ARTICLE 1

Prevent the Most Prevalent Chronic Condition in Children: Provide Preventive Oral Health Care for Children on Medicaid & CHP+

Colorado Medicaid and CHP+ now reimburse primary care providers for children's preventive oral health care done in the primary care office.

Read on to learn more about why we need you to provide this essential service, how you can prepare your practice, and how to calculate the financial impact of adding this service to your practice!

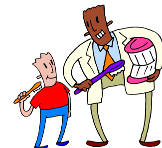
Why is preventive oral health so important for children on Medicaid and CHP+?

Dental caries is the number one chronic disease of children in America, and it is the most preventable. It is five times as common as asthma and seven times as common as hay fever. Dental caries is also a disease of poverty. Children on Medicaid/CHP+ are almost twice as likely to have untreated tooth decay compared to commercially insured children. *This can affect a child's ability to eat properly, grow, attend school and learn.* The state of Colorado has designated Oral Health as a Colorado Priority "Winnable" Battle.

Why don't these children get the preventive oral health services they need?

In most of Colorado there are not enough dentists who are willing to provide this care to Medicaid/CHP+ children. Only 16% of Colorado dentists accept children on Medicaid/CHP+ and even fewer accept children less than 5 years of age. It is this time in a child's life when dental caries is most preventable. *Primary care providers are very much needed to address this gap.*

What services help to prevent dental caries in children?



Early detection and treatment of dental caries, educating parents about oral hygiene and dental care, and fluoride applications.

How do Colorado Medicaid and CHP+ reimburse primary health care providers?

Colorado Medicaid and CHP+ will reimburse primary care medical providers to provide the services below for children under age 5:

- A physician or a mid-level practitioner can do a screening risk assessment to be kept in the child's medical record. (Click here to see the assessment form.) Training and orientation to Cavity Free at Three forms and materials is available. As you can imagine, almost all children on Medicaid and CHP+ are moderate or high risk.
- Any trained member of the office staff may provide oral health education for caregivers.
- Any trained member of the office staff may apply a fluoride varnish to the teeth of children with moderate to high risk for caries.

Primary care pediatric and family practices can provide these three services for children covered by Medicaid and CHP+ at well child visits, no more than twice per year for children under age 2 and no more than once per year for children ages 2 to 4. All three services must be done at the same time of service. It takes a small amount of time by medical assistants and the primary care

provider, the supplies needed to do this are readily available at a very reasonable cost, and the reimbursement is very fair.

How can providers and staff be trained to provide this benefit?

To provide this benefit and receive reimbursement, the medical provider must either participate in on-site training from the *Cavity Free at Three* (CF3) team or complete an on-line training program (Modules 2 & 6). Click here for more details.

How should primary care providers code and bill for these services?

Medical personnel who may bill directly for these services include MDs, DOs, and nurse practitioners. Click here for billing codes and guidelines.

What if the primary health care provider identifies cavities or other oral conditions requiring a dental referral?

The primary care provider can consult the list of dental providers available on www.insurekidsnow.gov or http://www.colorado.gov.

What do providers get paid for these services?

Reimbursement ranges from $30.00 to $43.00 depending on the age of the child. Click here for more details and a quick calculator to determine the financial benefit to your practice.

Please seriously consider adding these services in your practice! Questions?

Karen Savoie 303-724-4750 or karen.savoie@ucdenver.edu
Anita Rich 720-777-5495 or anita.rich@childrenscolorado.org
Cavity Free at Three Website: http://www.cavityfreeatthree.org.

ARTICLE 2

PROVIDER CORNER

Post-partum Mood Disorder Survey

Please complete this very brief on-line survey on Post-partum Mood Disorder: it will help design a free "on-site" training program for providers and staff.

Untreated Perinatal Mood Disorders can have major effects on gestational outcomes as well as infant cognitive, emotional, and language development. The majority of women in Colorado with these conditions continue to go unidentified and untreated.

A recent state-wide collaboration between the University of Colorado Depression Center's Program for Perinatal Mental Health Systems Integration, Children's Hospital Colorado's Healthy Expectations Perinatal Mental Health Program, the Colorado Department of Public Health's Women's Health Unit, Access Behavioral Care and Behavioral Health, Inc was formed to improve identification, education, and access to appropriate perinatal mental health services for women with public, private, and no insurance.

Through this collaboration, free on-site trainings on how to identify, educate, and refer women to experienced perinatal mental health professionals will be available.

Please complete the following online survey to help us assess current attitudes, knowledge, and skill in identifying, treating, and referring women with these concerns and to register for free training.

