COLORADO
Department of Health Care Policy & Financing

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

December 1, 2018

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

Dear Senator Moreno:

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 2017-18. 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, David DeNovellis, at David. DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2018 Accountable Care Collaborative Implementation Report

Cc: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator-elect Dennis Hisey, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Eric Kurtz, Joint Budget Committee Analyst
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting
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Chris Underwood, Health Information Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Stephanie Ziegler, Cost Control Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, 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, 2018

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 Senate health and Human Services 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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Kim Bimestefer
Executive Director

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Enclosure(s): HCPF 2018 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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David DeNovellis, 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, 2018

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 House Public Health Care and Human Services 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,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2018 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
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Representative Kim Ransom, Public Health Care and Human Services Committee
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David DeNovellis, 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, 2018

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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Enclosure(s): HCPF 2018 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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David DeNovellis, Legislative Liaison, HCPF

ACCOUNTABLE CARE COLLABORATIVE FY 2017-18

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

December 1, 2018

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

Executive Summary

The Accountable Care Collaborative is the core of Colorado's Medicaid program. Launched in 2011, it has become the primary vehicle for delivering health care to nearly one million Coloradans. The program works on the principle that coordinated care, with needed community supports, is the best way to deliver care, especially to those with the complicated health needs of many Medicaid members.

This fiscal year concluded Phase I of the Accountable Care Collaborative, which was focused on connecting members to primary care services, making the system more user-friendly for members and providers, coordinating medical and non-medical services for members with complex needs, and using data to inform decision-making.

Over the course of Phase I, the program grew to serve about one million members, from a starting enrollment of 500 members in 2011. It successfully increased care coordination, improved the delivery of primary care, created payment structures that incentivized value and outcomes, and connected more Coloradans to a medical home to prevent and manage illness. Phase II of the program, which began in July 2018, is building on this foundation to promote coordination of physical and behavioral health at the administrative level and evolve payment structures to reward performance and outcomes. More information about Phase II may be found in the *Looking Forward* section of this report.

Enrollment in the Accountable Care Collaborative

In FY 2017–18, average monthly enrollment in the Accountable Care Collaborative was 1,001,779 members, about 76 percent of all Medicaid Members. This enrollment number includes members participating in the Accountable Care Collaborative: Rocky Mountain Health Plans Prime. Although members had the opportunity to opt out of the Accountable Care Collaborative every year, only four percent of those who were enrolled in FY 2017–18 chose to do so.

An important part of the enrollment process is connecting a member to a Primary Care Medical Provider (PCMP), which serves as the member's medical home. About three-quarters of Accountable Care Collaborative members were connected to a PCMP in FY 2017–18.

Program Performance: Member Health Impacts

The program measures performance by looking at outcome and utilization measures as well as practice transformation among PCMPs. Key Performance Indicators (KPIs) are utilization measures tied to payments for Regional Care Collaborative Organizations (RCCOs) and PCMPs. The following were KPIs during FY 2017–18:

- Well-child visits. The rate of annual well-child visits among children ages 3–9 has increased slightly from 48.1 percent in June 2017 to 49.4 percent in June 2018.
- Postpartum care. In FY 2017–18, approximately 34.0 percent of women received an outpatient postpartum exam in the 21–56 days following a live birth, similar to last year's rate of 34.6 percent.
- Emergency room visits. Risk-adjusted emergency room visits fell from 848.2 per 1,000 members per year in June 2017, to 820 per 1,000 members per year in June 2018. This continues a downward trend from the past few years.

The Department also tracked progress on an additional non-KPI measure: 30-Day Post-Discharge Follow-Up. The rate of members who received follow-up care within 30 days of discharge from a hospital increased to 53.0 percent from 51.3 percent the previous year.

Program performance is affected by the quality of the care members receive from their primary care medical provider. This fiscal year, the program helped more PCMPs increase their capacities as medical homes and become Enhanced Primary Care Medical Providers (ePCMP). In FY 2017–18, 374 practices met at least five of the nine criteria for ePCMP, compared to 269 in FY 2014–15 when the ePCMP program began.

Financial Performance

A goal of the Accountable Care Collaborative is to effectively manage costs while maintaining high-quality care for members. The program had two types of costs: administrative costs, which covered per-member-per-month payments for RCCOs and PCMPs as well as incentive payments; and medical costs, which include all pharmacy, inpatient, outpatient, emergency room, Long Term Services and Supports (LTSS), home health, and professional claims for services provided.

For FY 2017–18, total administrative costs for the Accountable Care Collaborative were **$150,154,532**, approximately $3.2 million less than the administrative costs in FY 2016–17, adjusted for inflation. The two primary reasons for this reduction are lower enrollment and the reallocation of the costs for the data and analytics contract (these

costs are no longer budgeted specifically for the Accountable Care Collaborative program).

From FY 2016–17 to FY 2017–18, the average paid amount per program member per month increased by 6.5 percent, or $18.98 per member per month (defined as one member enrolled for one month). This translates to approximately $142,240,726 in additional medical costs in FY 2017–18. After accounting for the decrease in administrative expenses from the previous year, additional costs totaled **$139,028,648**.

The higher costs were driven by increases in both reimbursement rates and utilization in service areas such as physician services, home health, LTSS, inpatient, and independent lab; increases in pharmacy expenditures were driven by higher costs per service while utilization per member declined. The Department is leveraging its enhanced contract with IBM Watson Health to analyze claims data from FY 2017–18 to understand which subpopulations are using services more frequently and which specific services are being used more often.

Additionally, to ensure future control of costs and utilization, the Department:

- Is integrating the administration of physical and behavioral health for Phase II of the Accountable Care Collaborative;
- Has established twelve work teams to identify and implement opportunities to better control Medicaid costs (for example, with more aggressive management of prescription drugs); and
- Is implementing Senate Bill 18-266, which was signed into law in May of 2018 to:
    - Establish a Cost Control and Quality Improvement Office to identify and implement future cost control solutions;
    - Provide the resources necessary to modernize the Department's claim edits;
    - Implement a Hospital Review program that better monitors and controls this costly benefit while also enabling improved care coordination by Regional Accountable Entities; and
    - Provide cost and quality tools to providers, hospitals, and Regional Accountable Entities to help them identify and address Potentially Avoidable Costs.

Other Accomplishments

The Accountable Care Collaborative made improvements in other key areas during the fiscal year.

- **Promoting Access to Services in Rural and Frontier Counties:** The Accountable Care Collaborative recruited providers, contracted with more Rural Health Clinics, supported practices to accept more Medicaid members, improved transportation services, and improved access to telehealth.
- **Coordinating with Long-Term Services and Supports (LTSS):** During FY 2017 – 18, the Accountable Care Collaborative worked closely with Single Entry Point (SEP) and Community Centered Board (CCB) agencies to establish roles and responsibilities for case managers and care coordinators, developed shared workflows and aligned care plans, and coordinated joint home visits in an effort to reduce duplication of services and ensure members' needs were met.
- **Reducing Waste and Inefficiencies:** The structure of the Accountable Care Collaborative, particularly the use of medical homes, provided administrative efficiencies while reducing duplicative and inappropriate service utilization.

Advisory Committees and Stakeholder Engagement

The Accountable Care Collaborative has been committed to staying connected to its members and being responsive to the input of stakeholders. The Program Improvement Advisory Committee (PIAC) was the program's main forum for stakeholder engagement and feedback. During FY 2017–18, the PIAC focused on improving care coordination, member engagement, connecting systems for populations with complex needs, and preparing for Phase II of the program. In addition, each RCCO also hosted a regional performance improvement advisory committee to identify community-level needs and develop solutions.

Looking Forward

The Department is moving toward a more coordinated and integrated health care system. Phase II of the Accountable Care Collaborative began in July 2018 when contracts went into effect for seven Regional Accountable Entities (RAEs). Each is a single administrative organization for behavioral health and physical health.

