COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2017

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

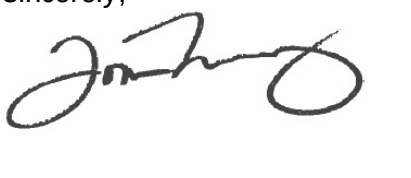
Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

Attached is the Accountable Care Collaborative annual report for FY 2016-17. This report provides information regarding program enrollment, performance with an emphasis on member health impacts, program costs and fiscal performance, activities that promote access to services for Medicaid members in rural and frontier counties, efforts to coordinate with Long-Term Services and Supports, information on advisory committees and other stakeholder engagement, future areas of program development and efforts to reduce waste and inefficiencies through the Accountable Care Collaborative.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,



Tom Massey
Interim Executive Director

TM/smt

Enclosure(s): HCPF 2017 Accountable Care Collaborative Implementation Report

Cc: Representative Kent Lambert, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Megan Davisson, Joint Budget Committee Analyst
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2017

The Honorable Jim Smallwood, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Smallwood:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

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Sincerely,

Tom Massey
Interim Executive Director

TM/smt

Enclosure(s): HCPF 2017 Accountable Care Collaborative Implementation Report

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator John Kefalas, Health and Human Services Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

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Sincerely,

Tom Massey
Interim Executive Director

TM/smt

Enclosure(s): HCPF 2017 Accountable Care Collaborative Implementation Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Marc Catlin, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Dan Pabon, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2017

The Honorable Joann Ginal, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Ginal:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Tom Massey
Interim Executive Director

TM/smt

Enclosure(s): HCPF 2017 Accountable Care Collaborative Implementation Report

Cc: Representative Daneya Esgar, Vice Chair, Health, Insurance and Environment Committee
Representative Susan Beckman, Health, Insurance and Environment Committee
Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment Committee
Representative Chris Kennedy, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

ACCOUNTABLE CARE COLLABORATIVE FY 2016-17

In compliance with Section 25.5-5-419, C.R.S

December 1, 2017

Submitted to:

Joint Budget Committee, Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate

COLORADO
Department of Health Care Policy & Financing

Section 25.5-5-419, C.R.S states:

> On or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

Executive Summary

The Department of Health Care Policy and Financing (Department) is pleased to submit this annual report on the Accountable Care Collaborative to the Joint Budget Committee. As requested, this report provides an update for FY 2016–17 on

- Program enrollment
- Performance with an emphasis on member health impacts
- Program costs and fiscal performance
- Activities that promote access to services for Medicaid members in rural and frontier counties
- Efforts to coordinate with Long-Term Services and Supports
- Information on advisory committees
- Future areas of program development
- Efforts to reduce waste and inefficiencies through the Accountable Care Collaborative.

The Accountable Care Collaborative is the core of Colorado's Medicaid. It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and to make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people and, in just six years, has shown real progress in creating a health care delivery program that improves health outcomes, better coordinates care, and reins in cost.

The four primary goals of the Accountable Care Collaborative program are:

- Ensure access to a focal point of care or medical home for all members;
- Coordinate medical and non-medical care and services;

- Improve member and provider experiences in the Colorado Medicaid system; and
- Provide the necessary data to support these goals, to analyze progress, and to move the program forward.

The program is built to accomplish these goals using three core components:

- Seven Regional Care Collaborative Organizations (RCCOs), each accountable for the program in a different part of the state;
- Primary Care Medical Providers (PCMPs), who function as medical homes for members; and
- Data and Analytics, which provide the Department, RCCOs and PCMPs with actionable information on individual members and the Accountable Care Collaborative population as a whole.

Enrollment

As of June 2017, there were 1,066,549 Medicaid members enrolled in the program, including those in the Accountable Care Collaborative: Medicare-Medicaid Program, the Accountable Care Collaborative: Rocky Mountain Health Plans Prime, and the Accountable Care Collaborative: Access KP.

Accountable Care Collaborative enrollment accounts for nearly 80 percent of all Medicaid Members; just five percent of those who are enrolled choose to opt-out. The program works best when members have a medical home with a PCMP. More than three-quarters of Accountable Care Collaborative members are now connected to a PCMP and have a medical home. Members may select or change their PCMP at any time.

Program Performance with an Emphasis on Member Health Impacts

During FY 2016-17, the Accountable Care Collaborative continued to see positive improvements in performance across the Department's Key Performance Indicators (KPI). The KPIs are performance metrics that are tied to payments for RCCOs and PCMPs. During this fiscal year:

- The rate of well-child visits for children ages 3-9 increased from 46.5 to 48.1 percent
- The postpartum care rate increased from 33.8 percent to 34.6 percent
- The emergency department visit rate decreased from approximately 880 visits per thousand members to 848 visits per thousand members

The RCCOs have formed partnerships with Healthy Communities programs and Family Resource Centers to ensure that more children receive well-child checks and new moms receive the care they need. Several RCCOs also provide financial incentives to families whose children receive well-child checks.

To impact the emergency department rate, the RCCOs are using hospital admission, discharge, and transfer (ADT) data so that care coordinators and PCMPs can reach out to members soon after a hospital visit. Other RCCOs are partnering with first responders to identify members who frequently use emergency services so the RCCO can get them the ongoing care and services they need and support members in developing an ongoing relationship with a PCMP.

The Department administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to adults and parents of child members. The survey was administered at the practice level, and by most measures, Medicaid members are satisfied with the care they receive. There are opportunities for improvement and over the next fiscal year the Department will be working with the RCCOs to identify steps that can improve member experience.

Additionally, RCCOs used various strategies to gather feedback and assess member experience, including hosting member wellness forums, participating in community outreach events, and using member engagement through calls to customer contact centers to assess gaps and connect members to needed services.

Financial Performance

To estimate costs this year, the Department compared the current costs for program enrollees to the costs from last year. The Department estimates that the Accountable Care Collaborative resulted in an additional **$26,804,229** in medical costs avoided since the prior year; after accounting for the increases in administrative expenses from the previous year, costs avoided totaled **$21,568,767** over last year.

For FY 2016–17, total administrative costs for the program were $150,374,011. Approximately 14 percent of the payments are value-based payments tied to performance on the KPIs and to recognize and reward practices that meet enhanced primary care medical home criteria or are participating in federal initiatives such as the State Innovation Model (SIM) or the Comprehensive Primary Care Plus (CPC+).

Promoting Access to Services in Rural and Frontier Counties

Colorado's rural and frontier regions face unique challenges in ensuring access to health care. Both the Department and RCCOs have a responsibility to ensure access to services in these regions, and use various strategies to improve the availability and accessibility of services. RCCOs have developed and maintained PCMP provider networks to provide members with meaningful choice in selecting a provider. When gaps in care are identified, RCCOs recruit additional providers to the Accountable Care Collaborative, and work with existing providers to increase capacity.

Supporting practice transformation efforts is another mechanism by which the Department and RCCOs work to promote access to services in rural and frontier regions. Through practice transformation, providers work to increase their scope so they can offer additional services to their members, such as integrating physical and behavioral health care, and being accessible for individuals with disabilities. RCCOs encourage providers to participate in reform initiatives that offer technical and financial support to help practices improve the delivery efficiency of their practices.

Coordinating with Long-Term Services and Supports

Coordination among RCCOs and entities that authorize Long-Term Services and Supports (LTSS) is an important step in ensuring coordinated care for Health First Colorado members who are served by multiple health systems. In Colorado, LTSS are authorized by Single Entry Point (SEP) and Community Centered Board (CCB) agencies.

The Department worked with RCCOs, SEPs, CCBs and Behavioral Health Organizations (BHOs) to develop protocols that established guidelines for understanding roles and responsibilities when working with members shared across agencies. Through this work, RCCOs have formalized partnerships and data sharing agreements with SEPs and CCBs. The purpose of these agreements has generally been used to identify shared members, define a process for collaborating, establish communication and workflow processes, and identify a lead in care coordination.

Advisory Committees and Stakeholder Engagement

The Accountable Care Collaborative's Program Improvement Advisory Committee (PIAC) serves as an integral forum for stakeholder engagement and feedback. PIAC, and the four affiliated sub-committees, meet regularly to provide guidance and recommendations to the Department to help improve health outcomes, access, cost, and member and provider experience in the Accountable Care Collaborative. The Department engages key stakeholder groups through PIAC, including Medicaid members, physical and behavioral

health providers, substance use providers, Long-Term Services and Supports providers and advocates. During FY 2016-17, PIAC focused on various topics related to the Accountable Care Collaborative, specifically, providing feedback in the development of the Request for Proposals for the next phase of the Accountable Care Collaborative, primary care payment reform, member engagement, criminal justice, and transportation.

In addition to the work at the state-level PIAC, each RCCO hosts a regional performance improvement advisory committee, which serve as an important forum for RCCOs to identify community-level needs and develop solutions. Many RCCOs have formed advisory councils specifically for Medicaid Members to create an opportunity to hear and address member-specific issues.

Looking Forward

It is the Department's vision that Coloradans enjoy physical, mental and social well-being; to achieve this, the Department is moving toward a more coordinated and integrated health care system. Delivery system transformation is key to the Department's mission to improve access to services while demonstrating sound stewardship of financial resources. Specifically, the Department is implementing the next phase of the Accountable Care Collaborative and the Alternative Payment Model for Primary Care (AMP).

Over the last six years, the Accountable Care Collaborative has shown progress in creating a health care delivery program that improves health, better manages care, and is a smarter use of resources. To continue to move toward a more coordinated and integrated system, the Department will implement the next phase of the Accountable Care Collaborative in summer 2018 when contracts will go into effect for seven Regional Accountable Entities (RAEs). Each RAE will perform as a single administrative organization for behavioral health and physical health. In preparation for this change, in FY 2016-17, the Department issued a draft request for proposals to solicit input on program design and also issued the final request for proposals (proposals were submitted during FY 2017-18).

The Department is transforming payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is starting with primary care and worked closely with stakeholders to develop the Alternative Payment Model for Primary Care (APM) which is designed to provide long-term, sustainable investments into primary care while introducing accountability for

outcomes and rewarding performance. The RCCOs (and soon to be RAEs) will support providers to help them successfully implement the APM in their practices.

Reducing Waste and Inefficiencies

The Department works to reduce waste and inefficiencies in the Medicaid program through the Accountable Care Collaborative. The Accountable Care Collaborative allows RCCOs the flexibility to test innovative technologies to streamline care, reduce duplicative services and ultimately use heath care resources more efficiently. Specifically, RCCOs have piloted different tools to support care coordination, and have formalized data sharing agreements with other agencies that serve Medicaid members. RCCOs have also strengthened partnerships with Single Entry Points, Community Centered Boards, local public health agencies, county social and human services offices, and other key community partners to understand roles and responsibilities, establish workflows to better serve shared members, and streamline communications.

1. Introduction and Background

1.1. Program Overview

The Accountable Care Collaborative is the core of Colorado's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people.

The Accountable Care Collaborative works on the principle that coordinated care, with needed community supports, is the best, most efficient way to deliver care, especially to those with the complicated health needs many Medicaid members have due to disability or challenging life circumstances.

Over the last six years, the Accountable Care Collaborative has encouraged and rewarded coordinated and better managed care, resulting in a more efficient and effective system that drives improved health for members. Providers are given supports and resources by regional organizations to provide services to their members that they would not otherwise be able to provide. Those services are linked directly to improved health outcomes.

The program also gives providers essential data to understand how their members are doing and what they can do to improve health outcomes. The regional entities help providers to manage, understand and use these metrics. Data helps the program and its providers identify ways to improve health so they can intervene early. For example, the program has lowered the number of emergency room visits, helping members better manage their health before they are in crisis.

Using resources efficiently and effectively is a primary goal of the program, so it is designed to help providers get their members the care they need in the right place at the right time, and identify patterns that drive cost but do not improve health. The program continually monitors for waste and abuse by using data analysis and other predictive tools.