The survey link is: http://www.zoomerang.com/Survey/WEB22DQ64N6LAU

ARTICLE 3

ACCOUNTABLE CARE COLLABORATIVE CORNER

Accountable Care Collaborative (ACC) Update

As of December 2011, the ACC program has roughly 70,000 enrollees.

Benefits of being an ACC Primary Care Medical Provider (PCMP)

- Administrative Support: The Regional Care Collaborative Organizations (RCCOs) are charged with assisting providers in navigating Medicaid administrative systems.
- Practice Support: RCCOs are responsible for supplying providers with practical tools and resources to fulfill the basic elements of a Medical Home. Practice support may include clinical tools, client materials, operational practice support, data, reports and other resources.

- Data Analytics and Reporting Capabilities: Through the Statewide Data and Analytics Contractor, PCMPs will receive client level utilization data on the clients in their panel.
- Per Member per Month Payment (PMPM): PCMPs will receive $3 per member per month reimbursement for providing medical home level services and are eligible for an additional $1 based on regional performance. While the program is in the initial phase, PCMPs are receiving $4 PMPM. (Excludes CCHAP affiliated Medical Home for Children practices that already receive a Medical Home Incentive payment for preventive visits).

Interested providers are encouraged to contact the RCCO in their area. For contact information please click here.

Note: Becoming a PCMP does not ensure that clients will be enrolled in your panel. The contracting and enrollment processes may take several months.

Important Message to Communicate to Your Patients

Some ACC enrolled patients are getting confused when they call HealthColorado and they inadvertently request enrollment on the “old” Medicaid Primary Care Physician Program (PCPP) where a patient chooses a PCP. Many providers no longer accept patients on this plan and so, in this case, the patient will be enrolled on Regular Medicaid. If you are a contracted ACC provider, please advise your patients to tell HealthColorado that they want your practice to be their “PCMP”, or that they want to be enrolled with the ACC and with a certain provider. Please contact kevin.heckman@childrenscolorado.org or anita.rich@childrenscolorado.org if you need further help or clarification. Here are the current Medicaid Health Plan choices for patients:

Regular Medicaid – fee for service plan; patient can see any contracted Medicaid provider.

Primary Care Physician Program – patient may only see their PCP. The PCP must be open and accepting for the patient to be enrolled with the provider.

Managed Care – Denver Health Medicaid Choice and Rocky Mountain Health Plans are the two managed care organizations in Colorado. Patients may only see providers that are a part of those plans.

Accountable Care Collaborative – fee for service plan; patients must select a Primary Care Medical Provider (PCMP) to be their “medical home”. Any Medicaid

contracted provider can see these patients but only ACC contracted providers are eligible for a Per Member Per Month (PMPM) payment in addition to the fee for service payment. CCHAP affiliated providers receive the Medical Home for Children enhanced reimbursement for well child care and do not qualify for PMPM payments on children.

Medicaid ACC website: Click here

Accountable Care Collaborative Referral Requirement Update

Primary Care Medical Providers (PCMPs) in the Accountable Care Collaborative (ACC) are expected to provide a referral for their clients to see specialists and other primary care providers. There is currently a grace period in effect for referrals. During this grace period, PCMPs are expected to provide referrals for their clients; however, specialist and other primary care provider claims without a referral will be paid. The grace period will remain in effect until the policy is fully re-evaluated with our stakeholders.

Next ACC Program Improvement Advisory Committee Meeting

January 18, 2012
10:00 A.M. to 12:00 P.M.
225 E. 16th Avenue
Denver, CO 80203
1st Floor Conference Room
These meetings are open to public and there is a period for public comment. More information about the committee can be found on the HCPF ACC Program Improvement Advisory Committee web page. Feel free to contact Kathryn Jantz at Kathryn.Jantz@state.co.usor Greg Trollan at Greg.Trollan@state.co.us with questions.

ARTICLE 4

PRACTICE MANAGER CORNER

CCHAP Practice Manager Meeting Tuesday January 24th at Noon

Presentation by CORHIO with the latest updates and exciting news about EHR Incentive Registration

Robyn Leone, REC Director

Betsy Baker, Medicaid EHR Incentive Program Coordinator

New Information:

• CMS Registration for Medicaid EHR Program NOW OPEN!
• New FAQs About the Program Added to 'Provider Outreach' Website
• Updated Timeline for Registration & Attestation Available

Read More

Presentation by Maximus on Medicaid/CHP+ Enrollment and Eligibility
Jeff Gaskill, Communication Manager, Maximus

CCHAP Practice Satisfaction Survey - THANK YOU!

