register.



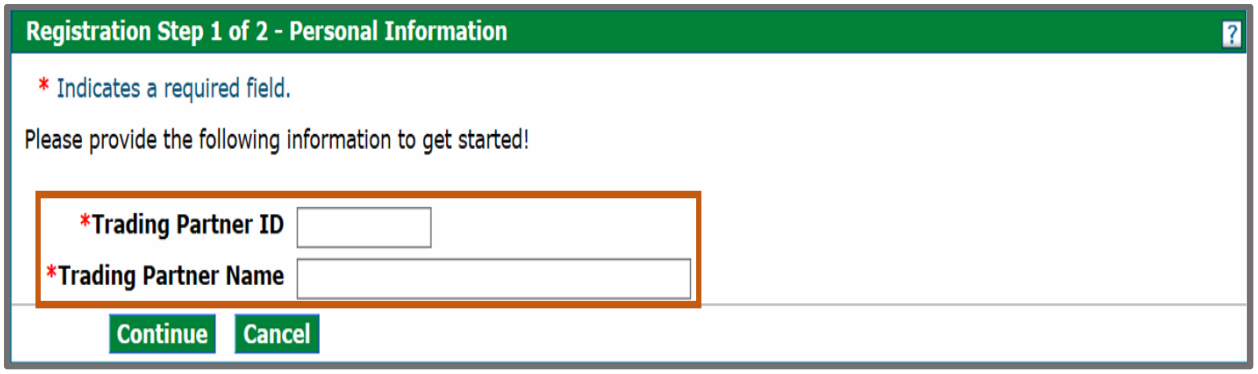
For registration as a "Delegate".

The information entered here must match the information that was used to create the Delegate Code. If there are difficulties with registration, double check with the person who created the delegate code.



For registration as a "Billing Agent".

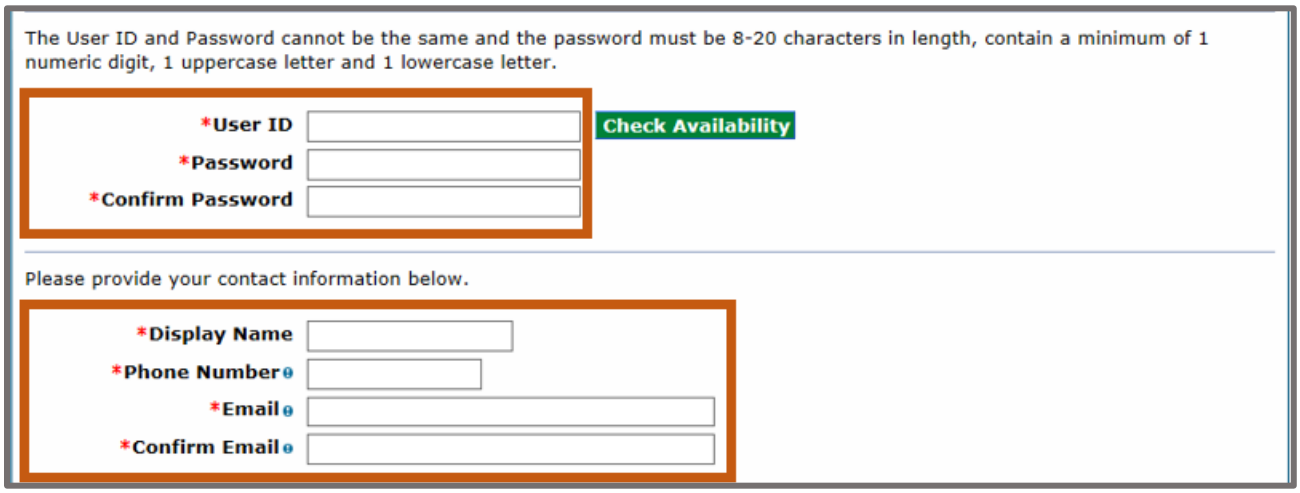
The Trading Partner ID entered here needs to come from DXC Technology (DXC). The TPID used in the legacy system will not work.