The four primary goals of the Accountable Care Collaborative program are:

- Ensure access to a medical home for all members
- Coordinate medical and non-medical care and services
- Improve member and provider experiences in the Colorado Medicaid system
- Provide the necessary data to support these goals, analyze progress, and move the program forward

The Accountable Care Collaborative program has three core components:

- Seven Regional Care Collaborative Organizations (RCCOs), each accountable for the program in a different part of the state
- Primary Care Medical Providers (PCMPs), who function as medical homes for members
- Data and Analytics, which provides the Department, RCCOs and PCMPs with actionable information on individual members and the Accountable Care Collaborative population as a whole

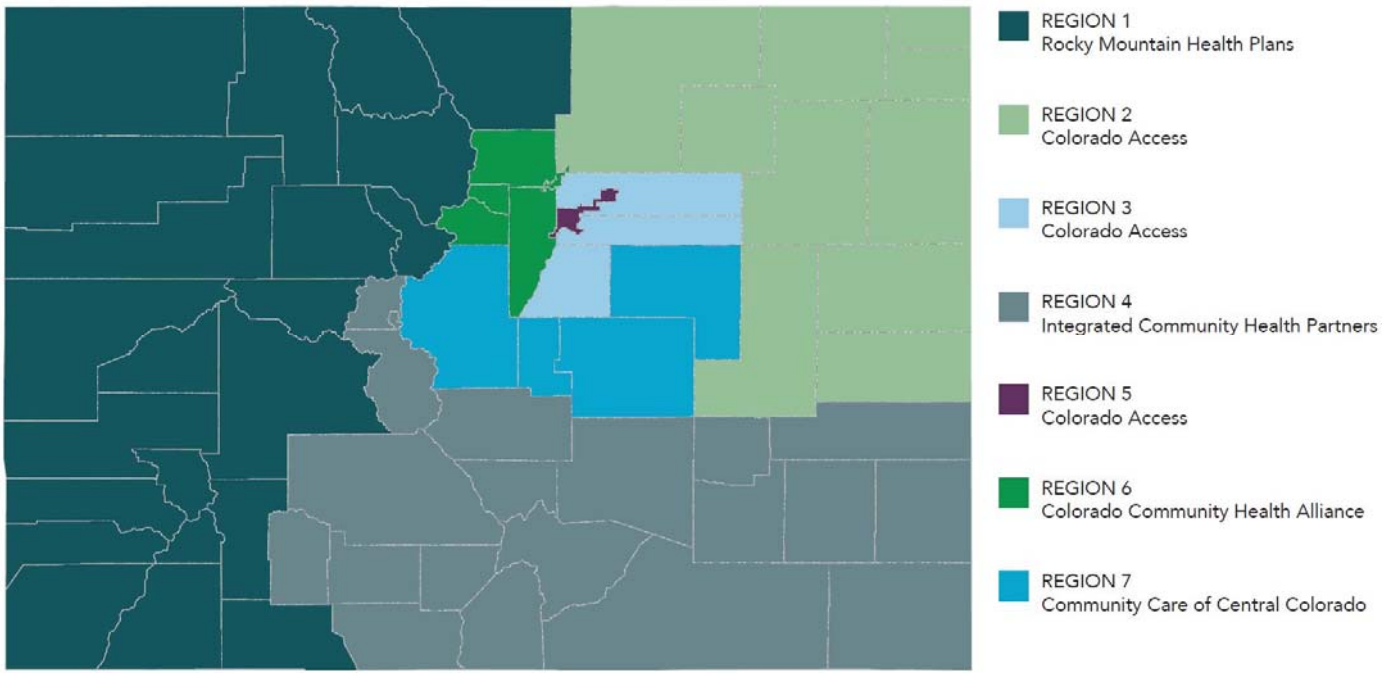
Regional Care Collaborative Organizations

The purpose of the RCCOs is to meet health and financial outcome targets in their region while ensuring appropriate care coordination and that members have a medical home. RCCOs work at the local level to support program members and providers. The RCCOs have the following responsibilities:

- **Medical management and care coordination**: ensuring that every member in their region receives coordinated, comprehensive, person-centered care, and other non-medical supports as needed to overcome barriers to getting appropriate care

- **Provider network development**: developing a formal contracted network of primary care providers, and an informal community network of medical and non-medical services
- **Provider support:** supporting primary care medical providers in providing efficient, high quality care by providing clinical tools, member materials, administrative support, and practice redesign
- **Accountability and reporting**: reporting to the state on the region's progress, and meeting programmatic and Departmental goals

Figure 1: Map of Accountable Care Collaborative Regions, by Regional Care Collaborative Organization



Primary Care Medical Providers

One of the program's goals is to link every member to a primary care medical provider (PCMP) as his or her central point of care. The PCMPs function as medical homes, a model that promotes comprehensive and coordinated care for a positive member experience and better health outcomes. PCMPs are responsible for ensuring timely access to primary care for members, but may provide care coordination directly, or work with RCCOs to give the best possible support to members.

The following are PCMP responsibilities:

- **Medical home**: be the focal point of care for members
- **Primary care**: provide the majority of their members' primary and preventive care
- **Connection to community and social services**: assess members' medical and non-medical needs, and help them access services they need to improve their overall health and well-being and attain their health goals

Data Analytics

The Department provides RCCOs and PCMPs with data and analytics for individual members and the entire Accountable Care Collaborative population. Population-level data is used to evaluate and improve the performance of RCCOs, PCMPs and the program overall. Member-level data is used to support care management and coordination activities, and can help RCCOs and PCMPs identify members with complex medical needs.

Since the beginning of the program in 2011 through April 2017, data was provided by way of the Statewide Data and Analytics Contractor (SDAC) via an online portal and as a direct data feed to the RCCOs. The SDAC web portal was used to track performance metrics so RCCOs, PCMPs and the Department were held accountable for meeting program goals. Some of the measures tracked were Key Performance Indicators (KPIs), which are used to determine incentive payments for RCCOs and PCMPs.

Near the end of FY 2016-17, the Department implemented a new data warehouse and suite of analytic tools through the Business Intelligence Data Management system (BIDM) contractor. In June 2017, the BIDM vendor, IBM Watson Health, implemented the new Health First Colorado Data Analytics Portal (Data Analytics Portal), which currently has three dashboards:

1) Performance Dashboard, which includes KPI performance;
2) My Members, which includes a list of members enrolled to each RCCO or PCMP; and,
3) Other Program Measures, which includes non-KPI measures. Each dashboard uses intuitive point-and-click technology that allows users to drill down to individual members and their gaps in care, or drill up and look at aggregate performance by user.

In collaboration with the Department, IBM Watson Health will continue to implement new functionality through the Data Analytics Portal. Planned enhancements include a Patient Health Record Dashboard that will show a summary of 18 months of claims history for

each Accountable Care Collaborative member, and a content management system, which will provide users with key resources, trainings, and documentation to help users understand their data.

1.2. In This Report

This report includes updates on the following:

- Accountable Care Collaborative Enrollment
- Program Performance with an Emphasis on Member Health Impacts
- Financial Performance
- Promoting Access to Services in Rural and Frontier Counties
- Coordinating with Long-Term Services and Supports
- Advisory Committees and Stakeholder Engagement
- Looking Forward
- Reducing Waste and Inefficiencies

With the exception of enrollment data, this report does not include an update on the Accountable Care Collaborative: Rocky Mountain Health Plans Prime, or the Accountable Care Collaborative Access KP program. These initiatives were developed under the Accountable Care Collaborative Payment Reform Initiative and codified at section 25.5-5-415, C.R.S; their progress will be addressed in a separate legislative report that will be submitted on April 15, 2018.

2. Accountable Care Collaborative Enrollment

This section provides data on the number of members enrolled and describes the process for enrolling Medicaid members into the Accountable Care Collaborative. It is divided into three subsections, as follows:

2.1 Enrollment Numbers
2.2 How Members are Enrolled in the Accountable Care Collaborative Program and into a Regional Care Collaborative Organization (RCCO)
2.3 How Members are Attributed to a Primary Care Medical Provider (PCMP)

2.1. Enrollment Numbers

In FY 2016-17, enrollment in the Accountable Care Collaborative continued to rise. As of June 2017, 1,066,549 Medicaid members were enrolled in the Accountable Care Collaborative, which is nearly 80 percent of all Medicaid members. This number represents all members, including the Accountable Care Collaborative: Medicare-Medicaid

Program, Accountable Care Collaborative: Rocky Mountain Health Plans Prime, and Accountable Care Collaborative: Access KP program members.

Figure 2 shows growth in enrollment since FY 2011-12, the first full year of the program and Table 1 shows the enrollment for FY 2016–17 by population.

Figure 2: Accountable Care Collaborative Enrollment and Medicaid Caseload from FY 2011–12 to FY 2016–17

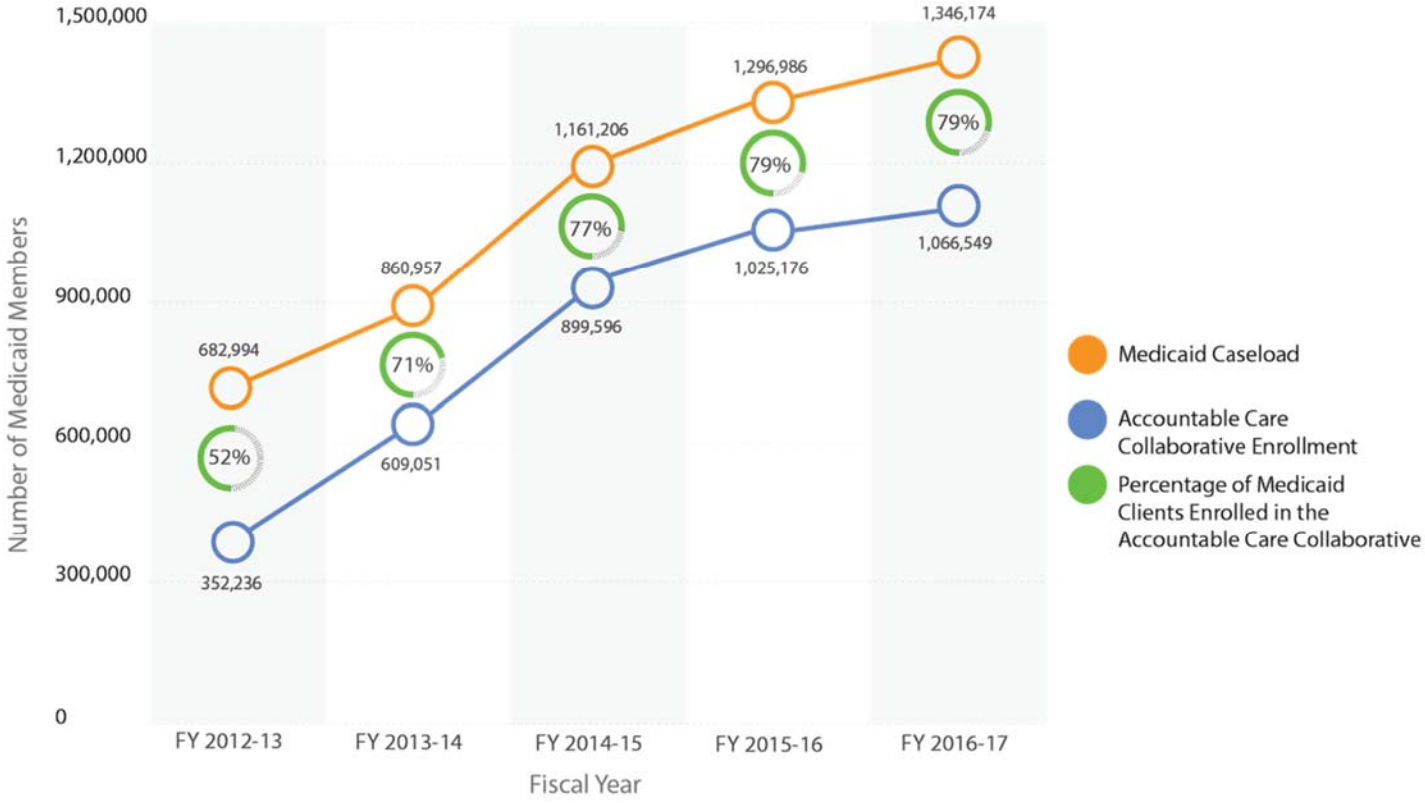


Table 1: Accountable Care Collaborative Enrollment by Population. FY 2016-17

Population	Number of Accountable Care Collaborative Members	Percent
Children without disabilities	457,423	43%
Adults (without disabilities) covered under the Affordable Care Act expansion	359,740	34%
Adults (without disabilities) eligible before the Affordable Care Act expansion	156,056	15%
Children and adults with a disability	63,345	6%
Medicare-Medicaid Program members	29,985	3%
TOTAL	**1,066,549**	

Note: Numbers add to more than 100 percent due to rounding.