The Department is also transforming payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department's Primary Care Alternative Payment Model is designed to provide long-term, sustainable investments into primary care while introducing accountability for outcomes and rewarding performance. The Department is working on new payment models to create incentives for federally qualified health centers as well. Finally, as described above, the Department is working strategically across the organization on cost containment efforts in the upcoming fiscal year and beyond.

1. Introduction and Background

1.1. Program Overview

The Accountable Care Collaborative is the core of Colorado's Medicaid program. Launched in 2011, it has become the primary vehicle for delivering health care to nearly one million Coloradans. The program works on the principle that coordinated care, with needed community supports, is the best way to deliver care, especially to those with the complicated health needs many Medicaid members have due to disability or challenging life circumstances.

The first phase of the Accountable Care Collaborative was focused on connecting members to primary care services, making the system more user-friendly for members and providers, coordinating medical and non-medical services for members with complex needs, and using data to inform decision-making. It relied on 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), which are medical homes for members
- Data and Analytics, to give the Department, RCCOs and PCMPs actionable information on individual members and the program population as a whole

Over the course of Phase I of the program, it evolved considerably to:

- Serve about one million members enrolled, from a starting enrollment of 500 members in 2011
- Connect more Coloradans to a medical home
- Increase coordination of care between systems
- Enhance Primary Care Medical Provider standards to align with national Patient-Centered Medical Home standards
- Make payment responsive to program needs and incent greater value
- Increase coordination with Long-Term Services and Supports by enrolling approximately 30,000 full benefit Medicare-Medicaid enrollees into the program

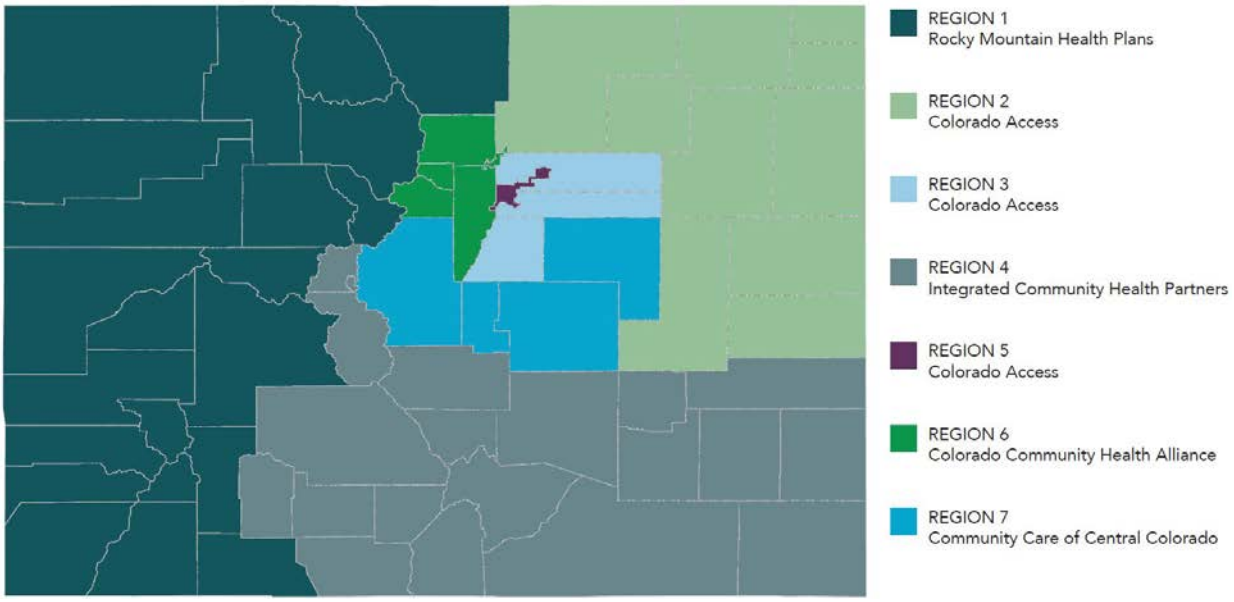
This fiscal year concluded Phase I of the program. For more information about Phase II of the Accountable Care Collaborative, see *Looking Forward* at the end of this report.

Regional Care Collaborative Organizations

During Phase I of the Accountable Care Collaborative, RCCOs had the following responsibilities:

- **Medical management and care coordination**: Ensured that every member in the region received coordinated, comprehensive, person-centered care as well as non-medical supports needed to overcome barriers to appropriate care.
- **Provider network development**: Developed a formal contracted network of primary care providers and an informal community network of medical and non-medical services.
- **Provider support**: Supported primary care medical providers in delivering efficient, high-quality care with clinical tools, member materials, administrative support, and practice redesign.
- **Accountability and reporting**: Reported to the state on the region's progress and met programmatic and Departmental goals.

Figure 1. Map of Accountable Care Collaborative Regions SFY 2017–18



Primary Care Medical Providers

One of the program's goals was to link every member to a primary care medical provider (PCMP) as a central point of care. The PCMP functioned as a medical home, a model that promoted comprehensive and coordinated care for a positive member experience better health outcomes and reduced costs. PCMPs were responsible for ensuring timely access to primary care for members and connecting members to non-medical community and social services. Some provided care coordination directly, while others worked with RCCOs to give the best possible support to members.

Data Analytics

The Department provided regional entities and PCMPs with data and analytics for individual members and the entire Accountable Care Collaborative population. Population-level data was used to evaluate and improve the performance of RCCOs, PCMPs and the program overall. Member-level data was used to support care management and coordination activities, and often was used to help RCCOs and PCMPs identify members with complex medical needs. Access to data was role-based; users accessed only the data they needed to do their work.

1.2. In This Report

This report includes updates on the following:

- Accountable Care Collaborative Enrollment
- Program Performance: Member Health Impacts
- Financial Performance
- Access to Services in Rural and Frontier Counties
- Coordination with Long-Term Services and Supports
- Efforts to Reduce Waste and Inefficiencies
- Advisory Committees and Stakeholder Engagement
- Looking Forward

With the exception of enrollment data, this report does not include an update on the Accountable Care Collaborative: Rocky Mountain Health Plans Prime. This initiative was developed under the Accountable Care Collaborative Payment Reform Initiative and codified at section 25.5-5-415, C.R.S; progress will be addressed in a separate legislative report to be submitted in April 2019.

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.

2.1. Enrollment Numbers

In FY 2017–18, enrollment in the Accountable Care Collaborative declined slightly, as did all Medicaid enrollment. The average Accountable Care Collaborative enrollment in FY 2017–18 was 1,001,779, which was about 76 percent of all Medicaid members. This enrollment number includes members participating in the Accountable Care Collaborative: Rocky Mountain Health Plans Prime. The Accountable Care Collaborative:

Medicare-Medicaid Program ended in December 2017, and these members are now integrated fully into the Accountable Care Collaborative.

Figure 2 shows average annual enrollment in the Accountable Care Collaborative for each year since FY 2012–13. Table 1 shows ACC enrollment by population in June 2018.

