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

December 1, 2019

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

Dear Representative Esgar:

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 2018-19. 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, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/mq

Enclosure(s): HCPF 2019 Accountable Care Collaborative Implementation Report

CC: Senator Dominick Moreno, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

December 1, 2019

The Honorable Susan Lontine, Chair
House Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

Enclosed please find a legislative report to the House Health and Insurance 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, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/mq

Enclosure(s): HCPF 2019 Accountable Care Collaborative Implementation Report

CC: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Sonya Jaquez Lewis, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
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Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

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

December 1, 2019

The Honorable Jonathan Singer, Chair
House 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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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/mq

Enclosure(s): HCPF 2019 Accountable Care Collaborative Implementation Report

CC: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Cathy Kipp, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
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Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

December 1, 2019

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

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.

Attached is the Accountable Care Collaborative annual report for FY 2018-19. 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, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/mq

Enclosure(s): HCPF 2019 Accountable Care Collaborative Implementation Report

CC: Senator Brittany Pettersen, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Faith Winter, Health and Human Services Committee
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

Accountable Care Collaborative FY 2018-19

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

December 1, 2019

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

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COLORADO
Department of Health Care
Policy & Financing

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. At a minimum, the state department's report must include the following information concerning the accountable care collaborative:

(a) The number of Medicaid clients enrolled in the program;

(b) Performance results with an emphasis on member health impacts;

(c) Current administrative fees and costs for the program;

(d) Fiscal performance;

(e) A description of activities that promote access to services for Medicaid members in rural and frontier counties;

(f) A description of the state department's coordination with entities that authorize long-term care services for Medicaid clients;

(g) Information on any advisory committees created, including the participants, focus, stakeholder feedback, and outcomes of the work of the advisory committees;

(h) Future areas of program focus and development, including, among others, a plan to study the costs and benefits of further coverage of substance use disorder treatment; and

(i) Information concerning efforts to reduce Medicaid waste and inefficiencies through the accountable care collaborative, including:

(I) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment; reducing avoidable, duplicative, variable, and inappropriate uses of health care resources; and the outcome of those efforts, including cost savings, if known;

(II) Any statutes, policies, or procedures that prevent regional entities from realizing efficiencies and reducing waste within the Medicaid system; and

(III) Any other efforts by regional entities or the state department to ensure that those who provide care for Medicaid clients are aware of and actively participate in reducing waste within the Medicaid system.

Executive Summary

The Accountable Care Collaborative program is the core of the state's Medicaid program. Launched in 2011, it is the primary vehicle for delivering health care to Colorado's Medicaid members. The program represents an innovative way to accomplish the Department's goals for Medicaid reform. The fundamental premise of the program is that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all members.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that to meet members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system. Fiscal year 2018-19 began the second phase of the Accountable Care Collaborative. For Phase II, one entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions.

Accountable Care Collaborative Phase II

In order to promote comprehensive and coordinated care for members, the RAEs contract with a network of Primary Care Medical Providers (PCMPs) to serve as members' central point of care. The RAE also provides or arranges for the delivery of mental health and substance use disorder services as the administrator of the Department's capitated behavioral health benefit. Combining these responsibilities under one entity improves the member experience and member health by establishing one point of contact and clear accountability for treating the whole person.

The implementation of Phase II of the Accountable Care Collaborative has set the stage for the Department to pursue both targeted and structural approaches to controlling Medicaid costs in alignment with state priorities. The unique design of the Accountable Care Collaborative provides a flexible delivery system within which the Department can innovate and expand efforts to improve the affordability of healthcare. For example, the RAEs have a primary role in the regional implementation of the Department's new statewide approach for clinical management of members with complex health needs and members with one of the Department's targeted health conditions. Through enhanced care coordination, leveraging existing community-based programs, and the delivery of preventive and supportive services, the Department expects to reduce

avoidable utilization that does not improve member health, prevent disease progression, promote members' ongoing health, and reduce costs.

Enrollment in the Accountable Care Collaborative

For Phase II of the Accountable Care Collaborative, the Department implemented mandatory enrollment into the program for all full-benefit Medicaid members, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). In FY 2018-19, average monthly enrollment in the Accountable Care Collaborative was 1,200,082. This enrollment number includes members participating in the Accountable Care Collaborative limited managed care capitation initiatives: Rocky Mountain Health Plans Prime (36,219 members) and Denver Health Medicaid Choice (78,909 members). FY 2018-19 enrollment reflects an increase from FY 2017-18 of 198,303 (19.8 percent).

FY 2018-19 Program Overview

As Phase II represented a significant shift in the delivery system, the Department spent the first part of FY 2018-19 ensuring the program was operating properly, members were able to access services, and providers were getting reimbursed for services. Additionally, the Department worked with the RAEs to provide the information and resources necessary to effectively manage members' behavioral and physical health needs and pursue innovative solutions to addressing members' whole health. With this solid foundation in place, the Department was able to spend the last six months refining programmatic requirements and goals to align with Governor Polis' *Roadmap to Saving Coloradans Money on Health Care.*

The following are some key activities the Department and RAEs undertook during FY 2018-19:

- Implemented process enhancements to ensure members were accurately connected to a PCMP.
- Addressed barriers to ensure the RAEs had adequate behavioral health provider networks to deliver the full range of covered services, including inpatient psychiatric care and services for special populations, such as children in child welfare.

- Promoted access to services in rural and frontier counties by implementing telehealth initiatives that improve both provider and member access to psychiatry and other behavioral health services.
- Coordinated with Long-Term Services and Supports by incorporating representatives of case management agencies into the RAEs' regional advisory committees and establishing documented policies and procedures.
- Conducted clinical and data-driven analyses to improve RAEs' care management and coordination efforts.
- Provided new data tools to the RAEs so they can more easily identify members with complex health needs and deploy the appropriate resources.
- Implemented numerous cost control initiatives, including:
    - ✓ Cost transparency reporting;
    - ✓ Inpatient hospital review program;
    - ✓ Enhanced benefit review and management processes; and
    - ✓ Statewide approach for the clinical management of Medicaid members.

Program Performance

The Department measures progress toward achieving programmatic goals using the Accountable Care Collaborative's Pay-for-Performance program. The RAEs are able to earn financial incentives for achieving performance and programmatic objectives through the following three components:

- Key Performance Indicators: A set of seven outcome and utilization measures that highlight the RAEs' progress toward building a coordinated, community-based approach to meet member health needs and reduce costs.
- Performance Pool: Annually identified performance and programmatic priorities that align with state and Department initiatives.
- Behavioral Health Incentive Program: Five outcome and utilization measures that indicate the effective and efficient performance of the behavioral health system.

The following are highlights of initial performance results from the first nine months (July 1, 2018 - March 31, 2019) of the program:

- The RAEs continued the downward trend in emergency department visits begun under the first phase of the Accountable Care Collaborative with an average decrease of 1.1 percent from the FY 2017-18 baseline average.
- Members appear to have greater access to behavioral health services during the first nine months of Phase II, as evidenced by the behavioral health engagement measure's average increase of 2.5 percent from the FY 2017-18 baseline average.
- There was an average increase of 5.5 percent from the FY 2017-18 baseline average in the percent of newborn deliveries where a woman received a prenatal care visit during pregnancy.
- The percent of members who received professional dental visits increased by 2 percent from the FY 2017-18 baseline average.

Financial Performance

Program costs for the Accountable Care Collaborative include administrative costs and all expenses for benefits and services provided during FY 2018-19, including capitations, pharmacy, inpatient, outpatient, emergency room, Long-Term Services and Supports (LTSS), home health, and professional claims. For this report, the Department performed a straight comparison of FY 2018-19 expenditures to FY 2017-18 expenditures for all full-benefit Medicaid members, excluding those enrolled in PACE. Costs reflect the following programmatic changes from FY 2017-18:

- Mandatory enrollment into the program resulted in a nearly 20 percent increase in program enrollment;
- Expansion of the Accountable Care Collaborative responsibilities to include the capitated behavioral health benefit; and
- Incorporation of all limited managed care capitation initiatives into the program.