2.2. How Members Are Enrolled Into the Accountable Care Collaborative Program and Into a Regional Care Collaborative Organization

Participation in the Accountable Care Collaborative is optional. The Department enrolls all new Medicaid members who are eligible to participate in the program[1], giving members the ability to opt out within 120 days of their initial notice of enrollment (30 days before enrollment and 90 days after the effective date of enrollment). This process is called *passive enrollment*. After the completion of the 120-day period, most Accountable Care Collaborative members may opt out only during their annual enrollment period. Accountable Care Collaborative: Medicare-Medicaid Program members may opt out of the program at any time for any reason. Only five percent of those passively enrolled in the program choose to opt out.

[1] All individuals who receive full Medicaid benefits are passively enrolled into the Accountable Care Collaborative, except for those who are already enrolled in another managed care program. In March 2017, the Department began enrolling individuals who are or were recently in a nursing home into the Accountable Care Collaborative; this population had formerly been ineligible.

At the time of enrollment into the Accountable Care Collaborative, all members are enrolled into a RCCO. Enrollment to the RCCO is done by geography; a member who lives in the RCCO's region is enrolled to that RCCO.

2.3. How Members Are Attributed to a Primary Care Medical Provider

One of the program's goals is to link every member to a PCMP that serves as the member's central point of care, a process called *attribution*. The PCMP functions as a medical home, a model that promotes comprehensive and coordinated care for a positive member experience and better health outcomes.

Upon enrollment in the Accountable Care Collaborative, the Department tries to attribute members to a PCMP through the following process:

1. Members are attributed to a PCMP they have recently seen based on claims history within the previous 12 months.
2. Members who do not have a claims history with a PCMP will be attributed to a PCMP that someone in their family has recently seen based on claims history within the previous 12 months.

Sometimes there is no claims history to show a relationship with a primary care provider, either for the member or any family members. These members are at risk of going without a PCMP for a long time. To reduce this risk, the Department checks every month to see if unattributed members or their family members have any new claims that show a relationship with a primary care provider. If so, the member is attributed to that PCMP. The member is notified by mail when they are attributed to a PCMP.

Members may select or change their PCMP at any time. Member choice always takes priority over system assignment based on claims history. More than three-quarters (77 percent) of members had a PCMP in FY 2016–17.

3. Program Performance with An Emphasis on Member Health Impacts

Improving health outcomes and health care experience for all Medicaid members are central goals of the Accountable Care Collaborative. As indicated in last year's report, Medicaid members who have access to coordinated care can realize improved health outcomes and member experience.[2]

[2] Accountable Care Collaborative Legislative Request for Information #3

This section describes the performance of the program, including an analysis of performance measures, and a description of RCCO activities to improve member health. This section is divided into the following four subsections:

3.1 Methodology for Evaluating Program Performance
3.2 Performance Measures
3.3 RCCO Initiatives to Improve Member Health
3.4 Member Satisfaction

3.1. Methodology for Evaluating Program Performance

In implementing the new data system described in Section 1, the Department has prioritized calculating measures that are used to incentivize improved health outcomes for this report, which are either a Key Performance Indicator (KPI), or a recently retired Pay for Performance measure. Specifically, measures included in this report are:

- Well-child visits among children ages 3-9;
- Postpartum visits;
- Emergency room visits; and,
- Follow-up within 30 days of a hospital discharge.

The measures are calculated using FY 2016-17 claims data for the Accountable Care Collaborative population and follow the methodology and calculation exclusions used to determine payments. The following populations are excluded:

- Those enrolled in the Accountable Care Collaborative: Medicare-Medicaid Program, or those who have Medicare coverage[3];
- Those enrolled in the Accountable Care Collaborative: Access KP program or the Accountable Care Collaborative: Rocky Mountain Health Plans Prime.[4]
- Those who were enrolled in a physical health managed care plan for more than three months of the reporting period,
- Those who are enrolled in Medicaid for less than three months of the reporting period.

[3] Members who have both Medicare and Medicaid coverage are excluded from this analysis because the Department does not have a full set of Medicare claims for these members.
[4] Performance for the Accountable Care Collaborative: Access KP and Accountable Care Collaborative: Rocky Mountain Health Plans Prime programs are reported in a separate legislative report that will be submitted in April 2018.

It is important to note that the methodology used to calculate each measure has changed from previous years due to the transition of data vendors. For example, the Department aligned the measure with the national Healthcare Effectiveness Data and Information Set (HEDIS) standards and added a requirement that the postpartum care visit must be within 21 to 56 days after delivery. This new time-limit, which the Department considers important for improving health outcomes and ensuring necessary access to care, has led to a decrease in the Postpartum KPI rate.

3.2. Performance Measures

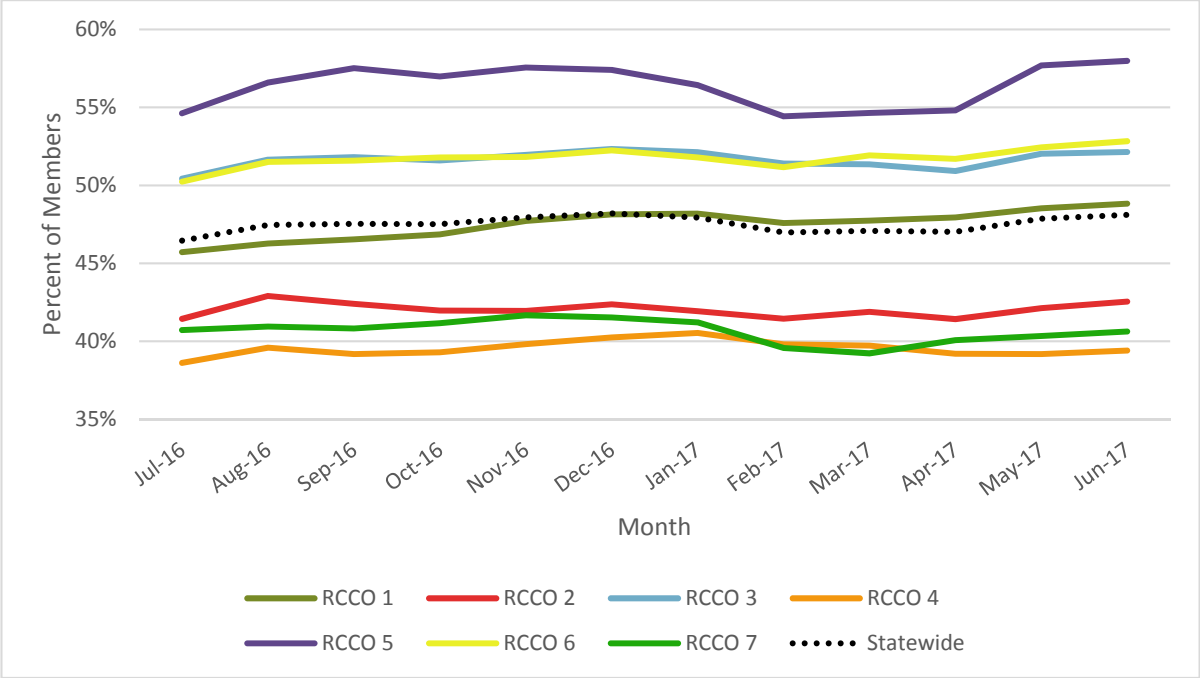
This section includes a description of each measure, demonstrates performance by RCCO across FY 2016-17, and provides examples of how RCCOs are addressing each measure to improve member health outcomes.

Well-Child Visits Among Children Ages 3-9

This measure tracks the rate of annual well-child visits among children in the program ages 3–9 years. Well-child visits are an important opportunity for caretakers and health providers to communicate about essential preventive care, such as childhood vaccinations. Additionally, caretakers receive information and advice on normal development, nutrition, sleep, safety, and diseases. The Department measures the member population ages 3–9 because rates of well-child visits have been historically low for this age group.

As Figure 3 indicates, the rate of well-child visits has increased on a statewide average in FY 2016-17, from 46.5 percent to 48.1 percent. The majority of RCCOs saw an increase in this rate in FY 2016-17, including Rocky Mountain Health Plans (RCCO 1) and Colorado Access (RCCO 5) who each realized a three-percentage point increase in well-child visits.

Figure 3: Annual Well-Child Check Rate for Children Ages 3–9 for Accountable Care Collaborative Population Members, FY 2016-17



The annual well-child visit rate is below the KPI targeted rates for two levels of incentive payments (set at 60 percent and 80 percent respectively), and the RCCOs are working on interventions to increase these rates. Several RCCOs (Rocky Mountain Health Plans, Colorado Community Health Alliance, and Community Care of Central Colorado) have formed partnerships with county Healthy Communities programs to coordinate care and reduce duplication for children receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Integrated Community Health Partners has partnered with a local community mental health center, Health Solutions, to leverage member relationships with their behavioral health provider to outreach children who need a well-child visit. Initial data shows well-child visit rates have increased from 46 percent to 66 percent for PCMPs for whom Health Solutions provides care coordination.

Colorado Access uses Interactive Voice Recognition (IVR) software and direct-mailings to target outreach to members who have not received a well-child visit. They also continued the Prevention Perks program in which all new members receive a coupon encouraging them to schedule a visit with their doctor. Once the member completes their well-visit, they receive a $10 grocery store gift card.

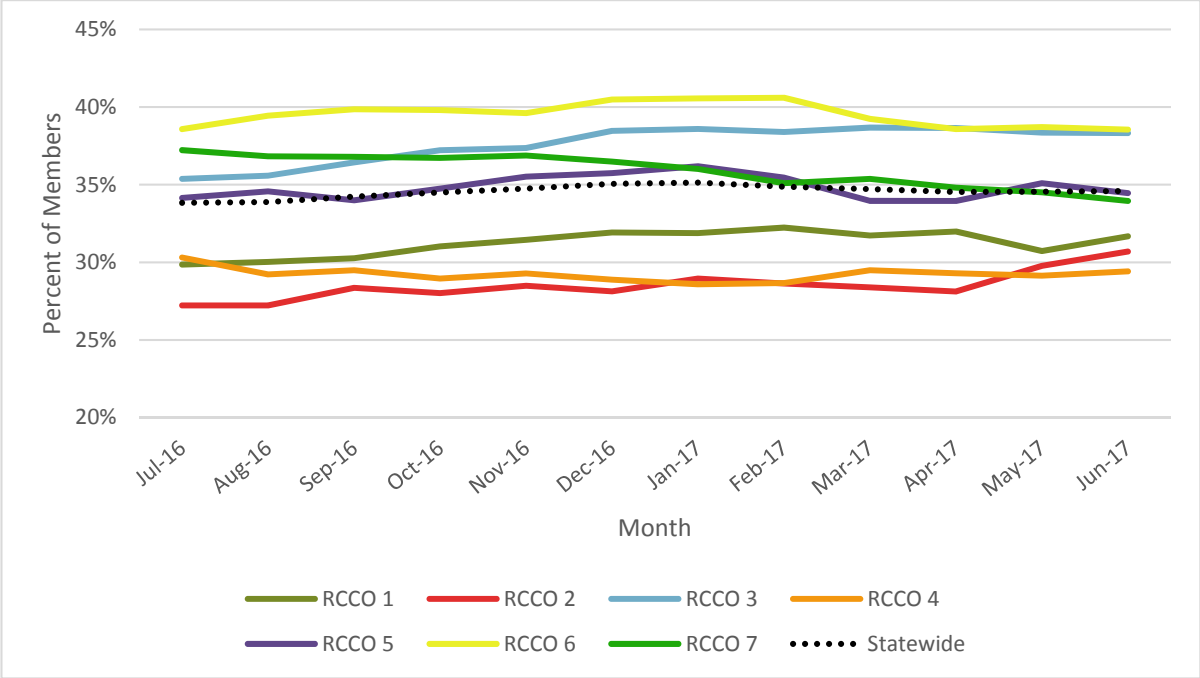
Colorado Community Health Alliance also used an incentive program to encourage families to complete an annual well-child check. They partnered with an elementary school in Broomfield to provide education about the impact of sugary beverages while concurrently encouraged children get their well-child checks. Data shows that 10 percent of eligible participants went in for a well-child visit to claim the incentive.