Many thanks to those of you who responded to our CCHAP 2011 Practice Satisfaction Survey! We received a great deal of **helpful** feedback and great ideas that we will work to implement in 2012. We would like to share with you some of the overall results:

Out of a possible high score of 4.00 (Excellent), you rated...

- New practice orientations **3.43**
- Practice Manager Meetings **3.24**
- CCHAP Monthly Newsletter **3.46**
- Overall satisfaction with CCHAP **3.47**

We would be happy to share with you the complete survey analysis. Please email kevin.heckman@childrenscolorado.org with your request.

Congratulations to our friends at My Family Doctor in Boulder, the winners of the $50.00 Visa Gift Card for completing our 2011 survey!

Lead Screening Diagnosis Code

Due to the Centers for Medicare and Medicaid (CMS) reporting changes, laboratories and providers who bill procedure code 83655 (Lead Screen) should begin to use the following diagnosis codes as applicable:
V15.86 – exposure to lead
V82.5 – special screening for other conditions such as screening for heavy metal poisoning
Codes billed without the use of one of these two diagnosis codes are not able to be reported to CMS. Please contact Gina Robinson at Gina Robinson at 303-866-6167 with any questions.

Tobacco Cessation Counseling for Pregnant Women on Medicaid

Effective for dates of service on or after January 1, 2012, tobacco cessation counseling for pregnant women and women in the early postpartum period (up to 60 days postpartum) will be covered with certain limitations. Reimbursement for a limited number of units is available when the counseling is face-to-face and consistent with the counseling practices described in the U.S.

ARTICLE 4

Public Health Service publication, *Treating Tobacco Use and Dependence (2008 Update): A Clinical Practice Guideline*. For more details Click Here.

Information about Medicaid coverage of tobacco cessation medications and nicotine replacement therapies can be found on the HCPF Tobacco Cessation Assistance site. Providers and clients should discuss the benefits and risks of using these products during pregnancy. All Medicaid clients who use tobacco and want to quit, including pregnant women, can also be referred to the Colorado QuitLine at 1-800-QUIT-NOW. A fax referral form is available here. Free QuitLine materials can be ordered at cohealthresources.org.

Annual Physical Exams For Medicaid Patients
Information recently received from Medicaid: Annual physicals need to meet certain billing criteria, however, if a client changes doctors they can get a physical as a new patient, but that is not considered "annual" and is not billed as an annual physical.

Physical exams for children must meet the age criteria for the billed physical. The EPSDT (Early and Periodic Screening Diagnosis and Treatment) program for children and youth 20 and under adheres to the following periodicity schedule: **Comprehensive Screenings:** 2-4 days after birth IF the newborn leave the hospital less than 48 hours after delivery; 2 mos.; 4 mos., 6 mos.; 9 mos.; 12 mos.; 15 mos.; 18 mos.; Once ***every year*** for ages 2 through 20. So for example, a child cannot get a 4th year physical when they are only 3 ½. There are certain functions associated with each year, vaccines, growth analysis, etc., that also cannot be administered or measured at an inappropriate time.

Adult clients can receive one annual preventive physical exam per state fiscal year (July 1st thru June 30th). Additional physical exams for school, sports, or employment are not a covered benefit, but the client can use the preventive physical exam results for school, sports, or employment.

Update on CPT 96110 (Developmental testing and screening)

An update with good news regarding discussion over the past few weeks on the Federal Register notice issued by CMS proposing discontinuation of CPT Code 96110 related to developmental testing and screening, as you'll see in the attached bulletin issued last week, (Dec 29) by CMS, the Dept has clarified that the Code should still be used. To quote their specific language:

"We want to be clear that Medicaid and other private payers will be able to continue to use code 96110 even though it is a statutorily non-covered service under Medicare. In addition, many State Medicaid programs rely upon Medicare-published relative value units, including those associated with code 96110. At the request of Medicaid and concerned stakeholders, in the next few weeks Medicare will provide the relative value units for this code."

No doubt, efforts by the pediatric community led to this policy announcement.

Steve Federico, MD
President

HIPAA 5010 Implementation Update

ARTICLE 4

Since the HIPAA 5010 update dated September and November 2011, the Department of Health Care Policy and Financing (HCPF) has made significant changes to the implementation plan and many transaction implementation dates have been moved to the January 1, 2012 compliance date. For updated implementation information, please refer to the current HIPAA 5010 Implementation Fact Sheet.

