All Kids Covered Initiative
Meeting Notes
December 4, 2015

Medicaid Primary Care Provider Reimbursement Rates – *Cody Belzley, American Academy of Pediatrics Colorado Chapter & Ryan Biehle, Colorado Academy of Family Physicians*

Please click here for the Primary Care Provider Reimbursement Rates fact sheet.

Background:

- Starting January 1, 2013, Medicaid reimbursements to primary care providers were increased to the same level as Medicare (through the ACA)
- Federal funding, through the ACA, covered the increase through 2014. Colorado extended the program (approximately $18 million General Fund), as a means of attracting and retaining Medicaid providers, realizing the long term benefit to the system and to patients served.
- Without taking action, primary care providers stand to take a 26% cut in Medicaid reimbursements in July of 2016.

Areas of Concern:

- Primary care providers need reimbursement to cover their costs in order to provide care for Medicaid patients. Since the cut would affect the bottom line of providers, this would affect care coordination as well access
- Enhanced primary care reimbursement rates have had a dynamic effect on the whole healthcare system and added value in almost every area the healthcare system. This large cut will undermine most of the healthcare reforms the state as seen in the past few years
- Enhanced PCP rates have supported rural access to care. This is significantly important when trying to expand access to new Medicaid patients as well the existing patients having access to the proper care.

What is the next step?

- We all understand this is a tough year for budget cuts. However, this is a large ticket item that has the potential to affect a large population
- This is also starting to be a political issue, given the hospital provider fee and the political issues associated with it.
- There was a report (LINK HERE) done using the claims data to evaluate the effect of primary care rates. Generally speaking, the report's findings are inaccurate, mainly because:
    1. The patients in the report do not include infants (the report only looks at 12 months and older)
    2. New enrollment populations are not part of the report (the report only looks at those who have been enrolled for at least 11 months out of the 12)
    3. Only adult metrics (one pediatrician)
    4. The data is only claims data: limited at best
- Looking at the same efforts in terms of lobbying and communications efforts to that of the 'Insuring our Future' campaign in 2013. The messaging around it affecting multiple parties (healthcare access for Medicaid patients, small business, continuing of healthcare reforms).

- The Health Foundation is looking at producing a similar tool kit as the 2013 "Insuring our Future" campaign as a defense to Medicaid from economic impact perspective. This will be very helpful for the messaging around this issue.
- There is a grant opportunity from the Colorado Health Foundation outside of the normal cycle for such efforts.
- **Please contact Cody Belzley (codybelzley@gmail.com) or Ryan Biehle (ryan@coloradoafp.org) if you are interested in being involved with this effort in one or more of the following ways:**
    - **Signing onto the fact sheet**
    - **Contributing lobbying resources**
    - **Signing up for the communications campaign**

Accountable Care Collaborative Phase II – *Mark Queirolo and Hanna Schum, Colorado Department of Health Care Policy and Financing*

Please click here for the presentation slides on ACC Phase II and here for the overview fact sheet.

Q1. Are you looking at a more target population goals in terms of spending?
- Even though the ACC was first proposed and designed as cost management and reduction program, Phase II is looking at increasing spending for target population such as kids who have high returns in the long run. It is also looking to increase spending in evidence based programs for prevention and early intervention

Q2. How are you collecting stakeholder input?
- Have been seeking input for all parties involved and who benefit from the ACC. Specifically, in looking at Key Performance Indicators and their alignment with already existing programs and systems, it has been very important. We would like the indicators to be complex enough to give us quality outcomes so input has been very important and very much appreciated

Q3. With Automatic Enrollment, what are the plans to manage panels? Who would providers and patient know which panels are open and which ones are closed?
- The New MMIS program will be integrated with data analytics to manage new assignment. However, this is one aspect that is now completely sorted and requires large input from stake holders as to how better to prepare for this. Most the responsibility for panel management will not be up to the providers but rather the county.

Q4. Will the automatic enrollment also mean automatic lock in?
- Still trying to figure out the best possible way to encourage patient to stay with the same provider at least for a year. It is not determined yet as to make lock in an option but strong encouragement to stay with a provider for a year will be part of the process

Q5. What would the brief screening process look like?
- This is at a very early stage. Some have suggested to make the screening be part of the process of enrollment (this is very important as the enrollment for Medicaid and ACC will be integrated into one process in Phase II)
- The aim of the screening is to connect patients with appropriate resources in a timely matter as well as to integrate care to cater to the whole person's health
- The when, how and where are not yet clear so feedback and ideas are welcome.

Data availability and integration:
- To make available for the health team (beyond just PCMP)
- Limited data for behavioral care coordinators and other members of the health team so that there is coordination of care that looks at both behavioral and physical health. At its core the

health team is the patient and the primary care provider. However, it is important that some data is made available so that care coordinators and the like can work together.

Regional Payment systems to support this effort: the ACC will be able to provide guidelines but allow regional entities room for innovation to come up with the best way to solve these issues.

Discussion of AKC Priorities in ACC Phase II

We appreciate the visionary efforts HCPF is undertaking with ACC Phase II. The long term planning and stakeholder input is invaluable.

Q1. As part of the screen that is going to be incorporated in ACC Phase II, what do we want to see for kids?

- It is important that the kids' screening is part of the family screening as kids do not exist in a vacuum
- Look for similar efforts and collect best practices
- The proposal has to take in account health providers' capacity
- Given limited resources and capacity, we might want to look at population of kids who can benefit the most from the screening
- Screening during enrollment: enrollment takes few hours and many hours of human capital and the individuals who are taxed with enrolling patients into the program might not be qualified to carry out the screening process. This is an especially sensitive issue when kids are involved.
- We can look at a process where a patient can fill out the screening questions after the enrollment process on their own time: limited accountability, might now benefit the patient's placement if we are looking at automatic placement.

Q2. What Key Performance indicators do we want to see?

- Key Performance Indicators beyond well child checks for children
- Revise the age (life stage) division as it stands (3-9 years). The metrics starts at 3 years and we know the first three years are critical in the wellbeing of a child.
- Vaccination checks (cost, access, knowledge should be looked at as the inhabiting factors)

Q3. The proposed data system

- The proposed data system: impressive
- Vaccine registration should be part of the data system
- Child wellbeing data
- Hospital registration including cancer registration should be pulled
- Real time hospitalization
- Claims data is limited

Next meeting: Friday, February 5, 2016