The total amount paid for the Accountable Care Collaborative in FY 2018-19 was $7.8 billion – a 4.9 percent increase from the previous fiscal year. Total costs are divided by total member months to yield an average program cost per-member-month (PMPM) for the fiscal year. In FY 2018-19, the average paid amount PMPM was $526. This was a 9.6 percent increase from FY 2017-18, when the average paid PMPM was $480.

Included in the total program costs are the administrative fees and costs for the Accountable Care Collaborative. The total administrative fees and costs consist of the administrative PMPM payments, the earned Key Performance Indicator payments, and

the earned performance pool payments. The $169,553,776 total administrative fees and costs represent an increase of $19,399,244 from FY 2017-18 administrative costs. These increased administrative costs are the result of mandatory enrollment (which resulted in higher enrollment in the program) and a $1 increase in the administrative PMPM payments to the RAEs.

The benefits and services saw increases from FY 2017-18 primarily due to an increase in utilization. The top five benefit groups driving the increase in benefits and services costs overall are: long-term services and supports, pharmacy, home health and private duty nursing, ancillary services, and other specialty care. Based on initial findings, the Department is conducting further research into specific benefits such as independent laboratory costs, outpatient physical and occupational therapy, physician administered drugs, and home health aide care.

As specific cost drivers are identified, the Department is reviewing benefits and programs to identify opportunities for interventions that can contain costs. Interventions may include reviewing claims processing procedures, implementing prior authorization requirements, coordinating services more effectively, or reinforcing existing fraud, waste and abuse investigations. Additionally, the Department's implementation of the statewide approach for clinical management will help the RAEs focus on members with complex health needs and the conditions associated with many of the highest cost trends.

Reducing Waste and Inefficiencies

The structure of the Accountable Care Collaborative, with the RAEs' combined responsibilities for behavioral health and physical health and the use of medical homes, provided administrative efficiencies while reducing duplicative and inappropriate service utilization. The Department also partnered with the RAEs and the Department's utilization management vendor to execute the Client Over Utilization Program for members identified as accessing a high quantity of services in a potentially inappropriate manner.

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. With the change in the program, the focus for FY 2018-19 was incorporating new committee members and re-establishing operating procedures, such as charters and by-laws. In addition, each RAE hosted a regional program improvement advisory committee to identify community-level needs and develop solutions. All RAEs formed Medicaid member advisory councils to incorporate the member perspective into program decisions and policies.

Looking Forward

The Accountable Care Collaborative is the delivery system for all Medicaid members. As such, almost all Department initiatives to control health care costs and/or improve member health impact or are supported by the Accountable Care Collaborative. The following are some key initiatives the Department will be implementing in the coming year:

- Implementation of RAE strategies to improve care coordination for members with complex health needs, to address identified top trending conditions, and to reduce potentially avoidable costs.
- Launch a multi-payer Pharmacy Tool that will give providers insight into the efficacy of a drug and its costs.
- Creation of a primary care provider Cost and Quality Variation Report to assist the RAEs in managing their PCMPs and deploying practice transformation resources.
- Addition of residential and inpatient substance use disorder services as a Medicaid covered benefit in accordance with House Bill 18-1136.

The Department has taken a significant step to improve health outcomes and bend the cost curve by joining the administration of physical health and behavioral health under the RAEs. Effectively leveraging this infrastructure in tandem with other Department initiatives will begin to generate greater improvements in member health, member experience, and cost containment.

I. Introduction and Background

A. Program Overview

The Accountable Care Collaborative Program is the core of the state's Medicaid program. Launched in 2011, it is the primary vehicle for delivering health care to more than one million Coloradans. It promotes improved health for members by delivering care in an increasingly seamless way. The Accountable Care Collaborative works on the principle that coordinated care, with needed community supports, is the best, most efficient way to deliver care to individuals. It is easier for members and providers to navigate and it makes smarter use of every dollar spent.

The Program represents an innovative way to accomplish the Department's goals for Medicaid reform. It differs from a capitated managed care program by investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The fundamental premise of the program is that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all members.

The Accountable Care Collaborative relies on four core components:

- Seven regional organizations, each accountable for the program in a different part of the state.
- Primary Care Medical Providers (PCMPs), which are medical homes for members.
- Comprehensive community-based system of mental health and substance use disorder services.
- Data and analytics, to give the Department, regional organizations, and PCMPs actionable information on individual members and the program population as a whole.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that to meet members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system. The program provides the platform from which other health care

initiatives, such as medical homes, health information technology and payment reform, can thrive as they better serve members and create value.

B. Accountable Care Collaborative Phase I

From 2011 to June 2018, the Accountable Care Collaborative operated as a managed fee-for-service model under a State Plan Amendment approved by the Centers for Medicare & Medicaid Services (CMS). It functioned as a Primary Care Case Management model following the applicable federal requirements in 42 C.F.R. § 438. Prior to the Accountable Care Collaborative, Medicaid members received their physical health services through an unmanaged fee-for-service approach.

Over the first seven years, the Accountable Care Collaborative invested in primary care practices, 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. The state was divided into seven geographic regions with each region served by one Regional Care Collaborative Organization (RCCO). Program members were assigned to a region and RCCO based upon their county of residence.

The Program demonstrated improved health, reduced costs, and improved service utilization patterns. Members who had been in the program for longer than six months were more likely to seek and receive preventive services and follow-up care, and less likely to receive services at an emergency room, receive high-cost imaging services, or be re-admitted to the hospital.

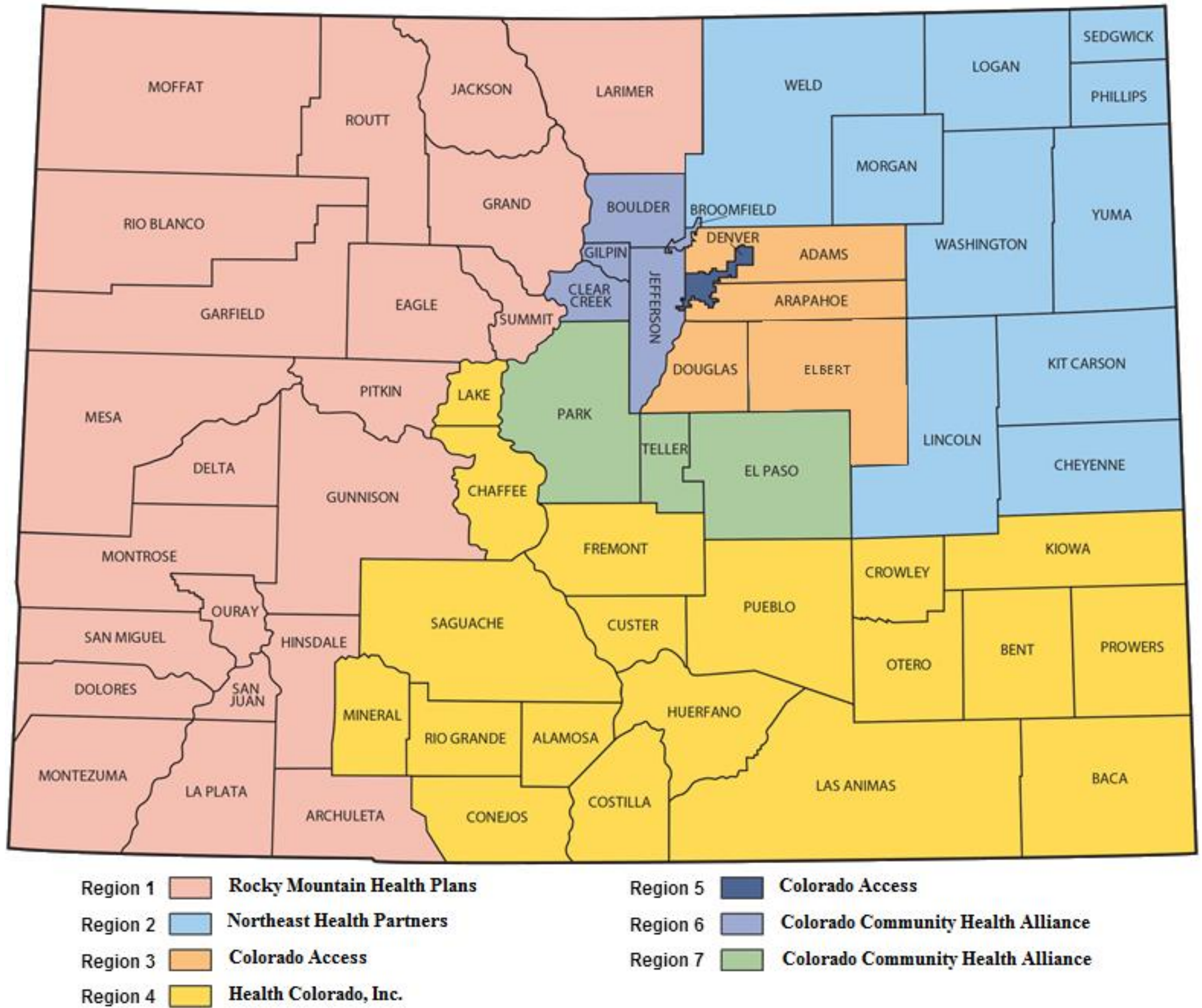
C. Accountable Care Collaborative Phase II