4. Choose a User ID and Display Name

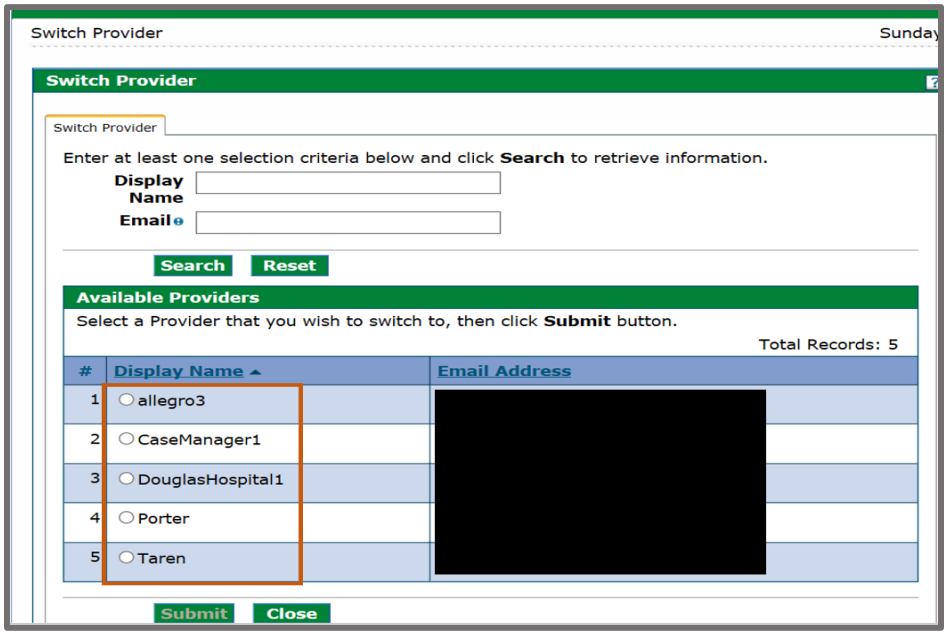
The User ID is what is used to log into the Web Portal account. **It is recommended to create a Display Name that will make it easy to identify which account is logged in.**

For example: If this provider type is a Hospital and the service location is 123 Fake Street – a good Display Name would be: "Hospital_123FakeSt". **Do NOT use spaces in the display name.**