Figure 2. Accountable Care Collaborative Enrollment and Medicaid Caseload: Annual Averages from FY 2012–13 to FY 2017–18

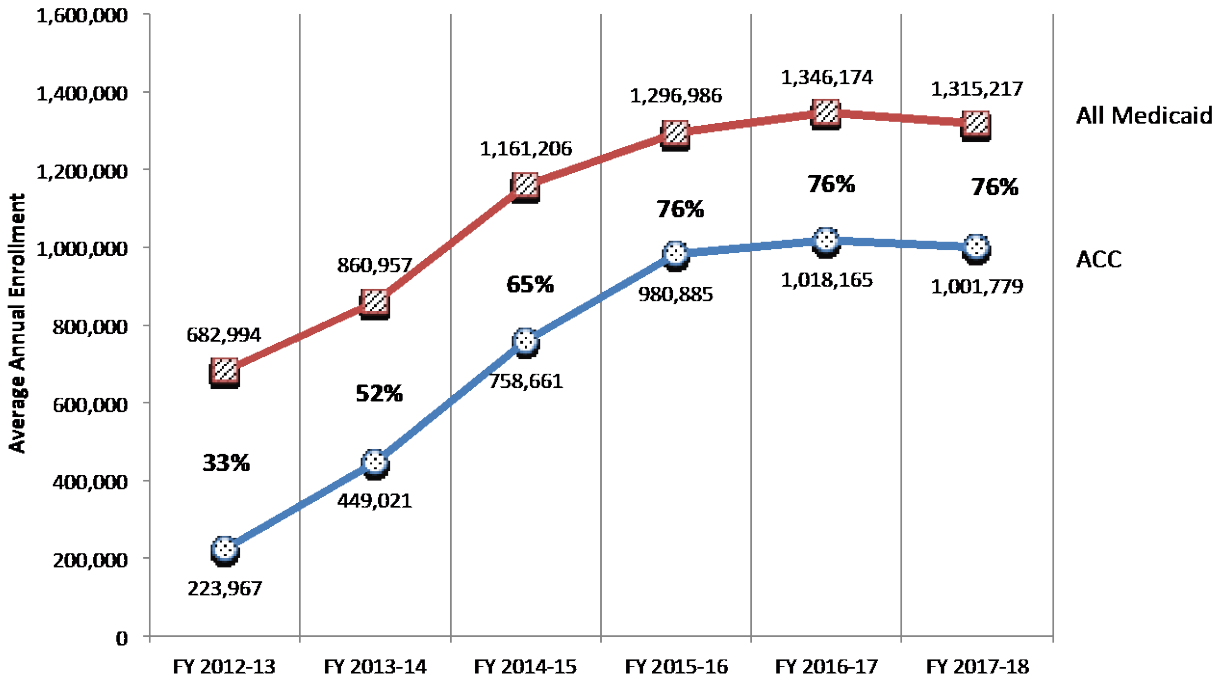


Table 1. Accountable Care Collaborative Enrollment by Population in June 2018

Population	Number of Accountable Care Collaborative Members	Percent
Children without disabilities	389,274	41%
Adults (without disabilities) covered under the Affordable Care Act expansion	286,448	30%
Adults (without disabilities) eligible before the Affordable Care Act expansion	143,597	15%
Children and adults with a disability, including Medicare-Medicaid members	88,126	9%
ACC: Rocky Mountain Health Care Prime members	34,836	4%
TOTAL	**942,281**	

Note: Numbers do not add to 100 percent due to rounding.

2.2. How Members Were Enrolled into the Program and a Regional Care Collaborative Organization

As in previous years of the program, the Department used *passive enrollment* in FY 2017–18 to enroll all new Medicaid members who were eligible to participate. Members were automatically enrolled into the RCCO in the region where they lived and given 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). After this period, most members could only opt out during their annual enrollment period. The exception was Accountable Care Collaborative: Medicare-Medicaid Program members, who could opt out of the program at any time for any reason. Only four percent of those passively enrolled chose to opt out.

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

One of the program's goals was to link every member to a PCMP that served as the member's central point of care, a process called *attribution*. The PCMP functioned 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 attributed members to a PCMP through the following process:

1. Members were attributed to a PCMP they had recently seen based on claims history within the previous 12 months
2. Members who did not have a claims history with a PCMP were attributed to a PCMP that someone in their family had recently seen, based on claims history within the previous 12 months

Sometimes there was no claims history to show a relationship with a primary care provider, either for the member or any family members. Such members were at risk of going without a PCMP for a long time. To reduce this risk, the Department checked every month to see if unattributed members or their family members had any new claims that showed a relationship with a primary care provider. If so, the member was attributed to that PCMP. Nearly three-quarters of members (72 percent) had a PCMP in June 2018.

Members were notified by mail when they were attributed to a PCMP and could select or change their PCMP at any time. Member choice always took priority over system assignment based on claims history.

3. Program Performance: Member Health Impacts

The Accountable Care Collaborative aimed to improve health outcomes and the health care experience for all Medicaid members. This section describes the program's progress on these goals during FY 2017–18.

3.1. Key Performance Indicators

The following were the Key Performance Indicators (KPIs) for FY 2017–18. These were used to evaluate program impact on member health outcomes:

- Well-child visits among children ages 3–9
- Postpartum care visits
- Emergency room visits

The following populations were excluded from the KPI analysis:

- Members with both Medicaid and Medicare coverage, because Medicare claims were not available for outcome data
- Members in the Accountable Care Collaborative: Rocky Mountain Health Plans Prime

- Members who were enrolled in a physical health managed care plan for more than three months of the reporting period
- Members who were enrolled in Medicaid for less than three months of the reporting period

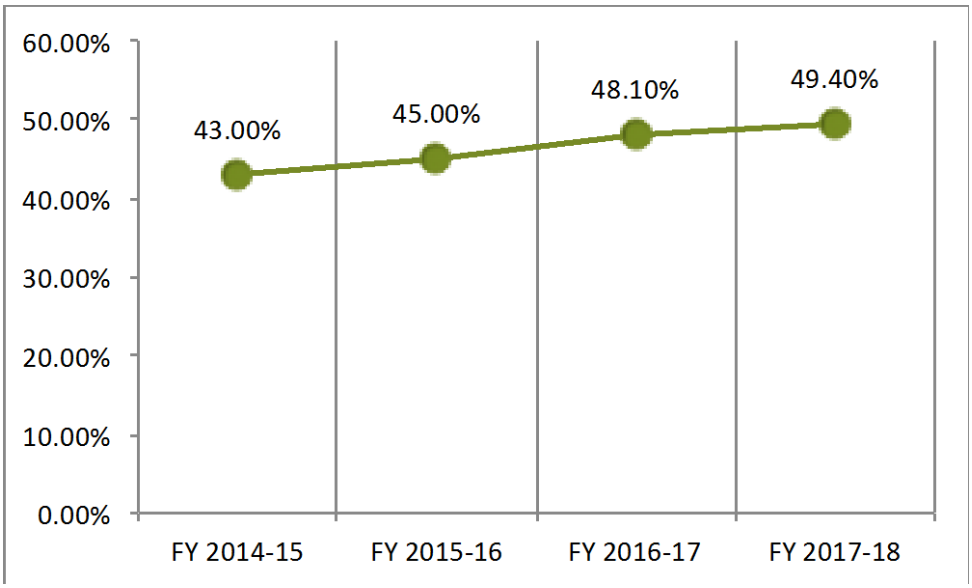
Below are the outcomes for these measures, which were calculated using FY 2017–18 claims data for the Accountable Care Collaborative population.

Well-Child Visits Among Children Ages 3–9

This measure tracked the rate of annual well-child visits among children ages 3–9 years; these visits are an important opportunity for caretakers and health care providers to communicate about child development, nutrition, safety, preventive care, and more. The Department chose to measure the 3–9 year-old age group because rates for this group have been historically low.

The rate of well-child visits increased only slightly statewide in FY 2017–18, from 48.1 percent in June 2017 to 49.4 percent in June 2018. It has hovered around 50 percent since July 2016, up slightly from an approximate statewide average of 43 percent in FY 2014–15 and 2015–16.