Fiscal year 2018-19 began the second phase of the Accountable Care Collaborative. For Phase II, the Department moved toward a more coordinated and integrated care model that increasingly rewards improved health outcomes.

One entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions. The RAE combines the duties originally contracted by the RCCOs with those duties of the Behavioral Health Organizations (BHOs) that previously provided comprehensive mental

health and substance use disorder services to individuals enrolled in Medicaid. The RAE contracts with a network of PCMPs and functions as a Primary Care Case Management Entity with accountability for fee-for-service physical health costs. In addition, the RAE administers the Department's capitated behavioral health benefit through a contracted network of behavioral health providers.

Figure 1. Map of Accountable Care Collaborative Regions



PCMPs are a core component of the Accountable Care Collaborative model. They serve as the member's central point of care and promote comprehensive and coordinated care for a positive member experience and better health outcomes. All members are attributed to a PCMP upon their enrollment into the program; members can select a different PCMP at any time. The RAEs are responsible for

distributing administrative payments to their contracted PCMPs to incentivize the delivery of comprehensive, team-based care and improvements in member health.

To support the continuity of care of members, the Department continued to operate the Denver Health Medicaid Choice and Rocky Mountain Health Plans Prime physical health limited managed care capitation initiatives as part of the Accountable Care Collaborative. These initiatives are authorized by C.R.S. 25.5-5-415. The RAEs in Region 1 and Region 5 were contracted to administer these limited managed care capitation initiatives in a manner that maximized the integration of behavioral health and physical health services for enrolled members. While these initiatives are operated as part of the Accountable Care Collaborative, detailed reporting of the initiatives will be provided in a separate report due April 15, 2020 as required by C.R.S. 25.5-5-415 (4) (a).

Effective management of the Department's capitated behavioral health benefit is also critical to the success of the Accountable Care Collaborative. The capitated behavioral health benefit offers an array of mental health and substance use disorder services for individuals with serious and persistent mental illness and serious emotional disturbance and has historically been credited with directly decreasing the length and number of psychiatric hospitalizations. As administrator of the capitated behavioral health benefit, the RAE has primary accountability for promoting optimized mental health and wellness for all members and providing or arranging for the delivery of medically necessary mental health and substance use disorder services.

The RAE is responsible for ensuring timely and appropriate access to medically necessary services offered by the full range of Medicaid providers in the Health Neighborhood, including specialty, hospital, and home-based care, to meet the health and functioning needs of members. The RAE is charged with establishing infrastructure and promoting provider access and utilization of tools and resources that will enable them to serve members with complex conditions, obtain brief specialty consults, and make appropriate, timely, and coordinated referrals for members requiring more intensive specialty care.

The RAE uses their expanded scope to promote the population's health and functioning, coordinate care across disparate providers, interface with Long-Term Services and Supports (LTSS) providers, and collaborate with criminal justice, child welfare, and other state agencies to address complex member needs that span multiple agencies and jurisdictions. A critical function of the RAEs is to create a cohesive network of providers that work together effectively to provide coordinated health care services to members. Having one entity improves the member experience by creating one point of contact and clear accountability for treating the whole person.

D. Health Care Affordability for Coloradans

During FY 2018-19, the state elected Governor Polis who has made it one of his administration's top priorities to ensure all Coloradans have access to affordable, quality healthcare. As a first step, Governor Polis created the Office of Saving People Money on Health Care and appointed Lieutenant Governor Primavera as Director of the new office. The goal of the Office is to identify and implement policies that will reduce health care costs while expanding access to quality care throughout the state. To achieve this goal, the office helps coordinate the work of Colorado state agencies that impact health care, including the Department.

The new office has published a *Roadmap to Saving Coloradans Money on Health Care,* providing short- and long-term action steps toward reducing patient costs and investing in long-lasting changes to improve the health system overall. The Department is a key player in achieving many of the action steps as they align with existing Department efforts focused on controlling Medicaid claim costs.

To advance the Governor's vision, the Department created a Health Care Affordability Roadmap that identifies cost drivers and cost control policies to address those drivers. The Department's roadmap includes strategies to:

- Constrain prices, especially hospital and prescription drugs,
- Champion alternative payment models,
- Align and strengthen data infrastructure,
- Maximize innovation, and
- Improve population health.

The Department's recently created Cost Control and Quality Improvement Office established by Senate Bill 18-266, has provided new analytics, tools, and insights to guide the Department's efforts. The unique design of the Accountable Care Collaborative provides a flexible delivery system within which the Department can innovate and expand efforts to improve affordability. This includes leveraging the Department's investments in data systems and analytics to help the RAEs identify those members who could most likely benefit from support and care coordination to improve their health and better control the costs of their care. In addition, the RAEs provide a valuable resource to disseminate, train, and educate providers about any new tools the Department makes available to providers, such as the planned release of a prescription tool. The implementation of Phase II of the Accountable Care Collaborative in FY 2018-19 has set the stage for the Department to pursue both targeted and structural approaches to controlling Medicaid costs.

II. Accountable Care Collaborative Enrollment

This section describes the process for enrolling members into the Accountable Care Collaborative and provides data on the number of members enrolled for FY 2018-19.

A. Enrollment Numbers

In FY 2018-19, enrollment in the Accountable Care Collaborative increased based on the transition to mandatory enrollment into the program for all full-benefit Medicaid members, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly. The average Accountable Care Collaborative enrollment in FY 2018-19 was 1,200,082, an increase of 198,303 (19.8 percent). This enrollment number includes members participating in the Accountable Care Collaborative limited managed care capitation initiatives: Rocky Mountain Health Plans Prime (36,219 members) and Denver Health Medicaid Choice (78,909 members).

Table 1 shows Accountable Care Collaborative average enrollment by population.