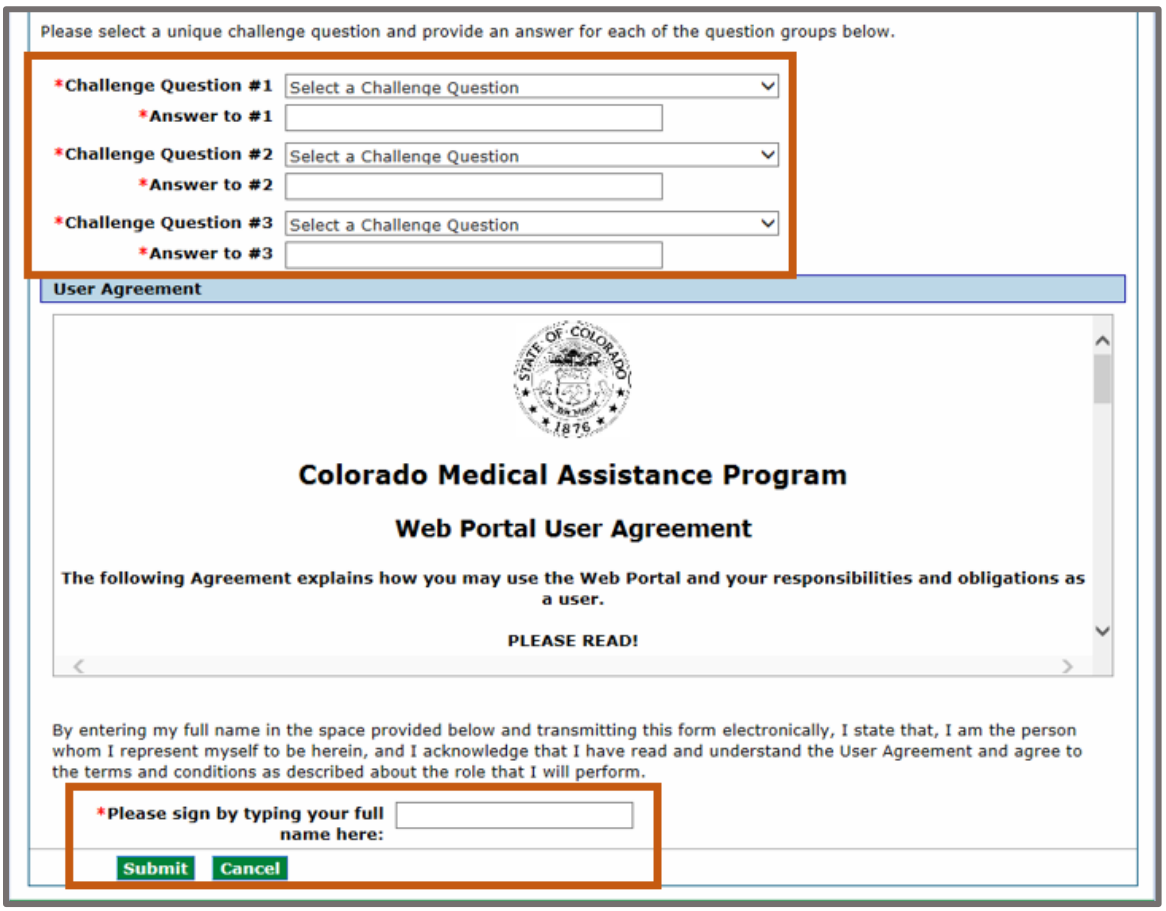


The Display Name is the name seen when logged into the Provider Web Portal account.

The Display Name is the name delegates will see when using the "Switch Provider" function.



5. Answer the Challenge Questions, Read & Sign the Web Portal User Agreement.

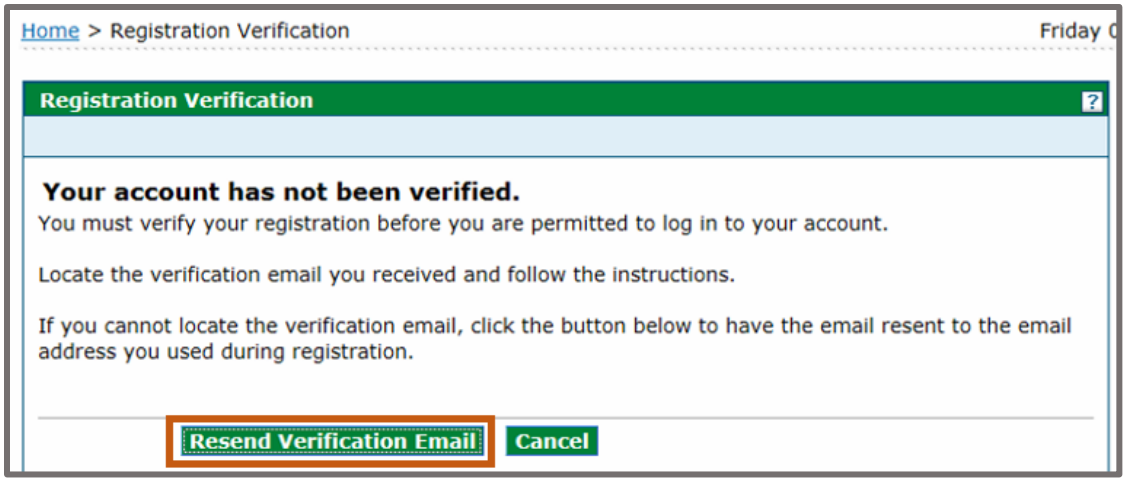


6. Click link in confirmation email.

A confirmation email from co_hcp_noreply@dxc.com will be received, **but it may take up to an hour**. If not receiving a verification email within an hour, use the system to request the verification email again.

1. Use the user ID and password to attempt to login to the Provider Web Portal account.
2. Click Resend Verification Email.

Please remember to check the junk, clutter and spam folders. If not receiving an email in one business day, call Provider Services as there may have been an issue with the email entered.