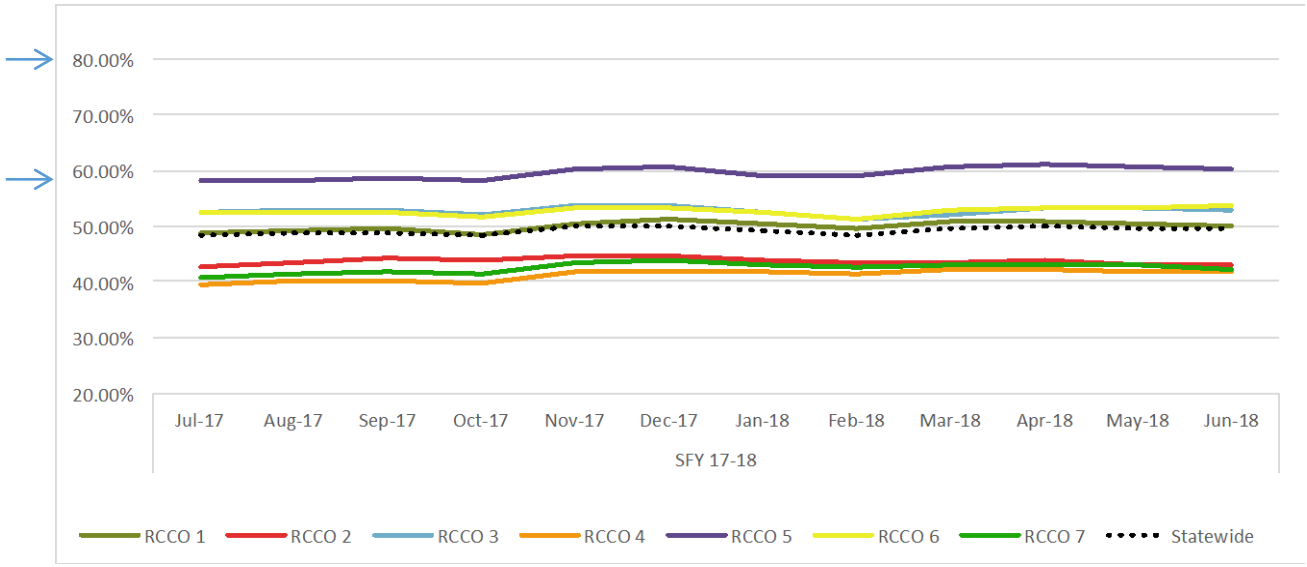
Figure 3. Well-Child Visits Ages 3–9, from FY 2014–15 to FY 2017–18



Most RCCOs were below the KPI targeted rates for two levels of incentive payments (set at 60 percent and 80 percent respectively). Three RCCOs were between 50 and 55

percent and three RCCOs had rates closer to 40 percent. Colorado Access (Region 5) was the first to reach the 60 percent goal. This RCCO worked with six practices to review population characteristics such as percentage of members attributed to a PCMP, children who were healthy but not seen, and missed appointment rates. They then worked with the practices to develop strategies based on the data.

Figure 4. Well-Child Visits Ages 3–9 for FY 2017–18, by RCCO



Postpartum Care Visits

This KPI measured the percentage of women who received an outpatient postpartum exam in the 21–56 days following a live birth. Postpartum care visits are an important focus area of the Accountable Care Collaborative because approximately 45 percent of babies born in Colorado are born to mothers covered by Medicaid.

A postpartum exam provides an important opportunity for checking the physical and mental health of new mothers and counseling them on family planning. The rate of postpartum visits among members who gave birth while enrolled in the program held steady at about 34 percent over FY 2017–18 and the previous year (FY 2016–17). The rate among individual RCCOs ranged from about 30 percent to 37 percent.

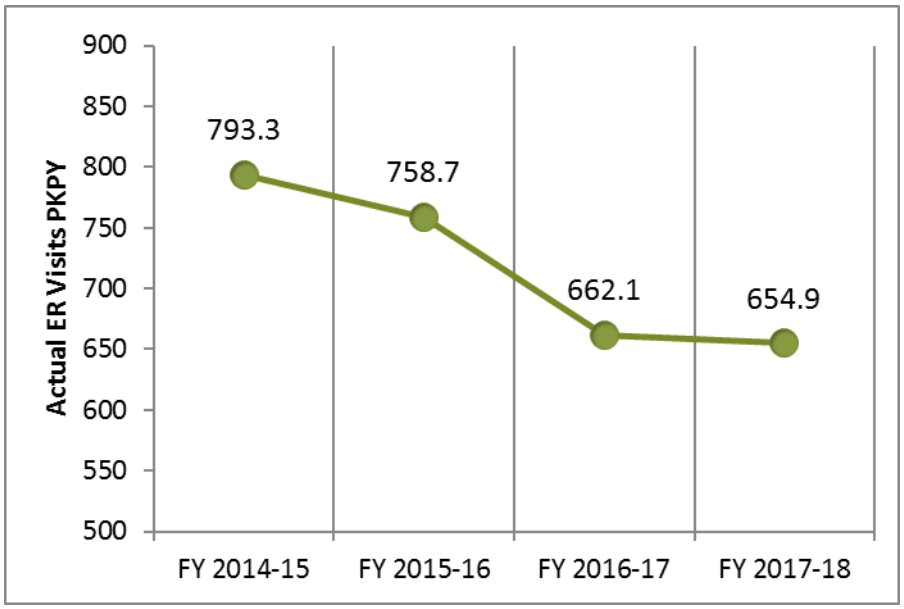
Some RCCOs used strategies to directly remind their members about postpartum visits. For example, Colorado Community Health Alliance worked with practices and hospitals to improve systems for tracking and reaching out to members who had recently given birth. This RCCO also worked to connect mothers with other resources and programs, acting as a coordination hub for clinic and community programs that serve mothers and babies.

Emergency Room Visits

One of the performance indicators of the Accountable Care Collaborative since its inception in 2011 has been the use of the emergency room to monitor whether members get the right care in the right place at the right time. This KPI evaluated the program's progress on reducing emergency room visits, which is any visit on a given day for a given member that did not result in an inpatient admission. This measure is risk-adjusted and expressed as "per thousand members per year (PKPY)." The risk-adjusted measure takes into consideration risk factors that can influence the health outcomes of the population the program serves.

Risk-adjusted emergency room visits fell from 880.0 visits per thousand per year in July 2016 to 848.2 in June 2017, and again to 820 in June 2018. This continues a downward trend from the past few years. Previous to FY 2016–17, the Department did not track the risk-adjusted rates, so Figure 5 shows the actual (not risk-adjusted) rates for the last four years of the program.

Figure 5. Actual Emergency Room Visits Without Hospital Admission, Per 1,000 Members Per Year, from FY 2014–15 to FY 2017–18



Over the course of the program, the Department, RCCOs, and PCMPs have been working together to implement programs and strategies to reduce use of the emergency room. Below are examples of strategies RCCOs have used:

- Improved tracking systems, data use, and provider partnerships to identify frequent emergency room users
- Connected frequent emergency room users with care coordinators
- Connected members with a Primary Care Medical Provider
- Worked with first responders in the region to identify high emergency service utilizers
- Coordinated with Single Entry Points and nursing facilities to share information and prevent unnecessary emergency room use among those in nursing facilities, or transitioning from a hospital stay to a nursing facility
- Incentivized practices to offer extended hours and access to medical advice in off hours
- Promoted the Nurse Advice Line
- Worked with practices to create welcome letters and other materials that tell members what to do for after-hours care and when to go (and not go) to the emergency room
- Improved care coordination and preventive services for members with multiple chronic conditions
- Improved access to substance use disorder treatment to prevent drug seeking in the emergency room
- Gave Primary Care Medical Providers access to training and expert advice on preventing and treating opioid addition

In addition to a wealth of knowledge and lessons learned, this work has shown the power of a coordinated and concentrated effort towards a goal. Phase II of the Accountable Care Collaborative seeks to build on this success by establishing regional entities that will be accountable for both the physical and behavioral health care of members. This positions them to work closely with all providers to meet the needs of members with conditions that lead to frequent emergency room use.