PAR Status Verification via the Automatic Voice Response System (AVRS)

At the end of December 2011, providers were able to begin to verify PAR status on the AVRS using one of the following criteria:

- Client ID *and* effective date; **or**
- PAR ID

The information the provider can access using the AVRS includes the following: status of a PAR; the approved amount; the number of approved units; the remaining amount; the remaining units; and the procedure codes or revenue codes available on the PAR.

Office-Administered Injections and Devices National Drug Code (NDC) Requirements

Two additional Current Procedural Terminology (CPT) /Health Care Procedural Coding System (HCPCS) codes for office-administered injections and devices now require a NDC to be included on the claim. As described in the November 2011 Medicaid Provider Bulletin (B1100308), NDCs for office-administered injections and devices should always be included on the medical claim. However, claims submitted with the CPT/HCPCS codes below will no longer be reimbursed unless a valid NDC from the crosswalk is included on the claim:

Codes Being Added to the Crosswalk and Associated NDCs

CPT/ HCPCS Code	CPT/HCPCS Code Description	NDC (Colorado Medicaid)	NDC Description
J7300	Intrauterine copper contraceptive	51285020401	ParaGard T 380-A IUD
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	60574411401	Synagis 50 mg/0.5 mL

Additional codes and NDCs can be found on the updated HCPCS / NDC Crosswalk for Billing Physician-administered Drugs located in the Billing Manuals section of the HCPF Web site. For additional questions, please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436.

New Web site Resources

This month the Centers for Medicare and Medicaid Services launched a new Medicaid and Children's Health Insurance Plan (CHP+ in Colorado) Web site, www.medicaid.gov.
The Colorado Health Benefit Exchange launched a new Web site this month, http://www.getcoveredco.org

January Medicaid Provider Bulletin click here

ARTICLE 4

And…Don't Forget to "Like" CCHAP on Facebook!

ARTICLE 5

Guidelines for Working with Interpreters

by Marcia Carteret, M.Ed.

Consistently, one of the biggest challenges faced by health care professionals is communicating with patients and families who have limited English proficiency. In this issue of the cross-cultural communications newsletter, we focus on some basic guidelines to follow when working with interpreters. Though the context of each patient encounter is unique, there are some fundamentals of working with interpreters that can make a significant difference in patient understanding and compliance. These guidelines may take a little more time and planning up front, but can actually save time in the long run by decreasing *missed* communication.

Hold a brief pre-interview meeting with the interpreter.

Plan to meet with the interpreter for a couple of minutes before the interview to explain the situation and any background needed for understanding what you plan to talk about. Agree with the interpreter in advance on such things as how the interview will start and where the interpreter should sit.

Plan to allow enough time for the interpreted sessions.

Schedule enough time for the interview, remembering that an interpreted conversation requires every statement or question to be uttered twice. If family members are part of the conversation, it will further extend the time needed. Remember that what can be said in a few words in one language may require a lengthy paraphrase in another.

Don’t ask or say anything that you don’t want the patient to hear.

Expect everything you say to be interpreted as well as everything the patient and his family says. In cross-cultural health care interactions it is important to remember that families may not want a patient to be told of a bad diagnosis directly. Be sure to discuss the expectations about full disclosure with the family member who seems to be leading the interaction if it is not the patient. Clearly, in pediatrics, it will be a parent. With older patients, it may be much less clear who speaks for the family/patient. Don't make assumptions. Ask.

Use carefully chosen words to convey your meaning, and limit the use of gestures.

When speaking English, you may be used to supplementing your words with gestures to help convey your meaning. Competent interpreters will convey the meanings of your words and not take the liberty of interpreting your gestures. The patient may be confused by gestures that are not linked to words they understand, and may misinterpret your meaning.

ARTICLE 5

Speak in a normal voice, clearly, and not too fast or too loudly.

You don't need to speak more loudly or slowly (unless the interpreter asks you to slow down). It is usually easier for the interpreter to interpret speech produced at normal speed, with normal rhythms, than artificially slow speech.

Avoid jargon and technical terms.

Avoid idioms, technical words, or cultural references that the interpreter might have difficulty translating. (Some concepts may be easy for the interpreter to understand but extremely difficult to translate

Keep your utterances short, pausing to permit the interpretation.

For consecutive interpreting, you should speak for a short time—one longer sentence or three or four very short ones at most—and then stop in a natural place to let the interpreter pass your message along. Be aware of the length and complexity of your speech so as not to unduly tax the interpreter. She may need to hear the whole sentence before she can even start to interpret it. Simple sentences that convey one thought or question should be the main communication tool. Compound sentences that combine ideas may be tricky to interpret. Leading off a sentence with a statement that eventually becomes a question can be very confusing. Make statements. Ask questions. Don't do both at once.