7. Confirm that logged in as an active provider

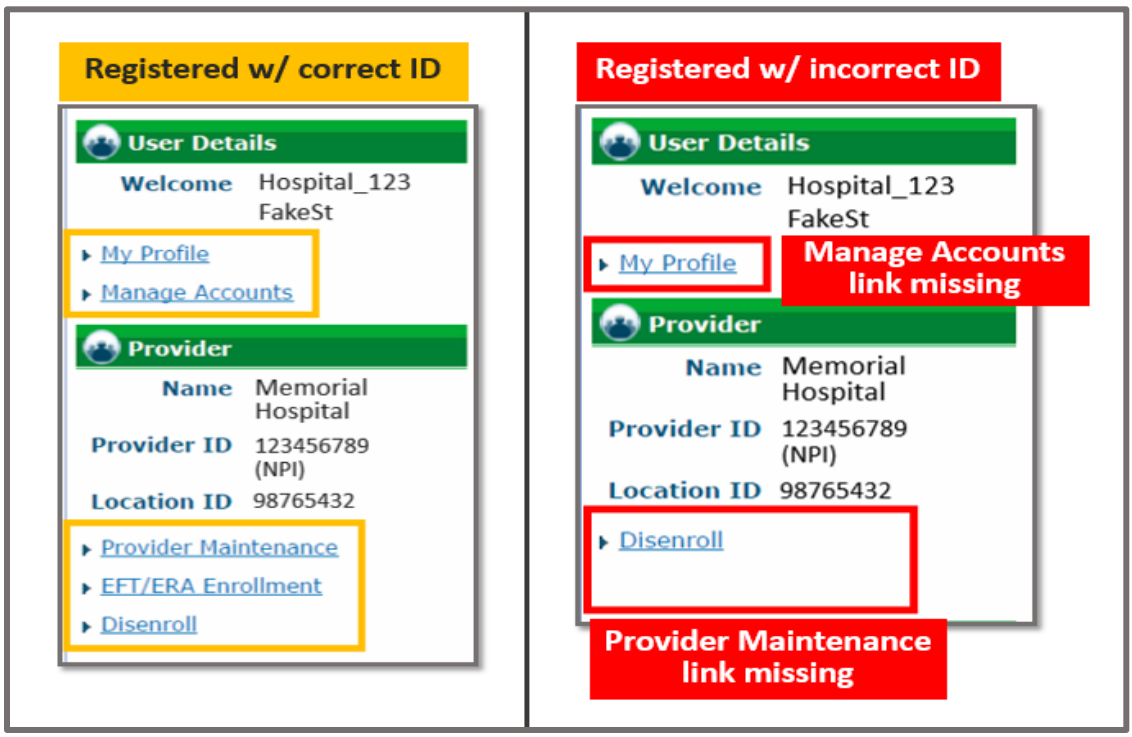
Being able to register for the Web Portal is NOT an indicator that the correct Provider ID is being used.

If <u>not</u> logged in as a delegate, and not seeing the Manage Accounts and Provider Maintenance links: either registered using the wrong Provider ID, or registered using the NPI and the Web Portal linked to the wrong account.

<u>How to fix it:</u>

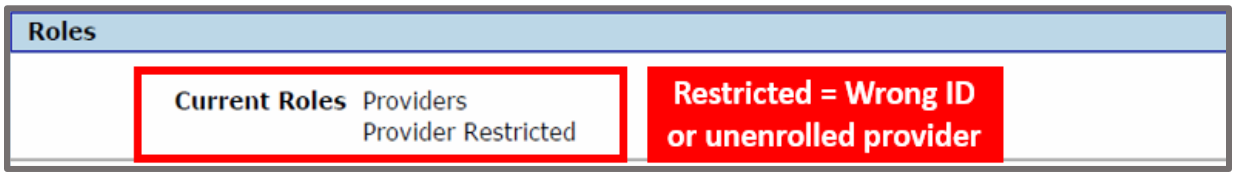
All that needs to be done is to register for a new Provider Web Portal account, using the correct Provider ID **(not the NPI)**. Please call 1-844-235-2387 the correct Provider ID isn't known.

Nothing needs to be done with the incorrect Provider Web Portal account, just stop using it.