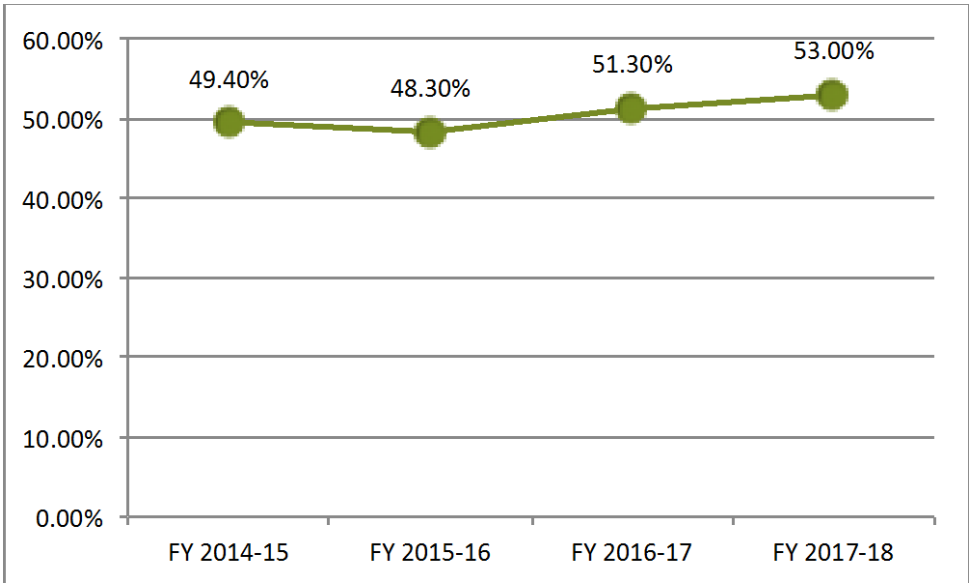
The Department will also continue to incentivize performance on reduction of emergency room utilization by retaining this measure as a KPI for Phase II of the Accountable Care Collaborative. In addition, the Department has included in the Hospital Transformation Program an incentive for hospitals to convert freestanding emergency rooms to something that the community prefers as noted in the community assessment, such as extended primary care or addiction counseling.

3.2. Additional Measure: Follow-Up Care Within 30 Days of a Hospital Discharge

This measure tracked the percentage of members who received a follow-up visit with a physician within 30 days of an inpatient hospital discharge. All members who were excluded from the KPI analyses were also excluded from this analysis. Members readmitted within 30 days were also excluded from this measure, as were members transferred to other facilities (including a skilled nursing facility and hospice), those transferred to law enforcement, and those who died. A follow-up visit is an opportunity to address the conditions that led to hospitalization and support home care. Members who do not see a provider within 30 days of hospital discharge are at high risk for hospital readmission.[1]

The rate of members who received follow-up care within 30 days of discharge from a hospital was 53.0 percent statewide, continuing an upward trend as shown in Figure 6.

Figure 6: Percent of Members Who Received Follow-up Care Within 30 Days of Discharge From a Hospital, FY 2014–15 to FY 2017–18



The RCCOs took several approaches to improve the rate of follow-up care after hospital discharge. Most RCCOs implemented care transition programs to streamline the transition from hospital to community. The RCCOs worked with hospitals, Primary Care Medical Providers, home health providers, and community service providers to ensure that

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

members had adequate support at home, follow-up visits were scheduled, and services were not duplicated.

Moving forward, the Department's Hospital Review program implemented in accordance with SB 18-266 will provide the Regional Accountable Entities with needed patient information to improve coordination of care post discharge. This information, in combination with performance incentives for timely follow-up after hospitalization for physical and behavioral health conditions, will support continued improvement in this critical performance area.

3.3. Practice Transformation

Practices that served as Primary Care Medical Providers (PCMPs) in the Accountable Care Collaborative participated in programs and initiatives to improve the way they deliver care to members. This section highlights some of the work that RCCOs and PCMPs did to become more efficient while engaging members and meeting their needs.

Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) Survey

This year, the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) Survey was administered to 20 program practices (12 pediatric and 8 adult) that were also participants in the State Innovation Model (SIM). The goal of the PCMH Survey is to give practices feedback that will help them improve member services. A total of 2,063 parents/caretakers (19.85 percent response rate) returned a completed survey on behalf of their child, and 1,901 adult members (23.01 percent response rate) returned a completed survey.

Results varied widely across practices surveyed, but overall, parents/caretakers and adult members were satisfied with their providers and their overall care. Nearly 75 percent of parents/caretakers rated their child's provider as a 9 or 10 out of 10, and just over 75 percent of them rated their child's overall care as a 9 or 10. About 67 percent of adults rated their provider as a 9 or 10, and 63 percent rated their overall care as a 9 or 10.

The results showed that when parents/caretakers are dissatisfied, it was because the child's provider did not follow up on test results, answer medical questions within the same day, or seem informed about the child's medical history and care received from specialists. In addition, clerks and receptionists were not always as helpful as respondents thought they should be.

When adult members were dissatisfied, it was because the provider did not answer medical questions within the same day; speak with the respondent about their prescriptions; provide needed care during evenings, weekends, or holidays; or schedule an appointment soon enough when the respondent needed care right away. In addition, written materials or information online about Medicaid/Health First Colorado did not provide respondents with the information they needed to understand how the program works.

Phase II of the Accountable Care Collaborative is designed to help practices address these issues of timely care and care coordination. In addition, the Department has been updating its correspondence and other materials and information to be more accessible.

Enhanced Primary Care Medical Provider

The Department rewarded PCMPs that met at least five of nine factors based on the National Committee for Quality Assurance criteria for medical homes: extended hours, timely clinical advice, data use, behavioral health integration, behavioral health screening, care coordination patient registry, specialty care follow-up, consistent Medicaid provider, and patient-centered care plans. In FY 2017–18, there were 374 practice locations that qualified for the Enhanced Primary Care Medical Provider (ePCMP) program, compared to 269 in FY 2014–15 when the ePCMP program began. The percent of ePCMPs meeting seven or more factors increased to 45 percent from 27 percent in FY 2014–15. This year was the final year of the ePCMP initiative, but most of the factors have been included in Phase II of the program as minimum requirements for PCMPs.

Participation in Other State and Federal Initiatives

The Accountable Care Collaborative gave Colorado the infrastructure to participate in other federal and state initiatives and invest in Colorado's communities. Accountable Care Collaborative PCMPs participated in federal initiatives such as the State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+), which helped practices improve care and integrate physical and behavioral health. RCCOs also partnered with the Colorado Regional Health Information Organization (CORHIO) to improve health information exchange in the region and the state.

4. Financial Performance

During FY 2017–18, the Accountable Care Collaborative operated as a Primary Care Case Management Entity program, in which medical services were paid fee-for-service (payment for each medical service delivered). Under this model, PCMPs and RCCOs were

paid a per-member-per-month fee as well as financial incentives to provide high-value care. These financial transactions made up the program's administrative costs.

To estimate the medical costs for the Accountable Care Collaborative this year, the Department compared the current costs for program enrollees to previous years' costs and administrative expenses. Note that this analysis does not include costs for which the RAE did not have contracted management responsibilities, including dental, nursing facility costs and capitation payments. Due to data challenges in obtaining the full costs for individuals with Medicare or third party insurance, costs for these members have also been excluded. As a result of this and other differences in methodology, the numbers and trends in this report may not be consistent with financial information reported in other Department reports.

4.1. Administrative Fees and Costs

For FY 2017–18, total administrative costs for the Accountable Care Collaborative were **$150,154,532**[2], which is approximately $3.2 million less than the administrative costs in FY 2016–17, adjusted for inflation**.** The primary reason for this cost reduction is that the Department switched to using one contractor to provide data and analytics for all of its programs. The costs for the data contractor ($2.4 million in FY 2016–17) are no longer budgeted specifically for the Accountable Care Collaborative program and are not included in this report. Another reason for the decline in administrative costs is the lower enrollment in the program compared to last year.