Postpartum Care

Maternity and postpartum care is an important focus area of the Accountable Care Collaborative as approximately 45 percent of babies born in Colorado are born to mothers on Medicaid or Child Health Plans Plus (CHP+). This KPI measures the percentage of women who received an outpatient postpartum exam in the 21-56 days following a live birth. Postpartum care visits are recommended by both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. A postpartum exam provides an important opportunity for checking the physical and mental health of new mothers and counseling them on infant care and family planning. These visits are also an opportunity to detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or obesity[5]. As Figure 4 demonstrates, the rate of postpartum care has increased slightly on a statewide level, from 33.8 percent in July 2016 to 34.6 percent in June 2017. Four RCCOs increased their rate in FY 2016-17, while the other three RCCOs saw a slight decrease.

[5] Chu, SY, et al. Postpartum Care Visits—11 States and New York City, 2004. MMWR Weekly, December 21, 2007. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a2.htm. Reviewed October 6, 2015.

Figure 4: Postpartum Care Rate for Women in the Accountable Care Collaborative Population, FY 2016-17



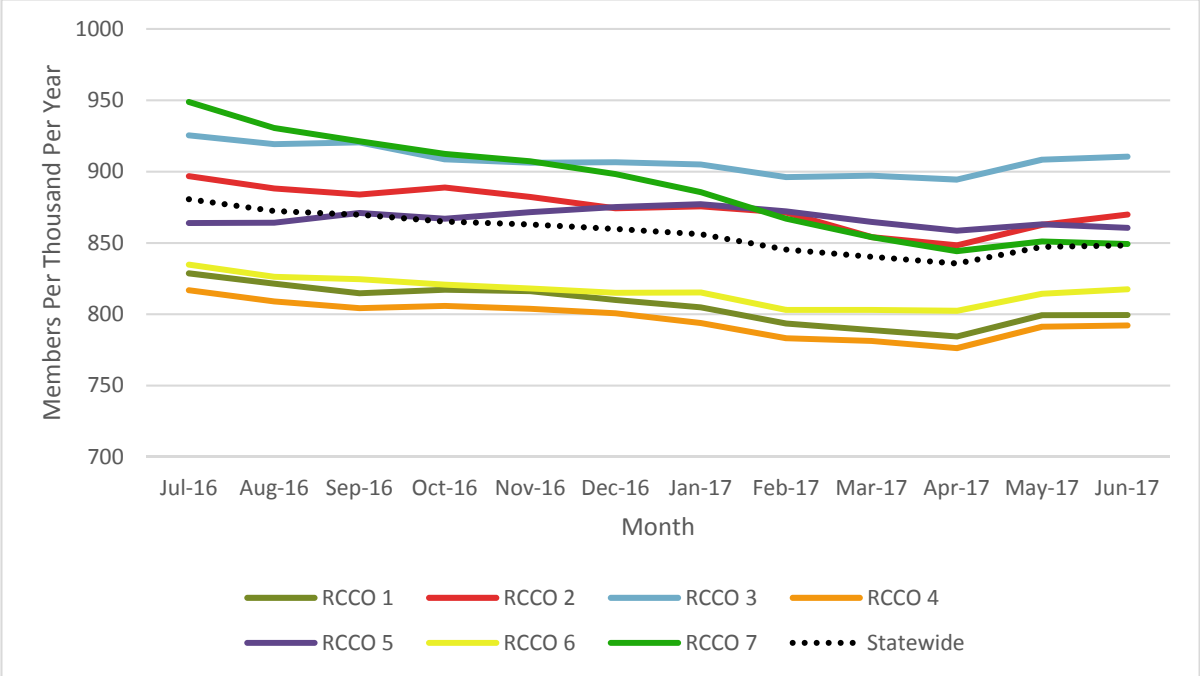
The RCCOs recognize this as an area for growth and are working together with the Department on interventions to improve performance. Colorado Community Health Alliance has implemented a maternity care coordination program that helps eligible women connect with necessary medical and social services during and after their pregnancy, and has implemented a referral process with a local hospital. Colorado Access is working closely with providers to ensure that practices correctly and consistently document (code) postpartum visits. Rocky Mountain Health Plans has partnered with the Piñon Project, a local Family Resource Center, to replicate and enhance the B4 Baby program to ensure that participants receive needed postpartum care, including screening and treatment for postpartum depression.

Emergency Room Visits

This measure looks at the risk adjusted number of emergency room visits on the same date of service for the same member that did not result in an inpatient admission, per thousand members per year. As Figure 5 shows, the risk adjusted rate of emergency room visits has decreased on a statewide average in FY 2016-17. The rate decreased from approximately 880 visits per thousand members per year (PKPY) in July 2016 to 848 visits PKPY in June 2017. Community Care of Central Colorado (RCCO 7) has seen

the largest decrease in emergency room visits, while other RCCOs have continued to see the rate slightly decrease over the year.

Figure 5: Emergency Room Visits Without Hospital Admission for Accountable Care Collaborative Program Members, Per 1,000 Members Per Year, FY 2016-17



Like Medicaid programs in other states, the Department continues to face a high rate of emergency room use and is continually looking for ways to reduce it. Visits to the emergency room are costly, and visits that do not result in an inpatient admission may be indicative of poor care coordination or inadequate access to primary care, due to transportation challenges or inadequate hours to access care. However, a number of factors contribute to emergency room use, including the increase in the number of emergency rooms and departments, more aggressive advertising by hospitals promoting their emergency rooms, and a co-pay structure that sometimes makes the emergency room a cheaper option for Medicaid members. In addition, it may be easier for members to get the care, lab work, imaging, and other services they need in an emergency room than through multiple physicians and imaging centers.

The Department is addressing this challenge by using a range of solutions. Incentivizing RCCOs to connect members to a PCMP increases the chances that members will have a place to go for routine care. Practices receive an incentive for meeting enhanced medical home standards (including after-hours care), which may encourage members to go to their PCMP instead of visiting the emergency room.

At the RCCO level, several RCCOs are working to get all members, especially those most at risk for emergency room use, connected to a PCMP. For example, Community Care of Central Colorado co-locates patient navigators in other community agencies, including county jail, soup kitchens, and mental health centers. Rocky Mountain Health Plans gives its members access to My Digital MD, which allows them to connect with doctors via secure text and possibly avoid a trip to the emergency room.

Colorado Access is working with Salud Family Health Center to support an integrated pharmacy program where clinical pharmacists work directly with members to ensure proper medication management, mitigating the effects of mismanaged chronic conditions and cutting down on emergency department usage. Similarly, Community Care of Central Colorado has implemented prescription guidelines for emergency departments and other prescribers to help facilitate understanding of the recent changes in opioid dispensing rules.

Integrated Community Health Partners (ICHP) provides hospital admission, discharge and transfer (ADT) data to their care coordinators to help in identifying members for outreach after a hospital admission. ICHP sees this as a successful strategy for reducing ED visits, as their rates have decreased this FY from 816 PKPY to 792 PKPY. This RCCO also gives members co-pay vouchers to provide financial support to members who go to their primary care provider rather than the ED.

Colorado Community Health Alliance (CCHA) has partnered with Dispatch Health, a mobile and virtual health provider, to deliver health care services to members in their home or in a community setting. This pilot uses a number of strategies, from a smartphone app to PCMP outreach, to direct members back to their PCMP when they use the emergency room for non-emergencies. To date, this program has conducted 113 visits to CCHA members with an average response time of 30 minutes. Fewer than 8 percent of CCHA members served by Dispatch Health return to the hospital, and none of the members served by Dispatch Health were escalated to the emergency room.

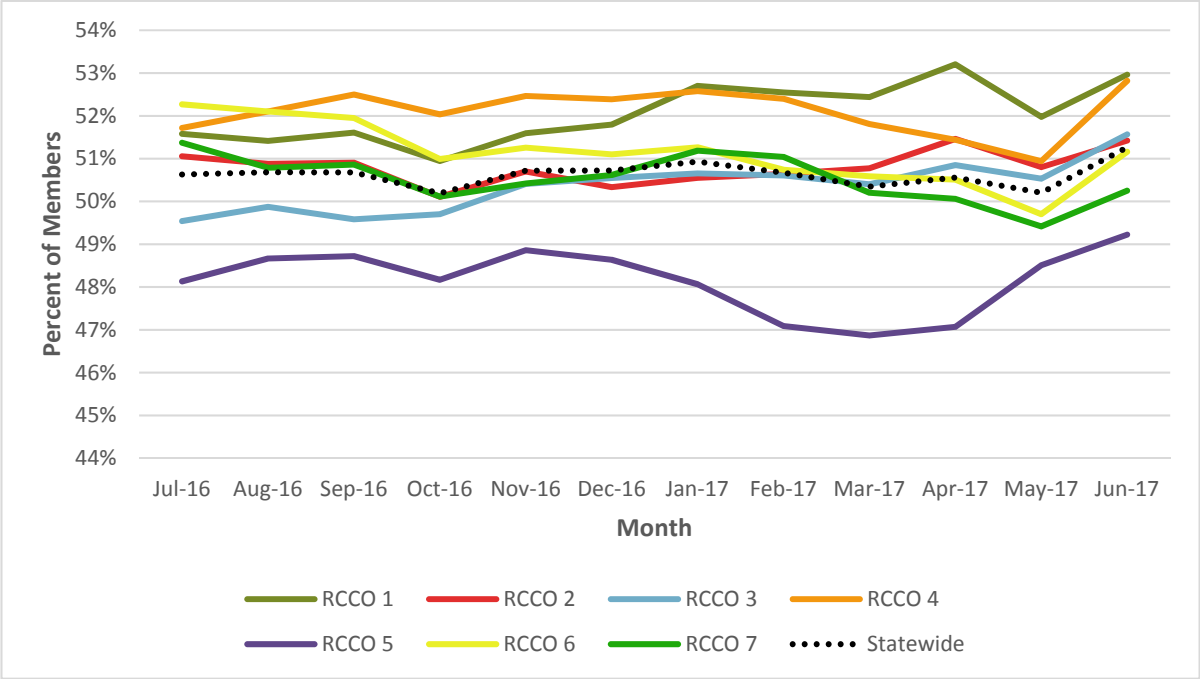
Colorado Access, Integrated Community Health Partners and Community Care of Central Colorado all work with first responders in their respective regions to identify members who frequently use emergency services, so the RCCO can get them the ongoing care and services they need.

Follow-Up Care Within 30 Days of a Hospital Discharge

This measure tracks the percent of members who received a follow-up visit with a physician within 30 days of an inpatient hospital discharge. Members readmitted within 30 days were excluded from this measure; readmission is measured separately. Also excluded were members transferred to a skilled nursing facility and certain types of health care facilities including hospice, those who transferred to law enforcement and those who died.

A follow-up visit with a primary care provider is an opportunity to address the conditions that led to hospitalization, and to prepare the member and caregiver for home self-care activities. Members who do not see a provider within 30 days of a hospital discharge are at high-risk for hospital readmission.[6] Figure 6 shows that the rate of members who received follow-up care within 30 days of discharge from a hospital increased slightly on a statewide average in FY 2016-17.

Figure 6: Percent of Members Who Received Follow-up Care Within 30 Days of Discharge From a Hospital, FY 2016-17



[6] http://nihcr.org/wp-content/uploads/2016/07/Reducing_Readmissions.pdf

The RCCOs are taking several approaches to ensuring follow-up care after hospital discharge for all members. As an example, Integrated Community Health Partners (ICHP) is working with the Southeast Colorado Transition of Care Consortium to streamline the transition from hospital to community and avoid duplication of transition services. ICHP provides data to assist the Consortium in identifying trends within specific populations of high utilizers. The goal of this group is to create a community-based care transitions program that enables member self-management, care coordination, and exchange of information during transitions of care. So far, their efforts have been successful as data indicated a 3 percent reduction in 30 day readmissions to the hospital as of December 2016.

Community Care of Central Colorado shares their KPI incentive payments with local community partners who also serve Medicaid members; specifically, The Resource Exchange, the CARES Program, Pikes Peak Hospice, and Ascending to Health. This RCCO also partners with community organizations on programs for its homeless members and those with chronic diseases.

Colorado Access has implemented a successful 30-day transitions of care model in which care coordinators conduct a hospital visit before release (if possible), a home visit after member is discharged, and attends the follow-up primary care appointment with the member. Colorado Access has realized slight increases on this metric across all three regions.

3.3. RCCO Initiatives to Improve Member Health

Medicaid members often have complex issues impacting their health, including lack of social resources combined with medical and behavioral health conditions. A central goal of the Accountable Care Collaborative is to improve member health and health care experience , which RCCOs target through a variety of multi-modal approaches.