Population	Number of Accountable Care Collaborative Members	Percent of Total Accountable Care Collaborative Members
Children without disabilities	493,698	41.14%
Adults (without disabilities) **eligible after** the Affordable Care Act expansion	386,557	32.21%
Adults (without disabilities) **eligible before** the Affordable Care Act expansion	230,876	19.24%
Children and adults with a disability, including Medicare-Medicaid members	88,990	7.41%
TOTAL	**1,200,082**	

B. How Members Were Enrolled into the Accountable Care Collaborative

With the transition to Phase II of the Accountable Care Collaborative, the Department made enrollment into the Accountable Care Collaborative mandatory for all full-benefit Medicaid members (except for those enrolled in Program of All-Inclusive Care for the Elderly [PACE]). As the Accountable Care Collaborative serves as the delivery system for Medicaid, members do not have a choice to opt out. That said, members do retain choice of their PCMPs and providers for all fee-for-service physical health benefits and can opt-out of the limited managed care capitation initiatives and choose, or be assigned, a PCMP.

A foundational principle of the Accountable Care Collaborative is that every member has a central point of care through a PCMP or limited managed care capitation initiative. To ensure that every member began with a central point of

care the Department established a two-step enrollment process that is active the day the Department receives notification of a member's Medicaid eligibility:

1. Members were first attributed to a PCMP or limited managed care capitation initiative (if they met the geographic and eligibility requirements for one of those initiatives).
2. Members were then assigned to a RAE based on the location of the member's PCMP or limited managed care capitation initiative.

Attribution to a PCMP (step 1 above) was based on the following process:

1. Members with claims history with a PCMP during the previous 18 months were attributed to that PCMP.
2. Members without any claims history were attributed to either a PCMP of a relative living in the member's household or a PCMP located close to the member.

Members were notified by mail when they were attributed to a PCMP or limited managed care capitation initiative and assigned to a RAE. The notification included information on how a member could select or change their PCMP at any time or how they had 90 days to opt out of the limited managed care capitation initiative and select a PCMP. Member choice always took priority over system assignment.

III. Accountable Care Collaborative FY 2018-19 Overview

In FY 2018-19, the Department spent the first six months ensuring the new program was operating properly, members were able to access medically necessary services, and providers were getting reimbursed for services delivered. Additionally, the Department worked with the RAEs to provide the information and resources necessary to effectively manage members' behavioral and physical health needs and pursue innovative solutions to addressing members' whole health. With this foundation in place, the Department was able to spend the last six months refining programmatic requirements and goals to align with Governor Polis' *Roadmap to Saving Coloradans Money on Healthcare.*

A. Operational Improvements

Typical to the launch of a large new program, the Department spent time and resources on identifying operational challenges and working to improve processes, procedures and system functions. Priority areas were improving member enrollment and attribution processes; promoting access to services in rural and frontier areas; establishing best practices for the coordination of care of members; and supporting RAE partnerships with critical providers, especially Institutions for Mental Diseases.

1. Member enrollment and attribution

A foundational principle of the Accountable Care Collaborative is that every member has a central point of care through a PCMP or one of the limited managed care capitation initiatives. To ensure this, the Department systematically attributes all members to a PCMP or limited managed care capitation initiative.

There are many factors that are utilized in the Department's systematic attribution process, including PCMP panel sizes, populations served by a PCMP, prior claims history, and the calculation of geographic proximity. The Department worked closely with the RAEs and PCMPs to ensure PCMPs were accurately enrolled in Colorado interChange and that their panel information was accurate. In addition, the Department closely monitored the processing of member attributions by Colorado interChange and implemented multiple system changes to correct errant processes and enhance the accuracy of attributions. While the majority of issues have been stabilized, the Department continues to closely monitor member attributions and pursue system enhancements.

In addition, the Department worked to improve processes for the enrollment and attribution of specific populations, particularly newborns. There is often a delay in newborns receiving their Medicaid ID which frequently creates delays in the reimbursement of providers for services they delivered. To address these challenges, the Department worked with providers and vendors to

implement updates to member communications and newborn Medicaid eligibility determination processes. In addition, the Department began working with two large provider systems to test new procedures for processing Medicaid eligibility for newborns. The Department will continue to test and improve newborn enrollment processes during FY 2019-20.

2. 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 RAE regions containing rural or frontier counties; region 3 (Adams, Arapahoe, Douglas, and Elbert) and region 5 (Denver County) are the two exceptions. Below are strategies the Accountable Care Collaborative used in FY 2018-19 to improve availability and accessibility of services in Colorado's rural and frontier counties.

- **Access network adequacy.** The RAEs regularly monitored their provider networks to ensure that each member has access to PCMPs and behavioral health providers within a reasonable distance from where they live. The RAEs also tracked calls to customer service centers and solicited feedback from advisory councils to identify trends in member concerns about access to providers.

- **Recruit providers.** RAEs worked to develop relationships with providers of all types in the community to build relationships and increase the size of the network.

- **Improve access to telehealth.** Several of the RAEs focused on improving access to psychiatry and other behavioral health services through telehealth.

- **Co-located staff.** Colorado Community Health Alliance has a care coordinator co-located at Centura Health Physician

Group Primary Care in Idaho Springs who works closely with providers and assists members with care coordination services.

- **Partner with public health and community-based organizations to deliver some services.** Colorado Community Health Alliance partnered with the Peak to Peak Alliance in Nederland, a rural zip code, to arrange for a mobile dental clinic to come to the area to provide dental services. In addition, Colorado Community Health Alliance partnered with Ute Pass Regional Health Service District (UPRAD) to create a mobile follow-up team for members who live in Teller County, Lake George and Green Mountain Falls that have trouble accessing behavioral health services given their rural location.

3. Care management best practices

The Department also continued its participation on multiple statewide committees and collaborative efforts to establish best practices for the care and management of individuals with complex health needs. Most notably, the Department worked with the Department of Corrections, the RAEs, and behavioral health providers to establish best practice recommendations for care coordination of members being released from state prisons. These best practices include activities prior to and immediately following a member's transition to the community. The result of these activities has been that 94% of individuals were attributed to a RAE upon their release, allowing for a more efficient transition of care.

4. Provider Contracting and Payment

As the second phase of the Accountable Care Collaborative changed a behavioral health system that had been in place for over 20 years under the Behavioral Health Organizations, the Department closely monitored how the RAEs contracted with behavioral health providers. The Department monitored, and

intervened when necessary, to ensure Community Mental Health Centers and behavioral health providers with unique specialties, such as serving the child welfare population, were contracted under reasonable reimbursement arrangements.

One particular area of work has been facilitating improved processes and procedures for the utilization management and reimbursement for members requiring inpatient behavioral health services at an Institution for Mental Diseases (IMD). Section 1905(a) of the Social Security Act and federal regulations at 42 CFR § 435.1008 and 441.13 preclude federal Medicaid funding for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to any individuals under the age of 21. In 2016, the federal Medicaid managed care regulations were revised to allow Medicaid agencies with a capitated managed care program to make monthly capitation payments for members receiving IMD services as an in lieu-of service for no more than 15 days during the month. Prior to this change in federal regulation, Colorado Medicaid was one of a few states that was able to allow reimbursement for IMD services under a 1915(b) waiver from the federal government, without a formal limit on the number of days.

The Department has been engaged in monthly meetings with the RAEs and IMDs to implement new policies that comply with the federal regulations, limit the financial risk for IMDs, and provide additional supports to reduce lengths of stay. The Department has asked the RAEs and IMDs to partner in aggressively managing member lengths of stay to reduce the number of members who exceed 15 days during a capitation month. The RAEs have also been asked to use the flexibility of their payment arrangements, such as the implementation of value-based payment arrangements, to support the continued viability of the IMD business models so that inpatient services remain available in their regions.