Another indicator that the wrong ID is being used is in My Profile → Roles.

"Provider Restricted" means it has been registered using the wrong ID, or that this provider isn't enrolled.



Need More Help?

Please visit the Quick Guides and Webinars web page to find all the Provider Web Portal Quick Guides.

COLORADO
Department of Health Care Policy & Financing

Health First Colorado and CHP+ Provider Revalidation and Implementation of Colorado NPI Law

Child Health Plan *Plus* (CHP+) and Health First Colorado (Colorado's Medicaid Program) providers must revalidate in the program at least every five (5) years to continue as a provider. Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.

Revalidation

- All providers must revalidate at least every five (5) years to continue their participation in Health First Colorado and CHP+. This is a federal requirement under the Affordable Care Act (42 CFR §455.414). Revalidation involves reconfirming some of the provider's enrollment information so the Department of Health Care Policy & Financing (the Department) has accurate data and can properly screen the providers to ensure they are eligible to provide services to members.

- Information about the upcoming revalidation cycle will be published several months before revalidation starts via Provider Bulletins, emails, etc. **It is crucial that providers update all email addresses in their enrollment profiles before they revalidate so they receive these notices.** The Department will also be doing outreach through provider associations, advocate groups, and other stakeholders.

- Providers will be given at least a six (6) month notice via email in advance of their enrollment deadline. Additional email notices will be sent every month that the provider has not begun a revalidation application.

- The first group of providers must complete revalidation in October 2020, and they will receive email notices starting April 2020. Each enrollment (individual or service location) must be revalidated separately using a link in the Provider Web Portal. ***This link will become available six (6) months before the provider's revalidation deadline.***

- Training materials, FAQs, and revalidation checklists will be available for providers on the Provider Main web page. Additional trainings may be offered in the community.

- Much of the information needed for revalidation will be pre-populated. Some examples of data required include licenses and certifications, W-9 forms and a voided check, insurance policies, disclosures, etc. Providers will not be able to change their enrollment type or tax ID during revalidation. If changes need to be made, a new enrollment application must be submitted, not a revalidation.

- The revalidation process will work similarly to the enrollment process, which will require providers to submit required information and documents. A new Application Tracking Number (ATN) will then be assigned upon submission. If the application requires additional information or changes, a notice will be emailed to the provider.
- Some applications will still require a new site visit by DXC Technologies (DXC) and some providers may require fingerprinting. Providers should begin revalidation as quickly as possible after they receive the notification to ensure that these processes are completed on time.

New Colorado NPI Law Requirements

HB 18-1282 requires newly enrolling and currently enrolled Organization Health Care Providers (not individuals) to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange.

- Starting 2020, the Department will require providers to submit a claim with a unique NPI so that the Department, members, and policymakers have more transparency to where services are being provided.
- Over the years, providers have expanded to create a number of separate physical locations for delivering health care. When individuals seek care in inappropriate locations, delivery of that level of care in that setting can increase costs in the overall health care system.
- Under this new law, providers will not share the same identifier across sites as their affiliated locations. Because the costs associated with care delivered at different locations are not transparent, it may be impossible for the Department to understand the basis for costs and for policymakers to evaluate the effects.
- Under federal regulations, most providers may obtain an NPI at no cost that identifies the services provided at each of their sites and their subparts. For more information about NPI, visit the National Plan & Provider Enumeration System (NPPES) website.
- What is an NPI? The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live, or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. As outlined in the Federal Regulation, HIPAA covered providers must also

share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

The implementation date for **new providers**, i.e., those not enrolled, is January 1, 2020.

The implementation date for **all off-campus hospital locations** is January 1, 2020.

The implementation date for **currently enrolled providers** is January 1, 2021.

When providers enroll, they will need to have a unique NPI for each Provider Type (e.g., Rural Health Clinic, Community Mental Health Center, Transportation) at each site from which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program. For a complete list of Provider Types please visit the Information by Provider Type web page.

Note: This new law does not apply to individual practitioners (Individuals Within a Group or Billing Individuals) who should have only one enrollment and one NPI per person.

The Department will provide more detailed information regarding the implementation of this new state law before a provider's revalidation deadline.