Regional Care Collaborative Organization Payments

In FY 2017–18, RCCOs were paid a total of **$120,159,731**, which is **80 percent of total program administrative costs**. These funds include:

1. **Per-Member-Per-Month (PMPM) Payment ($100,896,021):** RCCOs receive a PMPM payment for ensuring care coordination, provider support, network development, and reporting responsibilities. 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 and puts it into the Pay-for-Performance Pool.

[2] The pay-for-performance pool dollars will be paid out in FY 2018-19 but because the withhold from the administrative costs occurred during FY 2017-18 they have been included as part of the administrative dollars for the fiscal year covered by this report. For this reason, these costs will not match costs reported in other Department reports.

2. **Payment for Key Performance Indicators (KPIs) ($6,049,397):** RCCOs receive payments for meeting KPI targets, which are described in the Program Performance section of this report.
3. **Pay-for-Performance Pool ($11,356,639):** 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. This pool of funds is used as incentive payments for the RCCO or its PCMPs. Approximately $2,853,122 has already gone to practices that met criteria for becoming an enhanced Primary Care Medical Provider (ePCMP). The Department is working with the RCCOs to finalize the disbursement of the remainder of the performance pool dollars this year. In the past, practices received incentive payments for initiatives such as participation in the State Innovation Model (SIM) or Comprehensive Primary Care Plus (CPC+) programs, or for increasing the number of members who have a primary care visit after hospitalization.

Primary Care Medical Provider Payments

During FY 2017–18, PCMPs were paid a total of **$29,994,802**, which is **20 percent of program administrative costs**. These funds include:

1. **Per-Member-Per-Month (PMPM) Payment ($25,517,419):** PCMPs receive PMPM payments for providing medical home services to members.
2. **Payment for Key Performance Indicators (KPIs) ($4,477,383):** Like the RCCOs, PCMPs are eligible to receive incentive payments for meeting KPI performance targets.

4.2. Medical Costs

Medical costs include all pharmacy, inpatient, outpatient, emergency room, LTSS, Home Health, and professional claims for services provided during the fiscal year. Total medical costs are divided by total member months to yield an average medical cost per member month for the fiscal year.

From FY 2016–17 to FY 2017–18, the average paid amount per Accountable Care Collaborative member per month increased by 6.5 percent, or $18.98 per member per month (defined as one member enrolled for one month). This translates to approximately $142,240,726 in additional medical costs in FY 2017–18. After accounting for the

decrease in administrative expenses from the previous year, additional costs totaled **$139,028,648**.

Table 2 shows the top six service areas driving the increase in costs, in order from the largest to the smallest impact. The table also shows the percent increase in average costs and average service utilization for each service area.

Table 2. Primary Service Areas Contributing to Overall Medical Cost Increase for ACC Members FY 2017–18

Service contributing to cost increase (listed in order from largest to smallest impact)	% Change in average paid per member per month from FY 2016–17 to FY 2017–18	% Change in average # of services per member per month from FY 2016–17 to FY 2017–18
1. Physician Services	+11.6% ($32 to $36)	+7.3%
2. Home Health	+24.4% ($14 to $18)	+20.2%
3. Pharmacy	+4.6% ($72 to $76)	–1.1%
4. LTSS	+11.7% ($26 to $30)	+17.6%
5. Inpatient	+6.1% ($44 to $47)	+2.3%
6. Independent Lab	+31.1% ($6 to $8)	+13.9%

An overall rise in medical costs can be caused by an increase in rates, an increase in utilization, or both. In FY 2017–18, the General Assembly appropriated funding to increase most Medicaid provider rates by approximately 1.4%, and larger targeted increases to specific services such as, physical and occupational therapies, LTSS, and Home Health services. In addition, most service areas saw an average increase in utilization from FY 2016-17. The Table above reflects the impact of the combination of increased rates and utilization on medical costs for five of the six service areas. In contrast, the increase in pharmacy costs was not driven by a related increase in utilization. The continued introduction of high-cost specialty drugs is contributing to rising Pharmacy costs for Medicaid as well as employer-based health plans.

The reasons for the increase in service utilization are not yet completely clear. Such claim increases may be due to changing demographics (increasing populations of seniors and individuals with disabilities enrolled in Medicaid), and the changing health needs of the population. It is also possible that improved care coordination provided by

the RCCOs and PCMPs has connected members to services they might otherwise have gone without, causing an increase in preventative and primary care, intended to better control more chronic and acute claims over the long term. Since the beginning of the program in 2011, RCCOs have refined their care coordination models and made them much more effective. It is possible that this caused an increase in overall utilization and costs of professional visits and home health services, and that this investment will not be realized until future years.

As one of the goals of the Accountable Care Collaborative is to manage costs, the Department is taking the following steps to ensure control of costs and utilization:

- **Analytics.** The Department has a contract with IBM Watson Health (previously Truven) to develop the repository and analytics to be used to provide insights into utilization shifts. The Department put IBM Watson Health on draft breach notice in May, resulting in: 180 project completion plans that began August 6, 2018; increases in IBM staff; and $4 million in additional analytics innovations and care coordination tools. In the third quarter of SFY 2018-19, the Department should have more finite insights into the utilization, provider and unit cost contributors to the overall increase in costs.
- **Implement Phase II of the Accountable Care Collaborative**. The Accountable Care Collaborative was designed to be an iterative program that evolves to address new challenges to the delivery of effective and efficient health care. After seven years of operations, the RCCO model could have experienced a diminishing impact on costs, requiring implementation of a new model of care to maintain cost savings. Phase II is designed to create administrative efficiencies, improve member and provider experience, and to achieve savings through the administrative integration of physical and behavioral health under seven regional entities. In addition, the Department is creating specific initiatives for FY 2018–19 and beyond to equip providers and Regional Accountable Entities (RAEs) to help identify areas for cost containment and efficiency. RAEs will also be eligible to receive incentive payments for reducing potentially avoidable costs.
- **Department work teams:** The Department has established twelve work teams to identify and implement opportunities to better control costs inside the Medicaid population (for example, more aggressive management of prescription drugs).
- **Coordinate cost control efforts across the Department.** The Department created a Cost Control and Quality Improvement Office on July 1, 2018,

established by Senate Bill 18-266 with unanimous support. This office will lead the strategic development of a targeted, consistent, and comprehensive cost control approach across all programs, including the Accountable Care Collaborative. Initiatives for FY 2018–19 are focused on: pharmacy; home health (including additional prior authorization requirements), hospital costs; identifying and reducing "potentially avoidable costs"; better informing RAEs of high cost, vulnerable members for increased care coordination and management; instituting analytics that help stratify the population in order to improve care coordination; reducing fraud, waste and abuse including new medical claim system technology to prevent overpayments. Details are available in the Department's report released on November 1, 2018. As part of this work, the Accountable Care Collaborative will have its own Cost Collaborative, in which the Department and Regional Accountable Entities will work together to find opportunities for cost containment and institute cost control best-practices across the RAEs.

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 geographically diverse state with five of the seven program regions containing rural or frontier counties, except for Colorado Access' Regions 3 (Adams, Arapahoe and Douglas counties) and 5 (Denver). Below are strategies the Accountable Care Collaborative used in FY 2017–18 to improve availability and accessibility of services in Colorado's rural and frontier counties.

- **Assess network adequacy.** The RCCOs regularly monitored their networks using GeoAccess software, to ensure that each member has a choice of at least two PCMPs within their zip code or within a 30-minute drive of where they live. RCCOs also tracked calls to customer service centers and solicited feedback from advisory councils to identify trends in member concerns about access to providers. Additionally, the Department developed and submitted to the Centers for Medicare and Medicaid Services (CMS) an access monitoring review plan[3] to ensure that Medicaid members have comparable access to services as Coloradans with other public or private insurance plans.
- **Recruit providers.** RCCOs worked to develop relationships with providers of all types in the community to build relationships and increase the size of the network.