5. Coordinating with Long-Term Services and Supports

Colorado's system of LTSS provides comprehensive services to people with many types of long-term care needs, including those with physical disabilities, serious mental health needs, and developmental and/or intellectual disabilities. Most people access the LTSS system through two types of entities: Single Entry Points (SEPs) and Community Centered Boards (CCBs). SEPs predominately serve as the entry point and case management agency for older individuals, adults with mental health needs, individuals with traumatic brain or spinal cord injuries, and children with life-limiting illnesses. CCBs predominately serve as the entry point and case management agency for individuals with intellectual and/or developmental disabilities and children with autism. There are 24 SEPs and 20 CCBs throughout the state.

It is important that the RAEs collaborate with the SEPs and CCBs to support members in accessing the full range of Medicaid services, while reducing the number of care coordinators working directly with a member. To facilitate improved collaboration, many of the RAEs have included SEP and CCB representatives on their regional advisory committees.

The RAEs have also pursued a variety of other activities to improve the coordination of care for members shared with the SEPs and CCBs.

- The Colorado Community Health Alliance has executed memorandums of understanding with the local SEP and CCB in Region 7 to increase efficiency between agencies and improve communication workflows.

- Colorado Access leveraged its No Wrong Door pilot grant to solidify partnerships with CCBs, county agencies, Atlantis, Denver Regional Council of Governments, and other Long-Term Services and Supports organizations. Through

quarterly meetings, the partners are working to develop stronger processes for referrals and resource sharing.

B. Efforts to Improve Management of Co-occurring Behavioral Health and Physical Health Conditions

One of the primary objectives of the second phase of the Accountable Care Collaborative was to combine accountability for physical health and behavioral health under each of the RAEs. The Department has promoted this accountability by establishing and improving the systems and tools for sharing member claims data with the RAEs. A primary goal is to ensure the RAEs have access to and can easily act upon the data they receive to improve member health and cost outcomes.

During FY 2018-19, the Department implemented two tools to more effectively support the RAEs in managing their populations.

- **Clinical Risk Stratification Dashboard:** Developed by the Department's Cost Control and Quality Improvement office, this tool clinically stratifies the population enrolled in the Accountable Care Collaborative. It provides the RAEs with member-level data to identify members who are most vulnerable so they can implement evidence-informed allocation of care coordination resources. At the end of FY 2018-19, the RAEs used the Clinical Risk Stratification Dashboard to create complex care management plans specific to their region to improve the cost and quality of care for their targeted population in FY 2019-20. Using existing resources, the Department has developed cost trend and quality outcome metrics and is leveraging staff oversight to support and monitor the performance of the RAEs in reducing costs for their targeted individuals.
- **Potentially Avoidable Cost Tool (PROMETHEUS):** Working with the vendor Optumas, the Department gave the RAEs, hospitals, and other providers access to PROMETHEUS to raise awareness of the opportunities for cost savings and help them develop interventions to reduce variations in care. PROMETHEUS is an industry-standard tool that uses detailed clinical algorithms to group fee-for-service claims and managed care encounter data into episodes of care and compares the services provided, outcomes, and

associated costs against clinically determined best practices to identify any deviations that result in potentially avoidable costs. An example of a potentially avoidable cost would be a hospitalization for an individual with diabetes who did not participate in evidence-based, outpatient treatment. This information enables the RAEs and providers to improve their referral patterns towards more cost-effective, higher quality physicians and hospitals, and allows hospitals and providers to identify and self-correct inefficient, lower quality care delivery.

The RAEs also began to implement innovative programs to move toward more integrated care models. Almost all the RAEs focused their efforts on supporting primary care practices interested in more effectively managing and delivering behavioral health services to members within their clinic. One of the most common programs among the RAEs was the implementation of tele-behavioral health programs that enable primary care practitioners to access behavioral health consultative services, including consultations with psychiatrists.

- Northeast Health Partners partnered with Colorado Psychiatric Access and Consultation Program (C-PAC) to provide consultation for PCMPs with an adult or pediatric psychiatrist.
- Colorado Access' telehealth arm, AccessCare Services, provided tele-behavioral health services to PCMPs in its network, and is launching additional services for providers who are licensed to deliver medication assisted treatment for substance use disorders.
- In Region 4, Health Colorado Inc. contracted with two telehealth service providers, Heart Centered Counseling and ReNew Behavioral Health, to offer members access to mental health counseling and tele-psychiatry services.
- Through a partnership with CirrusMD, Rocky Mountain Health Plans created the CareNow telehealth platform which enabled members to directly contact emergency room trained providers, as well as mental health professionals employed by Heart Centered Counseling in Fort Collins, CO.

Other examples of primary care based initiatives implemented by the RAEs included:

- Colorado Access has implemented a flat-rate reimbursement for 23 behavioral health encounters delivered in primary care settings. The flat rate reimbursement is higher than the typical fee-for-service reimbursement in order to help PCMPs overcome some of the financial barriers associated with delivering integrated behavioral health services.
- Rocky Mountain Health Plans is also offering financial support to PCMPs in an effort to expand access to behavioral health services within primary care settings. They are currently funding 19 PCMPs so they can have integrated behavioral health care providers within the practice. While services differ between practice sites, the integrated behavioral health providers deliver a range of services from joint visits or consultations with primary care practitioners, scheduled outpatient therapy visits, and psychiatric/prescriber services. In addition, Rocky Mountain Health Plans is offering incentives to PCMPs to encourage them to obtain their drug enforcement agency license to increase the number of providers available to prescribe medication assisted treatment for opioid use disorders.

Some of the RAEs also implemented other programs within their region to more effectively address members' co-occurring behavioral health and physical health needs.

- Colorado Community Health Alliance is partnering with Jefferson Center for Mental Health and St. Anthony's hospital to develop an emergency department diversion program targeted at members who have substance use disorders and low acuity behavioral health symptoms. This diversion program is designed to reduce emergency department utilization by facilitating member recovery outside of the emergency department utilizing Jefferson Center for Mental Health's outpatient programming.
- Rocky Mountain Health Plans implemented a Hot Spotter program to identify and provide interventions for members with social, behavioral, and physical health complexities.
- The Care Management team at Colorado Access cross-trained members of the physical health and behavioral health teams to ensure they can more effectively assist members and promote whole member care. In addition,

they have implemented assessments so team members can better capture the physical and behavioral health needs of members.

C. Medicaid Cost Control Initiatives

One of the most critical factors impacting the Department, the state of Colorado, and the nation is the escalating cost of health care, especially where increased costs are not associated with similar gains in quality or health outcomes. The Department, in partnership with other health care thought leaders, is focused on research, analytics, and reporting that identifies the drivers of rising costs and alternatives to address them. In order to improve affordability of Medicaid, the Department is using three primary strategies:

1. Cost Transparency and Management
2. Benefit Design and Management
3. Statewide approach to addressing member health

As the delivery system for nearly all full-benefit Medicaid members, the Accountable Care Collaborative impacts and is impacted by all the initiatives the Department is implementing to control health care costs. Details on additional initiatives may be found in the Department's Annual Report to the General Assembly on Controlling Medicaid Costs.

1. Cost Transparency and Management

The participants in the health care delivery system—hospitals, physicians and other providers—are key stakeholders in the effort to control rising costs. However, in order for these participants to address costs, they need high-quality data regarding current service utilization and costs.

As hospitals are a critical component of the health care delivery system, as well as a significant cost expenditure, the Department is implementing several initiatives to monitor and control costs, while improving member health. The Department began collaborating with the Colorado Hospital Association to implement cost and quality analytics tools that help identify potentially avoidable costs and complications, enabling hospitals to improve member health

and control costs by procedures. Similarly, the Department is collaborating with the Attorney General's Office and the Colorado Hospital Association to create a new alternate payment methodology to be used by all payers to facilitate patient referrals to care centers of excellence.

a. Inpatient Hospital Review Program

The Inpatient Hospital Review Program was created under Senate Bill 18-266 and is Colorado Medicaid's program to review all inpatient hospital admissions to ensure appropriate care is provided in compliance with federal/state rules and regulations. The Inpatient Hospital Review Program provides industry standard review processes for fee-for-service non-behavioral health admissions to ensure care is provided at the appropriate setting, duration and time, as well as to identify suitable alternative services that may be available.