Aside from their initiatives to improve performance on the Key Performance Indicators (KPI), RCCOs have implemented a range of other initiatives to improve member health, which can broadly be grouped into the following three categories: care coordination, community partnerships, and practice support.

Care Coordination

Regional Care Collaborative Organizations help members navigate multiple systems, ensuring coordinated access to primary care, specialty care, behavioral health, Long-Term Services and Supports (LTSS), and other services the member needs to be healthy.

The Accountable Care Collaborative provides RCCOs with the flexibility to implement care coordination models that meet the diverse and unique needs of local communities. For example, Rocky Mountain Health Plans (RMHP) covers Region 1, which includes the entire western slope of Colorado, and Larimer County. RHMP developed community care teams to cover the various sub-regions across Region 1 that take the lead on care coordination efforts for some members or, in many instances, supplement existing community resources and efforts for the community's respective membership.

Since the beginning of the program in 2011, RCCOs have refined their care coordination models. RCCOs have recognized the effectiveness of reaching the member in the community, and have employed tactics such as care coordination co-location to reach members locally; which includes PCMP offices, emergency departments, community organizations such as food banks, homeless shelters, and county jails. For example, Community Care of Central Colorado co-located a care coordinator in the El Paso County Public Health Department to outreach foster children and families with the purpose of connecting members to a medical home and creating a single care coordination plan shared among all responsible agencies.

Community Partnerships

The structure of the Accountable Care Collaborative provides RCCOs with the flexibility to implement solutions that target community-level problems. RCCOs have implemented successful community partnerships to leverage local resources for Medicaid Members. Community partners have varied per region, but have generally aligned resources for Medicaid members including: housing, transportation, food, medical, behavioral, dental, public health agencies, county offices, and the criminal justice system.

For example, Colorado Community Health Alliance has partnered with local correctional facilities and other stakeholders to address health and care coordination needs of the justice involved population within Region 6. The goal of this work is to reduce recidivism and emergency department (ED) utilization, increase timely access to care and enhance quality of life for justice-involved individuals. For FY 2016-17, this RCCO participated in over 900 in-reach/out-reach/educational events specific for this population, established workflows and care coordination procedures to improve continuity of care during transitions, stationed a care coordinator at the Westminster Parole and Reentry office, and developed relationships with numerous local organizations involved in care for justice-involved members. Ultimately, Colorado Community Health Alliance assisted 86

individuals who were releasing from Department of Corrections on probation, or releasing from a community corrections facility.

Recognizing the need to leverage existing resources in rural Colorado, Integrated Community Health Partners developed relationships with Women, Infants and Children (WIC); Baby and Me, Tobacco Free; Nurse Family Partnership; Colorado Family Planning Initiative; and, Family resource Network, to increase referrals to and enrollment in these programs. Additionally, Integrated Community Health Partners offers technical support to these other programs to minimize administrative burden.

Provider Support

Supporting providers is another key tactic by which RCCOs strive to improve member health. Ensuring providers have what they need to successfully serve Medicaid members is a benefit that increases access and improves provider satisfaction. RCCOs support providers using a variety of techniques, including designating a single point of contact, and offering training and education.

For example, all RCCOs have designated staff that serve as provider support representatives. They assist providers in understanding Medicaid programs and policies, including benefit packages, prior authorization requirements, claims and billing procedures, and eligibility and enrollment. They also offer provider training, assistance with data reporting, assistance with specialty care referrals, and share member education tools and resources. Additionally, provider support representatives work with providers to understand areas for improvement, and assess a provider's interest in practice transformation.

Colorado Access provides technical billing and coding assistance to providers, ensuring postpartum and other visits are billed appropriately. They also work with critical access hospitals, such as Lincoln Community Hospital in Hugo, to aid in the behavioral health credentialing process to increase access to behavioral health visits.

3.4. Member Satisfaction

Improving member experience and member engagement is an important goal of the Accountable Care Collaborative. According to the 2017 Colorado Health Access Survey, members covered under expansion report satisfaction with Medicaid. Specifically, nine out of ten are happy with the range of services covered, and eight out of ten are happy

with their choice of doctors.[7] While these results generally indicate members are satisfied with Health Frist Colorado services, the Department continues to monitor member experience to understand areas for improvement.

In FY 2016–17, the Department administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) survey to Medicaid members. The survey was administered from March through June of 2017 and measured the member experience of care at the practice-level for the period from July through December of 2016. The survey was completed by parents/caretakers of child Medicaid members and by adult Medicaid members. The Department selected large PCMPs for inclusion in the survey, specifically twelve child and eight adult practices, with the sample size of 24,000 members at those practices.

Table 2 lists aggregate results for the FY 2016-17 CAHPS Survey for parents/ caretakers of children, and Table 3 lists aggregate results for the adult respondents.

Table 2: Aggregate results for the FY 2016-17 CAHPS Survey, Child Accountable Care Collaborative population

Parents or Caretakers responded:	Percent
Rated their child's provider favorably	**75%**
Felt they always received timely appointments for their children	**60%**
Felt their child's provider always explained things in a clear manner, and took the time to listen carefully	**80%**
Responded their child's provider always seemed to know important information about their child's medical history, and followed up with test results	**70%**
Responded they received information on how to get care for their child outside regular office hours (evenings, weekends, or holidays)	**82%**
Responded they received reminders about their child's care from the provider's office	**75%**

[7] https://www.coloradohealthinstitute.org/research/colorado-health-access-survey

Table 3: Aggregate results for the FY 2016-17 CAHPS Survey, Adult Accountable Care Collaborative population

Adults responded:	Percent
Rated their provider favorably	**70%**
Felt they always received timely appointments, care and information	**45%**
Felt their provider always took the time to listen carefully, explained things in a clear manner, and showed respect for what the member had to say	**77%**
Felt their provider always seemed to know important information about their medical history, followed up with test results, and discussed prescription medications with the member	**63%**
Received reminders from the provider's office regarding their care	**71%**
Medicaid customer service always provided the information or help they needed, and customer service staff treated the member with courtesy and respect	**65%**

The Department received results from the CAHPs survey in September 2017. Over the next year, the Department will further analyze the results to identify areas of improvement for the Accountable Care Collaborative and for Medicaid overall.

RCCO Initiatives to Improve Member Engagement and Experience

Regional Care Collaborative Organizations have modified their approach to member engagement over the years, and have shifted to prioritizing meeting the members where they are in the community. RCCOs seek to increase member engagement and improve member experience in a variety of ways. The goal of this work is ultimately to empower members to participate in their healthcare, and enable them to find what they need, when and how they need it. Several RCCOs have established Member Advisory Councils, which are described in greater detail in section 7.3 of this report.

Colorado Access gathers member feedback at multiple points of member engagement such as through customer service, care management and survey campaigns. They conducted a survey in December 2016, and had over 500 members respond. The results were subsequently used to inform member communications, population health interventions and care coordination. Through this survey, Colorado Access learned that

parents of child Medicaid members prefer to be reached via phone, email and mail, rather than receive automated calls or use a website to find information.

Colorado Access uses a mobile outreach van in the northeast part of the state to participate in community events and offer information and referrals for local services such as Women, Infants and Children (WIC). These events are an excellent opportunity to reach members and obtain feedback on direct, local needs. For example, while attending the Greeley Stampede, staff learned that members concerns within rural communities include lack of transportation and access to specialty and behavioral health care, and concerns of maintaining member privacy in small towns.

Integrated Community Health Partners hosted six luncheons for members focused on wellness, prevention and member empowerment. The meetings were used to educate members on the importance of receiving well care and preventive screenings, and to review member rights and responsibilities, such as communicating with your doctor and not missing appointments.

Colorado Community Health Alliance views its member call center as an important component of member engagement. They use targeted IVR campaigns to engage specific member populations. Staff respond to IVR-initiated calls with members to achieve a productive encounter based on the member's need. At which point, members can be referred to care coordination or other resources the member needs to be healthy.

4. Financial Performance

The Accountable Care Collaborative operates as a Primary Care Case Management Entity program in which medical services are paid fee-for-service (payment for each medical service delivered), and Primary Care Medical Providers (PCMPs) and Regional Care Collaborative Organizations (RCCOs) also have financial incentives to provide high-value care. These financial incentives and the structures that support them are the program's administrative costs. The Department invests in these costs to realize medical costs avoided as well as better health outcomes. In FY 2016–17, Department analysis again suggests that the Accountable Care Collaborative avoided medical costs in excess of program administrative costs.

This section is divided into three subsections, as follows:

- 4.1 Methodology- how the Department calculates costs avoided
- 4.2 Program Costs- the administrative costs of the program

4.3 Program Costs Avoided- an estimate of medical costs avoided

4.1. Methodology for Calculating Costs Avoided

To estimate the medical costs avoided this year, the Department compared the current costs for program enrollees to previous years' costs, demonstrating that costs have continued to decrease over time. First, the difference in average medical cost per member month from the baseline year (FY 2015-16) to the current year (FY 2016-17) is calculated. This difference is then multiplied by the total member months in FY 2016-17 to get an estimate of medical costs avoided for the fiscal year. Medical costs include pharmacy, inpatient hospital, outpatient hospital, emergency room and professional claims.

Then, the increase in annual program administrative expenses (capitations, incentive payments, pay for performance pool payments, the contract payment to the SDAC, and the contract payment to Truven for Quality Metrics) from FY 2015-16 to FY 2016-17 is deducted to yield a total cost avoided estimate[8]. This estimate represents the additional amount that the Accountable Care Collaborative has saved in comparison to FY 2015-16.

Due to data limitations related to Medicare costs, it was not possible to observe or estimate costs for the Accountable Care Collaborative: Medicare-Medicaid Program population. Therefore, they are excluded from this financial analysis.

FY 2015-16 costs were adjusted for inflation using the Medical Care Consumer Price Index from the Bureau of Labor Statistics. Note that due to a recent system change, data for the last six months of FY 2016-17 are currently under review as the Department continues to validate data and work through known data issues. In this analysis, medical costs for the last six months of FY 2016-17 were estimated using the average monthly medical cost of the previous six months. Appendix A has additional information about the methodology for calculating costs avoided.

Note that this is a changed in methodology from prior years when the Department calculated costs avoided by comparing current medical costs to an estimate of the medical costs had program enrollees received traditional fee-for-service Medicaid rather than participating in the program. However, as more time elapses from the original

[8] In calculating payments for this year's report, the Department identified an error in the expenditures reported last year. Specifically, the amount reported for the KPIs was higher than the actual payments made. As a result, the actual expenditures for last year are lower than those reported. The Department used the correct expenditures to calculate cost savings in this year's report.

program implementation year, this method becomes less accurate due to a greater reliance on assumptions to estimate the fiscal impact. Another frequently used methodology that compares a cohort of individuals enrolled in a program to those not enrolled does not make sense for this analysis since the vast majority of Medicaid members are enrolled in the Accountable Care Collaborative.

4.2. Program Costs

For FY 2016–17, total administrative costs for the Accountable Care Collaborative were **$150,374,011.** This amount covers payments made to the RCCOs, the PCMPs, and for data analytics. Approximately 14 percent of the total administrative costs were value-based payments tied to performance on the KPIs and to recognize and reward practices that meet enhanced primary care medical home criteria or are participating in federal initiatives such as the State Innovation Model (SIM) or Comprehensive Primary Care Plus (CPC+).