Email HCPF_ColoradoNPIlaw@state.co.us for questions regarding the Colorado NPI Law, or visit the Colorado NPI web page.

Contact Provider Services Call Center at 1-(844) 235-2387 for questions regarding the Provider Web Portal.

State Seeking Members for Program Improvement Advisory Committee

On behalf of the Colorado Department of Health Care Policy and Financing (Department), we would like to invite you to participate in the subcommittees of the state Program Improvement Advisory Committee (PIAC) Community of the Accountable Care Collaborative (ACC).

Over the past year, the Department has worked with our partners to renew the PIAC Community. The PIAC Community consists of:

- The state PIAC
- Three state PIAC subcommittees
- Seven regional PIACs
- Seven regional member experience advisory committees (MEACs).

Throughout this process, the Department and the new state PIAC have developed three strategic focus areas for the broader PIAC Community:

- Member Engagement and Performance Measurement Strategies
- Provider and Community Experience
- Behavioral Health and Integration Strategies

In choosing these strategic focus areas, the Department and state PIAC hope to foster meaningful change within the ACC through aligned efforts across the state. These focus areas are also meant to be broad enough to encompass the diverse work being done at the regional level.

The Department and state PIAC have now delegated these focus areas to their respective subcommittees to begin constructive conversations about how to improve ACC performance within these areas.

Learn more about each subcommittee and how to get involved below.

Member Engagement and Performance Measurement Strategies Subcommittee
Subcommittee Charge: To assess the overall performance of and experience within the ACC by investigating strategies to ensure member participation in all aspects of the health care system and to provide guidance for an effective and publicly accessible performance measure set that is member and health outcomes focused and aligned with other efforts of the broader health care system.

Time: 3:00 - 4:30 p.m., 3rd Thursday of the month
Location: Colorado Department of Health Care Policy and Financing, 303 E 17th St, Denver, 11th Floor, Room 11C
Subcommittee Listserv: Sign up here and select *PIAC: Member Engagement and Performance Measurement Strategies Subcommittee*

Provider and Community Experience Subcommittee
Subcommittee Charge: To assess the experience of providers and community-based organizations (CBOs) within the ACC by identifying, prioritizing, and investigating key challenges and solutions to best support and build capacity within providers and CBOs, to foster collaboration and development of a health neighborhood between providers, CBOs, and Regional Accountable Entities (RAEs), and to leverage their collective strengths in broader regional and state improvement work.

Time: 8:00 - 9:30 a.m., 2nd Thursday of the month
Location: Colorado Department of Public Health and Environment, 4300 Cherry Creek S Dr, Denver, 2nd Floor, Room A2A
Subcommittee Listserv: Sign up here and select *PIAC: Provider and Community Experience Subcommittee*

Behavioral Health and Integration Strategies Subcommittee
Subcommittee Charge: To assess behavioral health integration within the ACC by investigating the strategies by which RAEs and providers are joining behavioral and physical health at the practice and systems level, by improving foundational understanding of behavioral health issues, benefits, and services, including substance use disorders, by ensuring care coordination and continuity across benefits, and by identifying the barriers to accessing behavioral health including but not limited to gaps in care and stigma.

Time: 9:00 - 10:30 a.m., 1st Wednesday of the month.
Location: Colorado Department of Health Care
Policy and Financing, 303 E 17th St, Denver, 11th floor, Room 11C
Subcommittee Listserv: Sign up here and select *PIAC: Behavioral Health and Integration Strategies Subcommittee*

All subcommittee meetings are open to the public. You may participate in more than one subcommittee. Each subcommittee must create a voting membership that assures an effective variety of expertise and perspectives. If interested, you must demonstrate a commitment to the charge of the subcommittee and to regular attendance.

Participation in a state PIAC subcommittee does not prevent your participation in our regional PIAC and MEAC.

If you are interested in participating in our regional PIAC or MEAC, you can find more information here.

Stakeholders have provided invaluable guidance and conversation in our efforts to improve health, access, cost, and satisfaction of the Department's members and providers. The Department and state PIAC look forward to working with you to continue to make progress and thank you in advance for your participation.

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