The Inpatient Hospital Review Program provides daily data feeds to the RAEs with member diagnosis and treatment plans. These daily data feeds highlight opportunities for discharge planning, care coordination and case management for patients who are at risk for re-admission and in need of care transition support. The Department will be working closely with the RAEs during FY 2019-2020 to effectively leverage these new data feeds in conjunction with the daily data transfers of hospital admit, transfer, and discharge information also shared with the RAEs to improve discharge planning processes and member transitions of care.

b. Hospital Transformation Program

The Hospital Transformation Program is a five-year hospital reform initiative that builds upon the hospital supplemental payment program to incorporate value-based purchasing strategies into existing hospital quality and payment

improvement initiatives. Under the Hospital Transformation Program, hospitals will be required to implement quality-based initiatives, improve clinical and operational efficiencies, and embark on community development projects to receive supplemental payments. The quality-based incentives will require hospitals to be accountable for reducing avoidable inpatient and outpatient hospitalizations, addressing the needs of vulnerable populations, improving the coordination of care for individuals with behavioral health and substance use needs, and addressing population health and total cost of care.

Several of the Hospital Transformation Program measures are also RAE performance measures, while other measures require hospitals to share member-level information with the RAEs. Having aligned incentives and data sharing between hospitals and the RAEs is expected to improve communication and coordination among the entities and result in better member health and experience. The Department is working with the Centers for Medicare and Medicaid Services to finalize the financial model and framework of incentives.

2. Benefit Design and Management

With the creation of the Department's Cost Control and Quality Improvement, the Department has developed tools to more effectively analyze Medicaid cost expenditures. Through this work, the Department has identified some initial benefits that warrant enhanced management and policy review. As an example, costs for long-term home health have increased by greater than 13 percent in FY 2018-19. The Department has begun work to implement prior authorization requirements for adults requiring long-term home health services and a private duty nursing assessment tool for adults in an effort to ensure services are appropriate and medically necessary. In addition, the Department is incentivizing the RAEs to

increase the delivery of targeted care coordination for members receiving long-term home health.

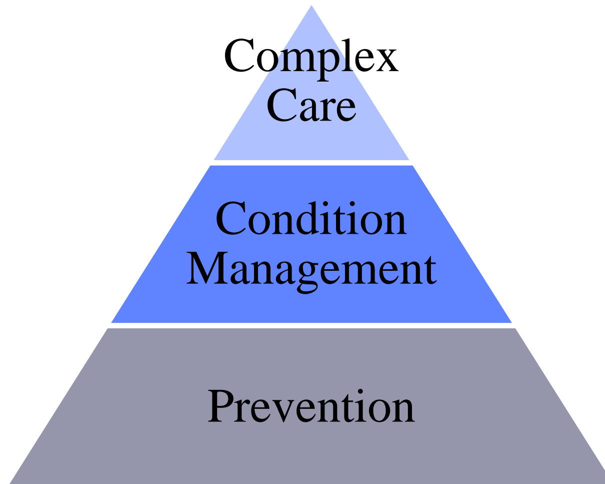
At the same time, the Department is reviewing its benefits to identify any potential gaps in the care continuum. Such gaps in the availability of lower-cost, evidence-based treatments could accelerate disease progression and/or drive members to higher-cost treatment services.

3. Statewide Approach to Addressing Member Health

With the implementation of both the second phase of the Accountable Care Collaborative and Senate Bill 18-266 during FY 2018-19, the Department has established a solid platform from which it can expand and pursue new efforts to improve the affordability of Medicaid services. In FY 2018-19, the Department conducted a clinical and data-driven analysis of the Medicaid population and a review of the RAEs' existing care management and coordination efforts to develop a statewide approach to addressing the health care needs of the Medicaid members.

The Department's statewide approach features three primary strategies. These are depicted in the figure below and also explained in more detail below. The Department is requesting funding through FY 2020-21 R-14 "Enhanced Care and Condition Management"[1] to provide targeted support to the RAEs to address these goals.

[1] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-14%20Enhanced%20Care%20and%20Condition%20Management.pdf



Complex Care Management

For the state's most vulnerable members with the highest acuity of conditions, the Department and the RAEs remain focused on identifying and implementing best practices that can improve member health and basic functioning. Many of the individuals identified for complex care management already receive a high-level of supportive services and coordination of care based on the complexity of their physical, behavioral, intellectual, and/or developmental conditions. The Department and RAEs continue to refine their programs to better serve these individuals in a cost effective manner, while also streamlining the coordination of care for these members who require services from multiple systems within the Department and provided through other state agencies.

Within the Department's analysis of the population identified for complex care management, the Department has identified a group of high-cost individuals with complex health needs who through targeted interventions could most likely experience improved health, more efficient utilization of health care services, and reduced overall costs. The initial targeted population of members with complex needs is composed of more than 37,000 members with an overall spend in excess of $2.5 billion in calendar year 2018, representing 2.8 percent of members and 32.4 percent of expenditures. As the initial analysis of these members shows that a majority have co-occurring physical and behavioral health conditions, the RAEs are well positioned to leverage their combined responsibilities to improve member health.

The Department has been working closely with the RAEs to identify best practices regarding care coordination and the management of special populations within the high-cost, complex population, such as complex newborns, to further enhance the effectiveness of the Accountable Care Collaborative.

Condition Management

To most effectively target the delivery of disease management and preventive services, the Department conducted additional analysis of the prevalence, comorbidity, and cost of the top conditions present across the Medicaid population. Among the top ten conditions by total spend are maternity, anxiety, depression, chronic pain, hypertension, diabetes, substance use disorder, and cardiovascular disease.

If not managed effectively, the Department's analysis suggests that many of these top conditions that are chronic have strong disease progression that frequently correlates with additional comorbidities. For example, diabetes that is not properly controlled is often associated with the development of hypertension. The presence of comorbidities increases cost significantly over the long term and impacts members' quality of life. The Department is working with the RAEs to understand existing programs and capabilities to prevent disease progression and improve the outcomes for these conditions. The RAEs improvement in the management of these members has been incorporated into the Department's Pay-for-Performance program explained in Section IV.

Prevention

While the majority of Medicaid members do not require complex care or condition management, they are often at high-risk for poor health and social outcomes. As a result, the Department is committed to partnering with the RAEs and providers in delivering preventive and supportive services that promote members' ongoing

health and reduce the risk of the development of chronic and complex conditions. Preventive services include prenatal and maternal care and support; and comprehensive, periodic evaluations of child and adolescent health, development, and nutritional status available through the Department's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

IV. Program Performance

The Accountable Care Collaborative aimed to improve health outcomes and the health care experience for all Medicaid members. One primary tool for the Department to measure and monitor program performance is the Pay-for-Performance Program.

The Accountable Care Collaborative's Pay-for-Performance Program enables the RAEs to earn financial incentives for achieving performance and programmatic objectives. It consists of three components:

1. **Key Performance Indicators:** The Key Performance Indicators (KPIs) are designed to assess the overall health of the ACC program and reward RAEs for improvement of the regional delivery system as a whole. The Department selected measures that highlight the RAEs progress toward building a coordinated, community-based approach to meet member health needs and reduce costs.
2. **Performance Pool:** Funds for the Key Performance Indicators that did not get distributed to the RAEs went into a pool of funds available for additional performance and programmatic incentives. Annually, the Department identifies the performance and programmatic priorities that align with state and Department initiatives.
3. **Behavioral Health Incentive Program:** The Department monitors the performance of the behavioral health system and rewards RAEs for performance improvement utilizing the Behavioral Health Incentive Program.