Regional Care Collaborative Organization Payments

In FY 2016–17, RCCOs were paid a total of **$114,418,781**, which represents **76 percent of total program administrative costs**. These funds served several different purposes, as follows:

1. **Per-Member-Per-Month (PMPM) Payment:** RCCOs receive a PMPM payment for ensuring care coordination, provider support, network development, and reporting responsibilities. In FY 2016–17, RCCOs were paid **$100,896,021** in PMPM payments. Because member attribution to a PCMP is so important to the success of the program, the Department reduces a RCCO's PMPM amount by 35 percent for any member who had been unattributed to a PCMP for six months or longer.
2. **Payment for Key Performance Indicators (KPIs):** RCCOs receive payments for meeting KPI targets, which are described further in the Program Performance section of this report. In FY 2016–17, RCCOs were paid a total of **$5,542,837** for performance on KPIs.
3. **Pay-for-Performance Pool:** The Pay-for Performance Pool is created with $0.50 of each RCCO's PMPM and dollars withheld for individuals not attributed to a PCMP for six months or longer. This pool of funds is used as incentive payments for the RCCO or its PCMPs. In FY 2016–17, the Department distributed **$7,979,923** of

these funds to the RCCOs to incentivize PCMPs to participate in the State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+).[9]

Primary Care Medical Provider Payments

During FY 2016-17, PCMPs were paid a total of **$33,530,228**, representing **22 percent** of all Accountable Care Collaborative administrative costs. The breakdown of these funds is as follows:

1. PCMPs receive PMPM payments for providing medical home services to members. In FY 2016–17, PCMPs were paid **$26,749,746** in PMPM payments.
2. Like the RCCOs, PCMPs are eligible to receive incentive payments for meeting KPI performance targets. In FY 2016–17, PCMPs received a total of **$4,207,707** for meeting these targets.
3. PCMPs can receive an additional payment for meeting the factors for becoming an enhanced Primary Care Medical Provider (ePCMP), such as co-locating physical and behavioral health providers or offering care after hours. (See Section 5.1 for more detail). Providers that met at least five of nine of the enhanced factors in FY 2016–17 received the payment, which totaled **$ 2,572,775**.[10]

Data Analytics Contractor Payments

For the contract period of July 1, 2016- April 30, 2017, the SDAC vendor, 3M, was paid the contracted rate of **$2,425,000.** This represents **2 percent** of the total administrative costs for the Accountable Care Collaborative.

As part of the larger Colorado Medicaid Management Innovation and Transformation (COMMIT) project, the Department contracted with IBM Watson Health to implement the Business Intelligence Data Management (BIDM) system. The BIDM will support all Department warehouse and analytic needs, in addition to hosting the Health First Colorado Data Analytics Portal. Due to the broad scope of the BIDM contract, costs are not specifically delineated for the Accountable Care Collaborative program, and therefore are not included in this report.

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[9] The pay-for-performance pool dollars will be paid out in FY 2017–18 but because the withhold from the administrative costs occurred during FY 2016–17 they have been included as part of the administrative dollars for the fiscal year covered by this report.

[10] The enhanced PCMP dollars were paid out in FY 2017–18 but because the withhold from the administrative costs occurred during FY 2016–17 they have been included as part of the administrative dollars for the fiscal year covered by this report.

4.3. Program Costs Avoided

From FY 2015-16 to FY 2016-17, the average paid amount per Accountable Care Collaborative member per month decreased by 1.0 percent, or $2.47. This translates to approximately **$26,804,230** in additional medical costs avoided in FY 2016-17. After accounting for the increases in administrative expenses from the previous year, costs avoided totaled **$21,568,767**.

The services provided by RCCOs, PCMPs, and data analytics provided by the Department work together to lower per capita medical costs for enrolled Medicaid members. Coordinated primary care is less expensive than episodic or emergency treatment of medical conditions. With a focus on coordination and education, the Accountable Care Collaborative shifts costs from inefficient and expensive periodic treatment to whole-person centered approaches to health care and health outcomes. The result is medical costs avoided.

5. Promoting Access to Services in Rural and Frontier Counties

The rural and frontier regions of Colorado face unique challenges in ensuring access to health care. Colorado is a diverse state and therefore, all Regional Care Collaborative Organizations (RCCOs) regions include rural and/or frontier counties, except for Colorado Access' regions three and five, which are Adams, Arapahoe and Douglass, and Denver counties. Both the Department and RCCOs have a responsibility to ensure access to services in these regions, and have developed and refined various strategies to improve availability and accessibility of services in Colorado's rural and frontier counties. This section is divided into four subsections as follows:

5.1 Monitoring Network Adequacy
5.2 Provider Recruitment and Capacity Building
5.3 Supporting Practice Transformation
5.4 Improving Access to Telehealth Services

5.1. Monitoring Network Adequacy

RCCOs maintain a network of primary care providers, and other Medicaid providers, to meet the needs of their members. RCCOs regularly monitor their networks to ensure members have access to a medical home and other services they need to be healthy. They are required to ensure that network providers meet the needs of special populations, including: individuals with a physical, intellectual or developmental disability; children and foster children; adults and the aged; members with complex behavioral or

physical health needs; individuals for whom English is a second language; individuals involved with the justice system; and, individuals living with HIV/AIDS.

RCCOs work to ensure their members have meaningful choice in selecting a Primary Care Medical Provider (PCMP) so that each member has a choice of at least two PCMPs within their zip code, or within 30 minutes of driving time from their location. To monitor choice in provider, RCCOs use GeoAccess software to measure the accessibility of their networks. They also gather additional information to monitor access, including: tracking calls to customer service centers, identifying trends in member complaints/ grievances, input from member advisory councils, and feedback from community partners.

Often, RCCO provider support representatives/ practice transformation coaches play a large role in monitoring networks. They do so through building new relationships, establishing regular meetings with providers, contracting new practices, and offering support in practice transformation and other quality improvement activities.

The Department monitors network adequacy through contract management and oversight of the Accountable Care Collaborative; particularly through monitoring RCCO PCMP networks, and other community partnerships. Additionally, the Department developed and submitted to the Centers for Medicare and Medicaid Services (CMS) an access monitoring review plan[11]. This plan is part of an ongoing effort to ensure Medicaid members can access medical services in a manner that is comparable to Coloradans with other public or private insurance plans.

5.2. Provider Recruitment and Capacity Building

Rural Health Center Recruitment

Rural Health Centers (RHCs) play a critical role in providing access to services in some of the most remote parts of Colorado. Recognizing that, the Department has made it a priority to recruit RHCs to be PCMPs in the Accountable Care Collaborative. Department staff have partnered with the Colorado Rural Health Center to collaborate on provider recruitment activities. Together, they provide education on the benefits of being a provider in the Accountable Care Collaborative, particularly how financial incentives can help providers achieve their practice goals. As of June 2017, 51 RHCs, or 58 percent, are contracted providers in the Accountable Care Collaborative. Department staff will continue to prioritize RHC recruitment in FY 2017-18, and refine outreach strategies as appropriate.

[11] https://www.colorado.gov/pacific/hcpf/access-monitoring-review-plan

Improving Provider Network Capacity

In addition to network monitoring activities, RCCOs have developed and maintained their PCMP networks over the years, continually working to recruit local providers to serve Medicaid members. To encourage providers to join the Accountable Care Collaborative, RCCOs offer providers support in navigating the Medicaid program, and help with practice transformation efforts.

Despite efforts on provider recruitment, there are barriers to ensuring access to care in some rural and frontier counties. In some of the more remote areas of the state, providers are retiring; recruiting new providers to work in these communities has proven challenging. This can create a health care emergency when a provider in a rural or frontier community elects to stop providing services.

The barriers identified require RCCOs to take a different approach to ensuring access to services. For example, Colorado Community Health Alliance formed a partnership with county officials and Centura Health to open a primary care clinic in Clear Creek County after their only provider closed his practice. This new clinic ensures members in Clear Creek and Gilpin counties can now receive preventive care and other medical home services.

RCCOs also encourage existing network providers to accept more Medicaid members. For example, Rocky Mountain Health Plans uses Community Care Teams to optimize a practice's capacity to accept more members with complex health care needs. Community Care Teams support the member by identifying medical, behavioral health and social needs and subsequently connecting the member to those services. In turn, the provider can serve more members knowing they have the support of the care team. Rocky Mountain Health Plans also has dedicated provider network representatives who work with provider groups and other community organizations to develop community-based solutions to access issues.

5.3. Supporting Practice Transformation

Encouraging practice transformation and incentivizing providers to increase their scope, is one strategy for improving access to services, particularly in rural and frontier regions. The Department and RCCOs invest directly in practices participating in practice

transformation efforts such as the State Innovation Model (SIM)[12], Comprehensive Primary Care Plus (CPC+)[13], and Enhanced Primary Care Medical Provider (ePCMP)[14]. Practices participating in these initiatives are supported using funds from the Accountable Care Collaborative Performance Pool.

Integrating physical and behavioral health services was an important focus of practice transformation efforts in FY 2016-17. For example, Rocky Mountain Health Plans supported practices on the western slope by expanding access to rural team-based health care. They collaborated with local partners to bring practice transformation training and support to small practices in rural communities who wish to begin behavioral health integration. Colorado Access encourages behavioral health integration by supporting practices in the behavioral health credentialing process. Community Care of Central Colorado's practice transformation coaches assess network PCMPs on an annual basis using the Integrated Practice Assessment Tool (IPAT); they use the results to work with practices on improving levels of integration, either through local partnerships or other telehealth programs. These coaches meet with practices monthly to monitor progress and provide assistance.

Colorado Community Health Alliance implemented a provider incentive program to encourage network providers to participate in practice transformation efforts. They use funds from their Key Performance Indicator (KPI) incentive payments to reward practices that achieve some goal in practice transformation. For example, practices are rewarded for working with a practice transformation coach, participating in a specific practice transformation effort, or realizing improvement in KPI performance. Colorado Community Health Alliance's practice transformation coaches work closely with practices, providing a monthly dashboard to help monitor performance. For FY 2016-17, 30 practices were eligible to participate in the provider incentive program, and 29 practices received incentive payments for achieving one or more goals. Four practices achieved all points, earning more than $7,500 each.

Another component to practice transformation is helping providers improve their practice's accessibility for individuals with a disability. Integrated Community Health Partners, which serves nineteen counties in rural southeast Colorado, implemented the Disability Competent Care tool to help providers assess their practice facility for

[12] https://www.colorado.gov/healthinnovation
[13] https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus
[14] https://www.colorado.gov/pacific/hcpf/medicaid-primary-care-providers-we-need-you-acc

accessibility. To date, 14 providers have participated in the assessment, and eight providers have made upgrades to their offices based on assessment results. Upgrades include installing ramps and bathroom rails; removing barriers such as tree branches and standing water; creating accessible parking spaces and rearranging the office space to better accommodate wheelchairs. This RCCO continues to assess local practices, and assists providers in applying for grant funds to help with the cost of installing important upgrades.

5.4. Improving Access to Telehealth Services

Telehealth initiatives provide the Department and RCCOs with additional opportunities to increase access to services in rural and frontier counties. Telehealth can be a benefit to members living in rural/frontier areas because it can improve access to specialty care, and can reduce burden of transportation and long wait times for appointments. Additionally, it can be more feasible for providers to offer specialty care to rural/frontier communities through a telehealth platform.

Recognizing the potential to increase access to services for Medicaid Members, RCCOs have piloted various telehealth programs. Rocky Mountain Health Plans uses telehealth services to improve access to services on the western slope. For example, they developed an app called My Digital MD to connect their members to physicians outside of the clinic setting. They also developed a platform for providers called EasyCare. This platform allows staff within a practice to connect with their members over a telehealth platform. Both applications have the potential to improve access to after-hours care, and potentially reduce unnecessary emergency room visits.

To improve access to behavioral health services, Colorado Access is working to offer tele-psychiatry for all Accountable Care Collaborative members across regions two, three and five. Additionally, they formed a partnership between the RCCO and Behavioral Health Organization (BHO) in region two, both operated by Colorado Access, to develop an in-home tele-psychiatry program, which helps integrate services for vulnerable members who are homebound.

In addition to RCCO initiatives, the Department tested two telehealth programs in FY 2016-17, the Chronic Pain Disease Management Program and eConsult. The Chronic Pain Disease Management Program (modeled after the University of New Mexico's Project ECHO) concluded on schedule in April 2017 after its second year of operation. During the two years that the program was in place, the Department offered two curriculums, chronic pain and buprenorphine. Over 170 providers participated across both

curriculums. The eConsult initiative allows PCMPs to consult with specialty physicians using an electronic consultation system. The initiative was implemented in July 2016 on a very limited basis with six PCMP practices and two rheumatology specialist practices. The Department is currently working with community partners on a statewide solution.

6. Coordinating with Long-Term Services and Supports

Coordination among RCCOs and entities that authorize Long-Term Services and Supports (LTSS) is an important step in ensuring coordinated care for Medicaid members who are served by multiple health systems. In Colorado, Long-Term Services and Supports are authorized by case management agencies, specifically Single Entry Point (SEP) and Community Centered Board (CCB) agencies. In addition to authorizing services, SEPs and CCBs provide case management, care planning, and arrange for services for individuals on a home and community-based waiver.