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

Some are also working with large physician networks to bring practices to rural areas. Colorado Community Health Alliance worked with Centura Health to bring a primary care practice to Clear Creek County after the sole primary care doctor there retired.

- **Contract with more Rural Health Clinics**. Rural Health Clinics (RHCs) play an important role in providing access to services in remote parts of Colorado, especially for Coloradans who are Medicaid-Medicare eligible. The Department has made it a priority to recruit these clinics to be PCMPs for Accountable Care Collaborative members. In FY 2017–18, 58 of the 88 RHCs in the state (66 percent) were contracted with the program, up from 51 in FY 2016–17. The Department will work with the RAEs to strengthen outreach to Rural Health Clinics in the next phase of the Accountable Care Collaborative.
- **Support practices so they can accept more Medicaid members.** RCCOs offered practice support that made it easier for practices to participate in Medicaid and accept more Medicaid members. For example, Rocky Mountain Health Plans used Community Care Teams to support members and reduce some of the workload on practices. A Colorado Community Health practice coach offered weekly support to a PCMP with over 300 attributed members, as one of the few PCMPs in the area. Integrated Community Health Partners worked with practices to improve their ability to serve members with disabilities, so these members could get appropriate care even in rural areas.
- **Improve access to telehealth**. Several RCCOs focused on improving access to psychiatry and other behavioral health services through telehealth. Integrated Community Health Partners made online counseling available to its members with anxiety and depression (through Ieso Digital Health). Colorado Access used AccessCare to deliver virtual psychiatry services and give PCMPs access to consultations with child and adult psychiatry specialists, as well as specialists with the cultural competence to deliver care to American Indian and Alaska Native members. Rocky Mountain Health Plans used a platform called EasyCare to allow a practice to connect with their members through telehealth.
- **Partner with public health and community-based organizations to deliver some services**. Some services, especially prevention or chronic disease management, can be provided by public health nurses, public health clinics, or other partners. Colorado Community Health Alliance partnered with Clear Creek Health and Human Services to provide diabetes education and a weight-loss program in the community.

- **Improve transportation services**. RCCOs worked with county providers of non-emergency medical transportation to improve transportation to appointments. Colorado Community Health Alliance partnered with two of its counties and Centura Health to purchase a bus to bring members to appointments, including specialty appointments in Denver and Boulder.

6. Coordinating with Long-Term Services and Supports

In Colorado, Long-Term Services and Supports are authorized by case management agencies: Single Entry Point (SEP) and Community Centered Board (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. This is especially true for Medicare-Medicaid members, who are most likely to use LTSS services.

During FY 2017–18, the Department concluded The Accountable Care Collaborative: Medicare-Medicaid Program, a three-year demonstration project with the Center for Medicare and Medicaid Services. This project was instrumental in advancing the Department's progress in improving coordination of services for Medicare-Medicaid enrollees and others who use LTSS services.

As part of the Accountable Care Collaborative: Medicare-Medicaid Program, the Department required collaboration across RCCOs, SEPs and CCBs to coordinate care for shared members, and outlined a process by which case management agencies and RCCOs could work together to reduce duplication of services and ensure that members' needs are met. Below are some of the strategies RCCOs have used to accomplish this:

- Worked with SEPs and CCBs to establish roles and responsibilities for all case managers and care coordinators involved in a case, and acted as "coordinator of the coordinators"
- Developed shared workflows and referral processes, working closely with Home and Community Based Services (HCBS) case managers to ensure that work on shared cases is member-directed and efficient
- Created ways for RCCO staff and SEP/CCB staff to meet one another before they worked together on a case
- Used the Benefits Utilization System (BUS), which houses long-term care plans and assessments conducted by SEPs and CCBs, to identify case managers and share information
- Aligned member care coordination plans with member care plans recorded in the BUS

- Coordinated joint home visits
- Used existing LTSS service delivery mechanisms and processes to meet the needs of their members

Annual medical chart reviews revealed the Accountable Care Collaborative: Medicare-Medicaid Program reduced fragmentation of the Medicaid delivery system and improved coordination as RCCOs became better able to share member assessment data among different agencies and providers. The advances and lessons learned from this program have been incorporated into the design and contract requirements for Phase II of the Accountable Care Collaborative. In this way, the Department will continue to pursue ongoing improvements in coordinating services for members accessing LTSS services.

7. Reducing Waste and Inefficiencies

The Accountable Care Collaborative is one of the Department's efforts to reduce waste and inefficiency in the Medicaid program. It was designed and developed to promote service efficiency and the reduction of duplicative and inappropriate services, as well as to provide administrative efficiencies for both providers and members.

7.1. Efforts to Contain Costs and Reduce Unnecessary Services

Each of the three core components of the Accountable Care Collaborative contributed to containing costs and reducing unnecessary services in FY 2017-18.

Regional Care Collaborative Organizations

As the umbrella organization within each region, the RCCOs served as a single resource to help both providers and members navigate the Medicaid system of care. Based on practice needs, RCCOs helped practices enroll as a Medicaid provider, establish relationships with hospitals and other providers in the region, create effective administrative systems, implement data and technology tools, improve billing and coding practices, and implement better patient communication strategies. For members, the RCCOs helped explain Medicaid benefits, establish relationships with PCMPs, coordinate care with other Medicaid providers, address grievances, arrange non-emergency medical transportation, and connect members with community resources to address non-medical needs.

Each of the RCCOs served as a convening organization within its region to improve coordination of services among different providers and reduce waste and inefficiencies.

RCCOs developed partnerships with case management entities and other community partners to align resources and reduce duplicative care coordination efforts. RCCOs collaborated with local public health agencies and county human service departments to increase utilization of existing programs to meet the medical and non-medical needs of members, especially those with complex needs. RCCOs were also successful in leveraging networks of care to help members avoid needing the emergency room or a hospital stay, as described in Section 3 of this report.

Additionally, the RCCOs worked with the Department and its Utilization Management vendor on establishing new procedures for the Client Over Utilization Program. This collaborative effort helped identify members accessing a high quantity of services in a potentially inappropriate manner. The RCCOs then leveraged their network of PCMPs and care coordinators to perform more comprehensive member needs assessments to design and implement interventions.

These RCCO administrative functions were an essential tool for the Department in reducing administrative waste and promoting more efficient and cost-effective care.

Primary Care Medical Providers

The medical home model is designed to promote efficient use of medical resources by improving coordination of care for members and reducing use of inappropriate or duplicative services. With 72 percent of members in the Accountable Care Collaborative attributed to a PCMP, PCMPs played an important role in the Department's cost containment strategy. A primary way in which PCMPs supported these efforts was by ensuring members received coordinated care with specialty providers and sharing relevant test results to prevent inappropriate use of specialty care resources and duplication of laboratory and other services. PCMPs also offered 24/7 phone coverage for members to effectively triage calls and prevent unnecessary utilization of the emergency room.

The Enhanced Primary Care Medical Provider initiative also promoted cost containment efforts by encouraging more practices to establish advanced medical home functions. Extended practice hours, use of behavioral health and other screening tools, patient registries, and the other criteria all supported increased access to and utilization of

coordinated primary care and related services instead of uncoordinated higher-cost services.

Data and Analytics

A core principle of the Accountable Care Collaborative is that data sharing and analytics enables regional organizations and PCMPs to more easily identify and address patterns of inappropriate and duplicative service utilization. The Department utilized the Data Analytics Portal to provide comprehensive monthly claims data to RCCOs and PCMPs for their enrolled members. This allowed RCCOs and PCMPs to monitor service utilization and work together to provide interventions and advanced care coordination when required.