Ask only one question at a time.

If you string questions together, you may not be able to match questions with answers, and you may confuse the patient.

Expect the interpreter to interrupt when necessary for clarification.

Let the interpreter know that you are prepared for him to interrupt when necessary, to ask you to slow down, to repeat something he didn't quite get, to explain a word or concept he might not be familiar with, or to add background information for the patient's increased understanding.

Expect the interpreter to take notes if things get complicated.

Don't be surprised if the interpreter takes notes to facilitate recall. This is an aid to memory, not an interruption.

ARTICLE 5

Be prepared to repeat yourself in different words if your message is not understood.

If mistranslation is suspected (for example, the response doesn't seem to fit with what you said), go back and repeat what you said in different words simplifying your speech even further if possible.

Have a brief post-interview meeting with the interpreter.

Meet with the interpreter again after the interview to assess how things went, to see if the interpreter is satisfied or has questions or comments about the process of communication.

Remember that the interpreter is not there (just) to interpret for the patient or to interpret the patient's language.

The interpreter is there to interpret for two clients who don't know each other's languages, you and the patient. The interpreter is there to facilitate communication between the two of you.

Use a seating arrangement in which you, the patient, and the interpreter form the points of a triangle.

This arrangement makes it easy for the provider and patient to address each other directly, both verbally and visually, and for the interpreter to support both parties in the exchange of information.

Read related newsletters on this topic listed under newsletters at www.dimensionsofculture.com

- Some Basics for Conversing Across Cultures
- 8 Tips for Conversing With Limited English Proficiency Patients and Families

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Resources:

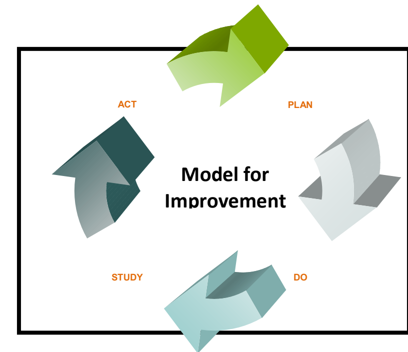
The information provided in this newsletter is borrowed with permission from The Provider's Guide to Quality and Culture, a joint project of: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, and Management Sciences for Health (MSH) at erc@msh.org.

ARTICLE 6

Quality Improvement – Measurement

You Can't Manage What You Don't Measure ~ author unknown

PDSA: a simple and effective way to evaluate and improve current or future processes by PLANNING what you want to do, IMPLEMENTING the plan, STUDYING the results, and then ACTING on your findings in order to produce better outcomes. (Click ***here*** to log in and view the CCHAP QI Chapter for more details.)



When you are PLANNING and IMPLEMENTING your QI project, it's extremely important that you consider how you will measure your progress. What data will tell you whether or not your intervention is working?

QUALITY IMPROVEMENT MEASUREMENT

A vital piece of QI is measurement of progress. In order to measure progress, you need to first clearly define what you want to change, as well as your desired outcome. Next, you need to find your baseline. Once you've implemented your project, you will periodically measure your progress against this baseline in order to determine whether or not your specific change has actually led to an improvement.

When defining your measurements, keep the following in mind:

- Keep it simple: gather just enough data to learn what you want to learn.
- Don't rely only on hunches.
- Look at data that you are currently using to see if that data meets your needs.
- How can data be collected most easily? And can this new data be gathered concurrently with existing data queries?
- What data is easily available from other sources?

It is important to ensure data validity. During your planning, be sure to consider:

- Who will collect the data?
- How will the data be collected and how often?
- Are results consistent with reality?

Experts agree that there are certain Keys to QI Success

★ Assess current performance & choose focus area.
★ **Develop & implement a plan of action that is precise, understandable, and practical. (PDSA)**
★ Embed QI philosophy into organizational goals & priorities (including Job Descriptions).
★ **Gain buy-in from leadership:** QI is most successful when adopted by leadership & the entire organization.
★ **Start small & keep it simple!**
★ **ID all stakeholders & invite them to join your team.**
★ Don't get lost in the data; Instead use it to show progress!
★ Educate staff & seek their support through empowerment & involvement.
★ Consider appointing a team leader to manage "day to day" QI activities
★ **Review. Measure. Evaluate.**
★ **Commit to the Process.**

Remember: A QI Coach is available – for FREE – to CCHAP affiliated practices wishing to improve their medical home. Call or email today!

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ARTICLE 6