This section is divided into two subsections as follows:

6.1 RCCO Coordination with SEP and CCB Agencies
6.2 RCCO Access to the Benefits Utilization System

6.1. RCCO Coordination with SEP and CCB Agencies

There is overlap in functions across RCCOs, SEPs and CCBs, which is why it is important for these entities to collaborate to reduce duplicative efforts. Collaboration entails understanding roles and responsibilities, developing processes for identifying shared members, and establishing workflows and communication channels. Much of this work has been initiated through the Accountable Care Collaborative: Medicare-Medicaid Program.

The Department implemented contract amendments for RCCOs, SEPs, CCBs, and Behavioral Health Organizations (BHOs) requiring collaboration across these entities to coordinate care for shared members. Prior to that, the Department worked with RCCOs, SEPs and CCBs to establish guidelines for understanding roles and responsibilities across these agencies. Written protocols were developed to strengthen relationships and improve coordination between case management agencies and RCCOs. The protocols were designed to be bi-directional and collaborative, and outlined a process by which case management agencies and RCCOs would work together to reduce duplication of services and ensure members needs are met.

While the protocols were established in 2012, RCCOs have done a lot of work to ensure collaboration continues. RCCOs have formalized partnerships and data sharing agreements with SEPs and CCBs through Memorandum of Understanding or Business Associate Agreements. The purpose of these agreements vary, but generally are used to identify shared members, define a process for collaborating, and identify a lead care coordinator for shared members.

For example, Colorado Community Health Alliance created shared workflows with the SEPs and CCBs in their region. They also hosted meet and greet sessions with SEP and CCB care managers to promote cross-agency education and discuss roles and responsibilities. Rocky Mountain Health Plans took a similar approach and hosted regular meetings to understand the scope of services offered at each agency, and to support care teams in providing services to shared members.

Integrated Community Health Partner care coordinators work with their local SEP and CCB agencies to identify the lead in care coordination. If the SEP or CCB is designated as the lead care coordination entity, ICHP care coordinators help "coordinate the coordinators" to ensure that the lead entity and member are both receiving the support they need.

Colorado Access is piloting the use of a single care manager between the RCCO and SEP to reduce duplicative services for members who interact with multiple programs. As part Additionally, their care coordinators hold regular meetings with the Weld County CCB to discuss shared care management services for members.

6.2. RCCO Access to the Benefits Utilization System

One component of improving collaboration across agencies is the ability to share data. RCCOs work to ensure the appropriate safeguards are in place to share data with other entities. To support these efforts, the Department has provided RCCOs with access to the Benefits Utilization System (BUS). The BUS is an important system that houses long-term care plans and assessments conducted by SEPs and CCBs.

RCCO care coordinators use the BUS to identify SEP and CCB care managers, and can also identify themselves as the RCCO care coordinator. This has helped identify care-team members, improve communication across agencies, and reduce duplicative services across RCCOs, SEPs and CCBs in a way that has led to more efficient partnerships.

7. Advisory Committees and Stakeholder Engagement

This section provides an overview of the state and regional stakeholder committees of the Accountable Care Collaborative. This section is divided into three subsections:

7.1 Program Improvement Advisory Committee
7.2 Subcommittees of the Program Improvement Advisory Committee
7.3 Regional Program Improvement Advisory Committees

7.1. Program Improvement Advisory Committee

The Accountable Care Collaborative's Program Improvement Advisory Committee (PIAC) serves as an integral forum for stakeholder engagement and feedback. Created in 2012, the PIAC has met ongoing on a quarterly, or monthly basis to monitor program performance and provide input into program operations and experiences.

The purpose of the PIAC is to provide guidance and recommendations to the Department to help improve health outcomes, access, cost and member and provider experience in the Accountable Care Collaborative. PIAC membership encompasses multiple stakeholder groups, including Medicaid members, physical and behavioral health providers, Long-Term Services and Supports members and providers, substance use disorder treatment providers, oral health providers, local advocacy organizations, behavioral health advocates, community mental health centers, Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs).

In FY 2016-17, PIAC focus areas included Accountable Care Collaborative Phase II, primary care payment reform, member engagement, criminal justice involved populations, access to care, transportation, the Colorado Medicaid Management Innovation and Transformation Project (COMMIT), and evaluations including the external evaluations conducted by the Colorado School of Public Health and the TriWest Group.

In FY 2016-17, PIAC made formal recommendations to the Department regarding improving the coordination of RCCO and Healthy Communities staff to increase the rate of Well Child Checks and improve performance on Early and Periodic Screening Diagnostic and Treatment (EPSDT). Specifically, PIAC recommended a platform for improved data sharing, leveraging existing incentive dollars to build community-based incentive programs, sharing best practices for care coordination, providing education, and improving member and family engagement by aligning messaging strategies. Department staff are working with community partners and other stakeholders to implement these recommendations, which PIAC will continue to monitor in FY 2017-18.

In addition to the formal recommendations, PIAC provided the Department with guidance and recommendations to help refine the draft request for proposals (RFP) for the next phase of the Accountable Care Collaborative. The Department reviewed committee feedback and made changes to the RFP that aligned with the Department's goals and approach for administering the program. One example of changes the Department made to the final RFP is regarding the Department's methodology to connect members to a primary care provider. PIAC suggested the Department give higher priority to primary care versus acute care visits in the attribution methodology. In response, the Department is working to change the methodology and intends to privilege well-child visits for the pediatric population to test this process. If successful, the Department will consider expanding this to the adult population as well.

While the Department has ultimate authority over programmatic decisions, staff rely on the expertise of PIAC members and other stakeholders when weighing potential changes to the program. Member, provider, vendor and stakeholder experiences are all important for understanding areas for program improvement. Department staff benefit from learning the shared experiences of all Medicaid stakeholders and consider stakeholder input when implementing policies and program improvements.

7.2. Subcommittees of the Program Improvement Advisory Committee

The Program Improvement Advisory Committee has four subcommittees that have a more defined scope and specific focus areas. Subcommittees are focused on provider and community issues, improving member health, improving and bridging systems for members with complex health needs who cross multiple health systems, and integrating care for members with Medicare and Medicaid.

The subcommittees work with RCCOs, providers, community partners and stakeholders to dive into specific issues, working to understand gaps and barriers, and ultimately make recommendations for program improvement. The subcommittees present their recommendations to PIAC for approval. For example, the recommendations regarding the coordination of RCCO and Healthy Communities staff was initiated from the health improvement-focused subcommittee.

7.3. Regional Program Improvement Advisory Committees

In addition to the state-level PIAC and subcommittees, each RCCO hosts a regional performance improvement advisory committee. Meetings are held monthly, or quarterly, and provide RCCOs with a forum for gaining stakeholder input on program improvement

activities at the local level. The regional PIACs are important for understanding community-level needs, and identifying solutions to address those needs. RCCOs use these regional meetings to engage with local partners, report on performance, gather input, and provide important Medicaid updates.

Some RCCOs have formed advisory councils specifically for Medicaid members. RCCOs are working to increase member feedback and improve engagement with members, to ensure members needs and perspectives are included in programming and communication decisions.

For example, Rocky Mountain Health Plans has formed a robust member advisory council in which group members are empowered to participate in various events in their local communities to increase awareness of Medicaid benefits and services. The group has received training on topics such as community organizing, communication, group decision making, and hosting educational/town-hall style meetings. Group members are currently pursuing grants and partnering with local community organizers to host events designed to interest and engage Medicaid members in the community. They also participate in other ways, including: meeting with State Representatives, leading other groups such as the Western Colorado Bridging Communication group, and pursuing local mental health empowerment projects to meet the needs of the local community.

Colorado Access hosts quarterly member forums to provide members with information regarding their health insurance. These forums have had high participation, approximately 200 participants, with an estimated 10 percent of participants new to each meeting. During these meetings, members indicate areas of need, such as transportation assistance, access to medications, care management and dental care. After the meetings, staff work to connect members to resources that were identified. Colorado Access also formed a local member advisory board, and has members participate in the state-level PIAC, and other quality improvement committees.

Colorado Community Health Alliance uses its member advisory council to give input on policy and program decisions, and give feedback on member communications such as IVR scripts and written materials. Potential advisory council members are engaged members identified through care coordination; however, all CCHA members are invited to participate. The group focuses on topics that are identified as important by the group.

8. Looking Forward

It is the Department's vision that Coloradans have integrated health care and enjoy physical, mental and social well being. The Department works to improve health for the Coloradans we serve and enhance the quality of life and community experience of individuals and families, while reducing the cost of health care in Colorado.

Delivery system transformation is key to the Department's mission to improve access to services while demonstrating sound stewardship of financial resources. The Department has several initiatives underway to continuously improve access to care, member and provider experience and the health outcomes of all Medicaid members. This section describes the Department's future areas of program focus, including:

8.1 Accountable Care Collaborative Phase II
8.2 Primary Care Alternative Payment Methodology
8.3 Studying Further Coverage of Substance Use Disorder Treatment Services

8.1. Accountable Care Collaborative Phase II

During FY 2016-17, the Department continued to develop the next phase of the Accountable Care Collaborative and released a draft request for proposals (RFP) for public comment, discussed the draft RFP at PIAC meetings, conducted an additional sixteen meetings across the state to engage stakeholders, and participated in ongoing conversations with CMS to receive program authority. In May, the Department released the final request for proposals; proposals were received in early FY 2017-18.

The next phase of the Accountable Care Collaborative program is scheduled to begin in July 2018 when new contracts go into effect for the Regional Accountable Entities, the new iteration of RCCOs and BHOs. Over the last six years, the Accountable Care Collaborative has shown progress in creating a health care delivery program that improves health outcomes, better manages care and is a smarter use of resources. Like every other organization in today's health care landscape, Colorado Medicaid must continue to serve members and navigate the increasingly complex health care landscape. One important improvement will be to continue to move toward more coordinated and integrated care that increasingly rewards improved health outcomes.

Below are some design decisions for the next phase of the program that will enable these important improvements:

- **Single entity**: What was previously called a Regional Care Collaborative Organization will now be called a Regional Accountable Entity (RAE), which will be a single administrative entity for behavioral health and physical health.
- **Seven regions**: The Department will continue a seven-region structure based on the current Accountable Care Collaborative regions with one change: Elbert County will move to Region 3.
- **Mandatory enrollment**: All full-benefit Medicaid members will be immediately enrolled in the Accountable Care Collaborative upon Medicaid eligibility.
- **Primary care payments**: New primary care payments will incentivize greater team-based care, integration of services and higher standards.
- **Behavioral health capitation**: The Department will use a modified capitation structure to pay for behavioral health services. Modifications in the covered diagnosis requirements will increase access to behavioral health services, particularly those delivered in primary care settings.
- **Disbursement of provider per-member-per-month payments**: The Regional Accountable Entities will pay PCMPs their per-member-per-month payments, rather than the Department disbursing these funds.
- **Enhanced care coordination**: The Accountable Care Collaborative will enhance care coordination requirements for the whole population in a Regional Accountable Entity's service area.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that delivery system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate to improve member outcomes and reduce health care costs, and is poised to continue to do so in the future.

8.2. Primary Care Alternative Payment Model

In addition to changes made in the next phase of the Accountable Care Collaborative, the Department, with input from stakeholders, is transforming payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is developing differential payment structures to change the way we pay providers and is currently pursuing two different payment reform models; the first for primary care providers and the second for Federally Qualified Health Centers (FQHCs).

First, the Alternative Payment Model (APM) for Primary Care Medical Practices is a transformation of the 1202 bump to primary care rates that was authorized under the

Affordable Care Act in 2013, and was supported using General Fund dollars after federal funding expired in December 2014. The Department requested a continuation of the 1202 bump in FY 2017-18, with the addition of a value proposition. The AMP is that value proposition.

The goals of the APM are to:

1. Provide long-term, sustainable investments into primary care;
2. Reward performance and introduce accountability for outcomes and access to care while creating flexibility of choice to PCMPs, and;
3. Align with other payment reforms across the delivery system. This new payment structure gives providers greater flexibility in business practices while rewarding performance and enhancing transparency and accountability in the Medicaid delivery system.

The Department will use the Accountable Care Collaborative as the platform for implementing the APM, and it is limited to providers participating as PCMPs in the Accountable Care Collaborative. To be eligible to participate in the APM, PCMPs must have more than $30,000 in annual billing associated with the code set designed for the APM. PCMPs who fall below this threshold will be excluded from the APM, and will not see a change in their rates. PCMPs who are eligible but choose not to participate will see a decrease in their rates.