For this report, most of the performance data that is reported reflects only the first nine months of the RAEs' contract (July 1, 2018-March 31, 2019). This is because at least three months are required following the end of the fiscal year to

allow sufficient time for the submission and payment of claims, and then time is needed to calculate the measures and validate the results. As a result, the performance data does not accurately reflect the RAEs' complete performance for the fiscal year.

A. Key Performance Indicators

For the second phase of the Accountable Care Collaborative, the Department reduced the amount of guaranteed administrative fee payments to the RAEs by linking a greater proportion of reimbursement to performance on the KPIs. Four dollars ($4) PMPM of the RAE's PMPM administrative fee is withheld for KPIs. The RAEs can earn quarterly (sometimes annual or semi-annual) KPI incentive payments equaling all or part of the $4 PMPM by achieving certain performance levels on the KPIs identified by the Department.

The following were the Key Performance Indicators (KPIs) for FY 2018-19. These were used to evaluate program impact on member health outcomes:

1. **Potentially Avoidable Costs:** The Department has recently begun utilizing the PROMETHEUS tool (described previously) with the RAEs that compares a standard cost of an episode of care to actual costs. The first year performance was based on developing strategies to implement this tool into RAE program operations and management.
2. **Emergency Department Visits:** Number of emergency department visits, per 1,000 members per year risk-adjusted. The RAEs continued the downward trend in emergency room visits begun under the RCCOs with an average decrease of 1.1 percent from the FY 2017-18 baseline average.
3. **Behavioral Health Engagement:** Percent of members who access behavioral health services. There was an average increase of 2.5 percent from the FY 2017-18 baseline average.
4. **Well Visits:** Percent of members who receive a well visit during the 12-month evaluation period. There was an average increase of approximately 0.5 percent for the nine-month period from the FY 2017-18 baseline average.

5. **Prenatal Engagement:** Percent of deliveries where a woman received a prenatal care visit during pregnancy. There was an average increase of 5.5 percent from the FY 2017-18 baseline average.
6. **Dental Visit:** Percent of members who received professional dental services. Dental visits increased by two percent from the FY 2017-18 baseline average.
7. **Health Neighborhood:** This KPI is comprised of two components that reflect connections and referrals between specialty care and primary care providers. While the RAEs have struggled to earn incentive payments on this measure, 320 PCMPs have established care compacts with specialty care providers to improve coordination of care for members. The Department is working with RAEs to improve performance, while also identifying ways to adjust the performance measurement to more accurately reflect efforts by the RAEs in this area.

The Department distributed payments on KPIs based on performance during the first six months of FY 2018-19.

B. Performance Pool

Utilizing Pay-for-Performance Program funds that were not distributed for achieving Key Performance Indicator targets during the first six months of FY 2018-19, the Department incentivized the RAEs to develop strategies and provide information on existing resources available to the Department's identified complex populations and top chronic conditions. This environmental scan will be used to inform statewide and regional gap analyses.

The Department is establishing outcome-based metrics for FY 2019-20 to hold the RAEs accountable for improving costs and health outcomes for targeted members with complex health conditions. Examples of the information submitted by the RAEs included:

- Care coordination delivered to the Department's identified complex populations from December 2018 through June 2019 and the RAEs' plans to increase the percentage of complex members receiving care coordination and demonstrate a return on investment.
- Perinatal/maternity programs available in the region and their utilization.

- Environmental scan of programs in the RAE's region addressing the Department's identified top chronic conditions, including member communications on the programs, the percent of members participating, and the number of providers for each program.
- Collaboration with institutions for mental diseases to improve processes, procedures, and reimbursement for members who require inpatient mental health treatment.

C. Behavioral Health Incentive Program

The Behavioral Health Incentive Program was developed in collaboration with the Office of Behavioral Health and the previous Behavioral Health Organizations in 2017 and is based on standard performance measures collected by the agencies. Payment is based on annual performance and is not finalized until 6-9 months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, no funds were distributed to the RAEs in FY 2018-19 for the Behavioral Health Incentive Program.

The following are the performance measures that will be used to evaluate program impact on member health outcomes:

1. **Engagement in Outpatient Substance Use Disorder (SUD) Treatment:** Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit
2. **Follow-up within 7 days after an Inpatient Hospital Discharge for a Mental Health Condition:** Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days
3. **Follow-up within 7 days after an Emergency Department Visit for a SUD:** Percent of member discharges from an emergency department episode for treatment of a covered SUD to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days

4. **Follow-up after a Positive Depression Screen:** Percent of members engaged in mental health service within 30 days of screening positive for depression
5. **Behavioral Health Screening or Assessment for Foster Care Children:** Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment

V. Financial Performance

During FY 2018-19, the Accountable Care Collaborative operated as both a Primary Care Case Management Entity, in which medical services were paid fee-for service, and a Prepaid Inpatient Health Plan, in which covered behavioral health services were paid through a capitated payment to the RAEs. Under this model, RAEs were paid a PMPM administrative fee for most members and a PMPM capitation payment.

As part of the Accountable Care Collaborative, 115,128 members were enrolled with a limited managed care capitation initiative rather than a PCMP. The RAEs for Region 1 and Region 5 operate the two current limited managed care capitation initiatives. For these members, the RAEs were paid two separate PMPM capitation payments: one capitation payment for covered behavioral health services and one capitation payment for covered medical services. The RAEs did not receive a PMPM administrative fee for members enrolled with a limited managed care capitation initiative.

As described in Section IV, the Accountable Care Collaborative also includes a Pay-for-Performance Program that enables the RAEs to earn financial incentives for achieving performance and programmatic objectives.

A. Accountable Care Collaborative Program Costs

Program costs include all expenses for benefits and services provided during FY 2018-19, including capitations, pharmacy, inpatient, outpatient, emergency room, Long-Term Services and Supports, home health, and professional claims. Capitations included in the program costs include the PMPM capitated payments to the RAEs for covered behavioral health services for all members, the PMPM

administrative fees to the RAEs, and the PMPM capitated payments for members enrolled with a limited managed care capitation initiative.

For this report, the Department performed a straight comparison of FY 2018-19 expenditures to FY 2017-18 expenditures for all full-benefit Medicaid members, excluding those enrolled in PACE. Costs reflect the following programmatic changes from FY 2017-18:

- Mandatory enrollment into the program resulted in a nearly 20 percent increase in program enrollment;
- Expansion of the Accountable Care Collaborative responsibilities to include the capitated behavioral health benefit; and
- Incorporation of all limited managed care capitation initiatives into the program.

The total amount paid for the Accountable Care Collaborative in FY 2018-19 was $7.8 billion – a 4.9 percent increase from the previous fiscal year. Total costs are divided by total member months to yield an average program cost PMPM for the fiscal year. In FY 2018-19, the average paid PMPM was $526. This was a 9.6 percent increase from FY17-18, when the average paid PMPM was $480.

Table 2. Accountable Care Collaborative Program Costs for FY 2018-19.

Financial Transaction	FY 2018-19 Expenditures
Administrative PMPM Payments	$148,685,644
Earned Key Performance Indicator Payments	$10,155,077
Earned Performance Pool Payments	$10,713,055
Behavioral Health Capitation PMPM Payments	$592,363,360
Limited Managed Care Capitation Initiative PMPM Payments	$400,359,785
Benefits and Services (not included in the capitation payments)	$6,641,030,406
TOTAL EXPENDITURES	**$7,803,307,327**

The total administrative fees and costs for the Accountable Care Collaborative consist of the administrative PMPM payments, the earned Key Performance Indicator payments, and the earned performance pool payments. The $169,553,776 total administrative fees and costs represent an increase of $19,399,244 from FY 2017-18 administrative costs. These increased costs are the result of two policy changes:

1. **Mandatory Enrollment:** As discussed in the Accountable Care Collaborative Enrollment section, the Department instituted mandatory enrollment for all full-benefit members. This means there are more members enrolled in the RAE which resulted in an increase in the total PMPM administrative fee distributed to the RAEs.
2. **Increased Administrative Fee:** As authorized by the General Assembly, the Department increased the PMPM administrative fee by one dollar ($1). This increase was made to support the RAEs' in providing a greater level of accountability and responsibility for both the physical health and behavioral health of members.