RCCOs also implemented care management systems to help providers and care coordinators understand the services a member receives, and coordinate care for that member. These platforms supported collaboration across entities, giving RCCOs information about the different providers involved in a member's care team, and helped RCCOs identify areas of potential duplication of services. They also had the ability to automate reporting and notifications, saving care coordinator time and resources. RCCOs also had access to the BUS, which is used to plan and track LTSS services. They used this to avoid duplication and align care plans.

The Accountable Care Collaborative also shared data with other state agencies and services that serve members. For example, the Department put a data use agreement into place with the Department of Corrections to improve care coordination for members transitioning out of the criminal justice system.

7.2 Additional Efforts Planned for Phase II of the Program

Phase II of the Accountable Care Collaborative will provide even more opportunities for reducing waste and inefficiencies. By joining physical and behavioral health under one Regional Accountable Entity within each of seven regions, the Department will reduce administrative duplication. This structure also promotes greater accountability for treating the whole person and ensuring member access to appropriate care, whether it be physical or behavioral health care. As a significant barrier to comprehensive care coordination has been the federal restrictions around sharing of behavioral health information, the new Regional Accountable Entity model will facilitate easier data sharing for improved coordination of all of a member's required services.

Also during Phase II, the Department will roll out a suite of powerful cost and quality assessment capabilities to the RAEs and providers, to help them make cost-conscious

decisions without sacrificing member safety or clinical efficacy. This is in response to the Medicaid Cost Containment bill (Senate Bill 18-266), which establishes a Cost Control & Quality Improvement Office at the Department to control costs and improve quality within Health First Colorado, Child Health Plan *Plus* (CHP+) and its other programs.

8. Advisory Committees and Stakeholder Engagement

In FY 2017–18, the Accountable Care Collaborative offered members and stakeholders several ways to participate in decision-making and offer feedback.

8.1. Program Improvement Advisory Committee (PIAC)

Created in 2012, the PIAC has met monthly or quarterly to solicit guidance and recommendations for improvement. Membership includes Medicaid members, physical and behavioral health providers, LTSS providers, RCCOs, Behavioral Health Organizations (BHOs), oral health providers, local advocacy organizations, and behavioral health advocates. Meetings were open to the public.

During FY 2017–18, PIAC subcommittees were focused on Bridging and Coordinating Systems (especially for members with complex needs), Health Impact on Lives (health outcomes and experience), and Provider and Community Issues. Subcommittees tackled issues such as member experience of non-emergency medical transportation; services for members transitioning out of the criminal justice system; the relationship between Healthy Communities and RCCOs; and policies and practices for missed appointments. The PIAC also reviewed the results of RCCO site reviews, paying particular attention to care coordination improvements that were needed to meet the needs of all populations. In addition, the PIAC prepared for the transition to Phase II of the Accountable Care Collaborative.

8.2. Regional Program Improvement Advisory Committees and Member Advisory Councils

Each RCCO hosted a regional performance improvement advisory committee, with meetings held monthly or quarterly. This provided each region a forum for stakeholder participation on program improvement activities at the local level. These meetings helped the program understand community-level needs and possible solutions. The regional committees focused on issues such as care coordination, provider network development, population health outcomes and quality, and member services. One region used the meetings to discuss how to invest the RCCO's incentive payments into the community.

Some RCCOs also formed advisory councils specifically for Medicaid members, which met quarterly or twice per year. Member advisory councils discussed member engagement and gave feedback on policy and program decisions as well as member communications.

9. Looking Forward

The Accountable Care Collaborative has achieved much of what it aimed to do when it began in 2011. It has improved the quality of care for Medicaid members and access to needed services, while controlling costs during years of expanding Medicaid caseload. It has supported primary care practices across the state in becoming medical homes, and established health care infrastructure that allowed practices to connect better with their patients and with one another. The program created systems and data platforms to track population health and coordinate care across providers and, in many cases, across care systems. It also reduced emergency room use and hospital stays, and promoted primary and preventive care. Finally, the Accountable Care Collaborative has created and tested innovative care delivery and payment strategies that have given the diverse regions of the state the ability to move towards more accountable care in ways that made sense for the region.

The state is now ready for the next step in more coordinated, integrated, and accountable care. Below are the initiatives that will move the program forward as it continues to serve members and reward providers for improved health outcomes.

9.1. Accountable Care Collaborative Phase II

The next phase of the Accountable Care Collaborative program began in July 2018, when new contracts went into effect for the Regional Accountable Entities (RAEs). The RAEs are responsible for coordinating both physical and behavioral health for their enrolled members, as well as the duties originally assigned to the RCCOs and BHOs.

The shift from twelve vendor contracts for the RCCOs and BHOS to seven RAE contracts creates important administrative efficiencies. As single entities responsible for promoting physical and behavioral health, RAEs now have greater leverage to reduce avoidable and unnecessary costs within the Medicaid program. The RAEs will participate in a Department-led cost collaborative to align incentives and work across the health continuum to improve savings, member outcomes, and Department performance.

For Phase II, the Department is also using multiple tools to measure and incentivize program performance, including:

- **Seven KPIs:** The Department has increased both the incentive pool available to the Regional Accountable Entities and the number of performance measures. The KPIs are designed to reward RAEs for achieving progress on Department priorities and improving the regional delivery system as a whole. New measures include reduction in potentially avoidable costs, prenatal engagement, and improved linkages and referrals between primary care and specialty care providers.
- **Behavioral health incentive program:** Regional Accountable Entities can earn up to 5 percent of their annual behavioral health capitation rate for reaching incentive goals on five behavioral health performance measures. The performance measures include engagement in substance use disorder treatment and behavioral screening and assessment of children in foster care.
- **Public reporting:** To support greater accountability and transparency, the Department will publicly report on its website the performance of the RAEs on a series of clinical and utilization measures, as well as public health metrics.

The next iteration of the Accountable Care Collaborative also includes critical policies to advance PCMP medical home performance and member access to a medical home. For Phase II, the Department has increased the requirements for PCMPs, incorporating most of the enhanced primary care medical provider factors from Phase I. Additionally, all full-benefit Health First Colorado members (excluding members enrolled in Program for All-Inclusive Care for the Elderly, or PACE) will be mandatorily enrolled in the Accountable Care Collaborative and immediately connected with a PCMP. Together, these policies give members access to high-quality support from their RAE and the provider network upon approval of Medicaid eligibility.

9.2. Alternative Payment Models

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 developing differential payment structures to change the way it pays providers and is currently pursuing two different payment reform models.

Under the Primary Care Alternative Payment Model (APM), Primary Care Medical Providers can earn higher reimbursement when designated as meeting specific criteria or performing on quality metrics. 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.[4] This allows the program to make a sustainable investment into primary care while rewarding performance and increasing provider accountability.

Federally Qualified Health Centers (FQHCs) will be eligible for two new value-based payments: value based encounter payments and prospective PMPM payments. The value-based encounter payments will tie four percent of payments to quality and is similar to the model used for the APM. The Department is also pursuing a limited pilot payment model for PMPM payments to FQHCs.

9.3. Further Coverage of Substance Use Disorder Treatment Services

The Department has begun work to implement House Bill 18-1136 that adds residential and inpatient substance use disorder services to Medicaid's covered benefits to ensure the full continuum of care is available for people needing treatment. The first stakeholder meeting occurred in October and the Department is participating in several technical assistance opportunities to design the benefit. The Department has initiated discussions with federal partners regarding the appropriate federal authorization needed for the new benefit.

In addition, the Department's Hospital Transformation Program is requiring hospitals to include an analysis of inpatient psychiatric and SUD beds as part of their community assessment. If the community identifies a need for additional inpatient SUD beds, the Department incentivizing hospitals to develop innovative solutions to address the gap in services.

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