The Department is working with RCCOs (and RAEs after implementation) and stakeholders to help PCMPs and their staff successfully implement the APM in their practices. The RAE will be responsible for supporting PCMPs by helping them select appropriate measures for their individual practices and provide ongoing support and education regarding changes to the payment model. RAEs will also be required to designate a single point of contact for practices to assist with transformation efforts and track the selected measures.[15]

Second, FQHCs will be eligible for two value based payments: value based encounter payments and prospective PMPM payments. The value based encounter payments will tie 4 percent of payments to quality and is similar to the points based model to the APM. The Department is also pursuing a limited pilot payment model for PMPM payments to FQHCs. The Department has worked closely with the FQHCs and the Colorado Community Health Network to develop these payment models.

[15] For more information on the Alternative Payment Model, visit the Department's website.

8.3. Studying Further Coverage of Substance Use Disorder Treatment Services

As required by House Bill 17-1351, the Department, in partnership with the Department of Human Services' Office of Behavioral Health, has submitted a report to the Joint Budget Committee analyzing the feasibility of providing residential and inpatient substance use disorder treatment as part of Medicaid. The Departments contracted with the Colorado Health Institute to complete this report. Please refer to that report for further information on expanding coverage of Substance Use Disorder Treatment services in the Medicaid program[16].

9. Reducing Waste and Inefficiencies

The Accountable Care Collaborative is one of the Department's main efforts to reduce waste and inefficiencies in the Medicaid program, and it does so by promoting coordinated care that reduces duplication and increases collaboration across agencies. While the data for this report only covers FY 2016-17, the Accountable Care Collaborative has demonstrated cost savings over time, suggesting the program is reducing duplication and inefficiencies by improving access to coordinated care and strengthening partnerships across the multiple systems that serve Medicaid members.

This section is divided in to the following subsections:

9.1 Technology-Based Efforts to Contain Costs
9.2 Partnerships to Improve Coordination and Reduce Duplication
9.3 Statutes, Policies or Procedures that Prevent Regional Entities from Realizing Efficiencies and Reducing Waste
9.4 Looking Forward

9.1. Technology Based Efforts to Contain Costs

Provider Revalidation

New federal regulations established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and revalidation for all existing, and newly enrolled, Medicaid providers. These regulations are designed to increase compliance and quality of care, and reduce fraud by ensuring all Medicaid providers are appropriately identified and enrolled to provide services. Colorado began provider revalidation in September 2015, and continued to work with Medicaid providers in FY 2016-17. Through this effort, the

[16] Report can be found online at https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf

Department expects to contain health care costs and reduce waste by ensuring providers are appropriately enrolled and able to bill for services provided to Medicaid members.

Care Management Systems and Data Sharing

Technology-based care management platforms have the potential to drive efficiency in health care and contain costs by providing doctors and care coordinators with timely, actionable information on their members. RCCOs have tested and implemented different care management systems to help providers and care coordinators understand the scope of services a member receives, and how to better coordinate care for that member. These platforms support collaboration across entities, providing RCCOs with insight into the different providers involved in a member's care-team, and help RCCOs identify areas of potential duplication of services. Additionally, care management platforms have the ability to automate reporting and notifications, saving care coordinator time and resources.

For example, Community Care of Central Colorado uses ClientTrack, which is an electronic care planning and tracking tool that is used by care coordination staff. ClientTrack automated and improved data and reporting, thus reducing demand for staff resources for manual reporting. Community Care of Central Colorado also developed a data warehouse that captures longitudinal and dynamic data on their members, which then feeds into the ClientTrack system to streamline functions and help care coordinators target specific populations. They also use this data platform to conduct analytics to help identify populations who may benefit from care coordination.

In addition to testing care management platforms, RCCOs have also recognized the importance of sharing data to increase collaboration and therefore reduce duplication. Colorado Community Health Alliance began sharing data with local public health agencies and county offices to coordinate across shared members and collaborate on special projects. Specifically, Colorado Community Health Alliance shares claims data on shared members with Boulder County to compare service data and identify and track needed services and gaps in care. In turn, Colorado Community Health Alliance uses this data to outreach members and connect them to local providers. This drives cost containment as members are directed to use

Rocky Mountain Health Plans worked with Quality Health Network (QHN), the health information exchange on the western slope, to implement the Community Resource Network (CRN). This "social information exchange" brings together physical and behavioral health with other social services to communicate on one platform. This

platform bridges service and communication gaps for the various entities that serve Medicaid Members. Facilitating communication across shared members is one mechanism to reduce duplicative services and inefficiencies.

9.2. Partnerships to Improve Collaboration and Reduce Duplication

RCCOs have developed partnerships with case management entities and other community partners to align resources and reduce duplicative care coordination efforts. By reducing duplication in the health care system, RCCOs drive cost containment through ensuring more effective use of health care resources. RCCOs worked to strengthen partnerships in FY 2016-17, establishing streamlined communication and workflow processes across agencies.

For example, Colorado Access partnered with the Colorado Department of Public Health and Environment (CDPHE) and Tri-County Health Department to improve coordination and collaboration across programs for children and youth with special health care needs. This partnership resulted in a step-by-step process mapping of care coordination services for shared members to ensure services weren't being duplicated. Colorado Access and Tri-County Health Department are in regular contact regarding shared members, and work to identify the lead in care coordination to reduce inefficiencies and duplicative services.

Colorado Community Health Alliance formed collaborative relationships with the SEP and CCB agencies in their region. Together, they conduct joint home visits to complete care assessments with members. They also established the appropriate agreements to share member data in a HIPAA compliant manner, and created a shared care coordination and referral workflow. This cross-agency collaboration has resulted in a reduction of duplicative services and inefficiencies for Medicaid.

Community Care of Central Colorado formed a partnership with CORHIO to encourage providers to connect their electronic health record systems with the state's health information exchange. Through this effort, they successfully connected imaging services, and other ambulatory care providers to CORHIO. Connection to the HIE has the potential to greatly reduce duplication, particularly for imaging and laboratory services.

9.3. Statutes, Policies or Procedures that Prevent Regional Entities from Realizing Efficiencies and Reducing Waste

Federal requirements, such as the new regulations for managed care entities, provider revalidation, and the Health Insurance Portability and Accountability Act (HIPAA) can be time and resource-intensive for RCCOs to understand and to work towards compliance, and can feel like barriers to efficiency. These federal requirements are important for providing necessary oversight and accountability of Medicaid programs and for protecting member privacy; however, the Department recognizes these requirements can be cumbersome to implement.

To alleviate some of the administrative burden on RCCOs, the Department provides RCCOs guidance to help inform business practices, including issuing policy guidance and providing education on the new requirements. For example, the Department developed a record retention policy to clarify federal regulations on this matter and to ensure compliance with state and federal auditing requirements. The Department is working to integrate the new federal requirements for managed care entities into RCCO contracts and is developing processes to ensure compliance with federal regulations.

In addition to federal requirements, the Department has identified certain processes within the Accountable Care Collaborative that have the potential to prevent RCCOs from realizing efficiencies in their efforts to reduce waste. Specifically, the Department's attribution process has been an area of frustration for RCCOs and PCMPs because, in some cases, members are not attributed to the appropriate provider. The Department has done considerable work to improve the attribution process to enhance member and provider experiences. To address this, the Department implemented a process to re-attribute members who are seeing a different medical home provider, and changed the methodology to ensure members are connected to a demographically-accurate medical home.

While these processes have helped refine the current attribution methodology, the Department continues to make improvements for the next phase of the Accountable Care Collaborative. For example, the Department intends to prioritize wellness visits in the attribution methodology moving forward. Additionally, the Department expects to be better able to attribute members to a specific practice site in the next phase of the Accountable Care Collaborative; the Department did not have the necessary information to do this prior to provider revalidation. The Department takes programmatic inefficiencies seriously and works with the stakeholder community, often through PIAC,

to develop solutions. Additional information on these efforts will be provided in next year's report.

9.4. Next Steps in Program Integrity

While many requirements for program integrity outlined in federal regulations do not apply to the Accountable Care Collaborative under the current federal operating authority, they will apply in the next phase of the Accountable Care Collaborative. The Regional Accountable Entity will operate under the requirements of a Primary Care Case Management Entity and a Prepaid Inpatient Health Plan set forth in 42 C.F.R. § 438.2. Therefore, contracts for the next iteration of the program will adhere to federal regulations in program integrity. Specifically, § 438.608 of the federal regulations require managed care plans to ensure they have policies and procedures in place to promptly report potential fraud and abuse to the Department. They will also be required to have a process in place to verify that members received the services for which they were billed. The Department will track implementation of these regulations through contract oversight and monitoring, and will provide more information in next year's report.

Additionally, Accountable Care Collaborative Program staff and Program Integrity staff within the Department have been collaborating to improve coordination across offices. The goal of this work is to develop and maintain a standard process for referring cases of potential fraud to the Department's Program Integrity section. This will help the Department improve contract oversight, and establish workflows and processes for identifying and reducing fraud, waste and inefficiencies within the Medicaid program.

Appendix A: Technical Documentation for Costs Avoided

The results in this report are the Department's best estimate of the impact of the Accountable Care Collaborative given several significant constraints. Because the majority of Medicaid members are enrolled in the Accountable Care Collaborative, the Department cannot reliably compare the costs for members enrolled in the program to the costs for members not enrolled.

In previous years, the Department has calculated costs avoided by comparing current medical costs to an estimate of the medical costs program enrollees would have incurred had they received traditional fee-for-service Medicaid rather than participating in the program. However, as more time elapses from the original program implementation year, this method becomes less accurate due to a greater reliance on assumptions to estimate the fiscal impact.

To estimate costs avoided this year, the Department compared the current costs for program enrollees to the previous year's costs, demonstrating that costs have continued to decrease over time.

Calculating Medical Costs

First, the difference in average medical cost per member month was calculated from the baseline year (FY 2015-16) to the current year (FY 2016-17).

Medical costs include all pharmacy, inpatient hospital, outpatient hospital, emergency room, and professional claims for services provided during the fiscal year. FY 2015-16 costs were adjusted for inflation using the Medical Care Consumer Price Index from the Bureau of Labor Statistics.

A member month is defined as one member enrolled for one month. For each fiscal year, total member months are calculated by summing the number of members enrolled each month of the year.

Total medical costs are divided by total member months to yield an average medical cost per member month for the fiscal year. The difference in average medical costs from FY 2015-16 to FY 2016-17 is then multiplied by the total member months in FY 2016-17 to produce an estimate of total medical costs avoided in FY 2016-17.

Accounting for Administrative Costs

Annual administrative expenses increased from FY 2015-16 to FY 2016-17. In order to account for the additional administrative costs in FY 2016-17, the increase in administrative costs is deducted from the total medical costs avoided estimate. The result is an estimate for total overall costs avoided in FY 2016-17.

Administrative costs are based on the costs reported in Exhibit I of FY 2018-19 R-1, "Medical Services Premiums," adjusted to include the total accrued incentive payments rather than paid incentives in FY 2016-17 and to include a payment for the SDAC contract from another line item.

Sample Calculation

FY 2015-16			FY 2016-17				
Medical Costs	**Member Months**	**Average Medical Cost Per Member Month**	**Medical Costs**	**Member Months**	**Average Medical Cost Per Member Month**	**Difference in Average Medical Cost per Member Month**	**Total Medical Costs Avoided in FY 2016-17**
$2,654,511,380	10,799,922	$245.79	$2,641,432,057	10,855,762	$243.32	$2.47	$26,804,230

In FY 2015-16, there were $2,654,511,380 in total medical costs and 10,799,922 total member months. The average cost per member month is $245.79 ($2,654,511,380 / 10,799,922 member months). In FY 2016-17, there were $2,641,432,057 in total medical costs and 10,855,762 member months. The average cost per member month is $243.32 ($2,641,432,057 / 10,855,762 member months). The difference in average medical cost between FY 2015-16 and FY 2016-17 would be $2.47 ($245.79 - $243.32). On average, $2.47 in medical costs is avoided for each member month in FY 2016-17 compared to FY 2015-16. $2.47 per member month is multiplied by the total number of member months in FY 2016-17 ($2.47 X 10,855,762), to yield a total of $26,804,230 in total costs avoided in FY 2016-17.

Administrative costs were $145,138,549 in FY 2015-16 and $150,374,011 in FY 2016-17. Therefore, administrative costs increased by $5,235,463 ($150,374,011 - $145,138,549) in FY 2016-17. This increase in administrative costs is deducted from the total medical costs avoided estimate, for an overall costs avoided estimate of $21,568,767.