The benefits and services saw increases from FY 2017-18 as a result of both changes in caseload and an increase in utilization. As the state's economy continues to improve based on major state economic indicators (such as unemployment and gross domestic product), the Department's caseload has begun to fall slowly. However, the people who are leaving the Medicaid program tend to be healthier and have lower costs than those people that remain. In addition, the Department's caseload is reflecting a greater proportion of adults over 65 and people with disabilities who have higher per capita costs than adults and children without disabilities and receive the least amount of federal funding available. As a result, while caseload has been going down, per capita expenditures have continued to increase.

Table 3 reports the top five benefit groups driving the increase in benefits and services costs overall. The table also reports the total paid amount for the fiscal year and the change in amount paid compared to FY 2017-18.

Table 3: Top Five Benefits and Services Contributing to Cost Increases for FY 2018-19

Benefit Group contributing to cost increase	Total Paid Amount FY 2018-19	Paid Amount Change from FY 2017-18 to FY 2018-19
Long Term Services and Supports	$1,931M	8.4%
Pharmacy	$1,122M	2.6%
Home Health & Private Duty Nursing	$488M	12.3%
Other Specialty Care	$378M	10.8%
Ancillary Services	$326M	15.6%

After factoring the impact of legislatively approved rate changes on total costs, the Department discovered these initial findings regarding increased costs in the five benefit groups listed above:

Long-Term Services and Supports (LTSS): This category includes costs for Home and Community-Based Services (HCBS) waivers, nursing facilities, and hospice. HCBS accounts for roughly 60 percent of all LTSS costs and contributes to about 80 percent of the change in trend. Within HCBS, In-Home Support Services (IHSS) and Consumer-Directed Attendant Support Services (CDASS) are the largest contributors to the change in trend. The increases in IHSS spend is being driven by increased spending on IHSS personal care and health maintenance activities.

Home Health and Private Duty Nursing: The total paid amount for long-term home health reached $360.8M in FY 2018-19, which represents a 13.0 percent increase from the previous year. Increases in home health aide care by Certified Nurse Assistants accounted for most of the change

in trend. The Department is in the process of developing an assessment tool for long term home health and private duty nursing.

Ancillary Services: Independent laboratory costs comprise 42.1 percent of ancillary costs and contributed to 72.0 percent of the trend for the benefit category. The FY 2018-19 total paid of $137.2M is an increase of 29.9 percent from the previous year.

Transportation costs comprise 22.3 percent of ancillary costs and contributed to 25.6 percent of the trend. This increase is being driven by non-emergent medical transportation, which contributed to 86.4 percent of the change.

The Department is conducting further research into providers with large increases in these two services over the past year.

Other Specialty Care: Outpatient physical and occupational therapy spend grew 24.3 percent from the previous fiscal year, contributing to 28.8 percent of the change in trend. Participation in physical and occupational therapy services was up 8.2 percent compared to the previous year.

Pharmacy: Pharmacy expenses include prescription drugs – including generic, brand name, and specialty drugs – distributed through traditional pharmacies, as well as those administered by health care professionals. While the number of members receiving drugs in these categories decreased by 5.9 percent, overall spend (non-rebate adjusted) remains high at $1.1 billion. Within this category, specialty drugs comprise the largest percentage of total spend (38.0 percent) and experienced the largest paid change (7.3 percent). The number of members receiving specialty drugs also increased by 7.3 percent. Spending for physician administered drugs increased by 19.6 percent in FY 2018-19 as well, driven largely by drugs administered by injection.

> A report on pharmaceutical costs will be released by the Department before calendar year end. This report will offer proposed solutions for reducing prescription drug spending in Colorado.

With the implementation of the Cost Control and Quality Improvement Office, the Department has been developing the tools and resources to more effectively analyze the primary drivers in increased costs for Medicaid. As drivers are identified, the Cost Control and Quality Improvement Office works with other Department staff to review benefits and programs and identify opportunities for interventions that can reduce avoidable utilization that does not improve member health. Interventions may include reviewing claims processing procedures, implementing prior authorization requirements, coordinating services more effectively, or reinforcing existing fraud, waste, and abuse investigations. Additionally, the Department's implementation of the statewide approach for clinical management and the clinical risk stratification dashboard will help the RAEs focus on members with complex health needs and the conditions associated with highest cost trends.

VI. 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.

A. Regional Accountable Entities

As the umbrella organization within each region, the RAEs served as a single resource to help both providers and members navigate the Medicaid system of care. Based on practice needs, RAEs 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 RAEs helped explain Medicaid benefits, establish relationships with PCMPs, coordinate care with behavioral health providers and other Medicaid providers, address grievances, arrange non-

emergency medical transportation, and connect members with community resources to address non-medical needs.

Each of the RAEs collaborated with local public health agencies, county human service departments, case management agencies, and other community partners within its region to align resources, improve coordination of services among different providers, and reduce waste and inefficiencies. Some specific examples include:

- Colorado Community Health Alliance is an active member in the regional Collaborative Management Program/Interagency Oversight Group. This multi-agency collaboration addresses children, youth and families involved with multiple county systems and agencies in order to reduce duplication, increase quality and effectiveness of service delivery, share costs, and achieve positive outcomes for children and families.
- Rocky Mountain Health Plans developed a robust statistical model for evaluating the impact of care coordination on health outcomes. For instance, members enrolled in Rocky Mountain Health Plan's Health Engagement Team program show a 41 percent decrease in emergency department utilization and a 22 percent decrease in inpatient stays.

B. Utilization Management

The RAEs 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, such as multiple opioid prescriptions, in a potentially inappropriate manner. The RAEs then leveraged their network of providers and care coordinators to perform more comprehensive member needs assessments to design and implement interventions. Members who are not engaging in the RAEs' interventions and continue to use a high -quantity of services will be locked into accessing only one PCMP and one pharmacy to try to better manage the member's care.

The RAEs also developed their own utilization management programs to reduce waste and promote more efficient and cost-effective care.

- Colorado Community Health Alliance actively monitors claims through data mining to ensure Medicaid dollars are being paid out in an appropriate manner. The Special Investigations Unit monitors billing trends by contracted behavioral health providers and compares those to national billing trends through internal data mining. Due to this practice, CCHA has identified multiple instances of potentially wasteful billing practices by providers. The Special Investigations Unit outreaches providers to ensure they are aware of Medicaid billing policies and monitors claims for any changes in billing habits, positive or negative. To date, Colorado Community Health Alliance has submitted one suspected fraud and one suspected waste notification to the Department for review.
- Colorado Access regularly reviews its utilization management practices to better understand where opportunities lie to contain costs while ensuring the best possible care for members. For example, Acute Treatment Units with their focus on recovery, strengths, and linkage to community resources can often result in shorter hospital stays for behavioral health conditions and return members to the community more quickly. This finding led to the implementation of training and processes that result in more efficient utilization management practices and more appropriate care for members. So far, this effort has decreased the behavioral health inpatient length of stay by an average of one to two days, resulting in cost containment of over $5 million during FY 2018-19.

VII. Advisory Committees and Stakeholder Engagement

In FY 2018-19, the Accountable Care Collaborative offered members and stakeholders several ways to participate in decision-making and offer feedback.

A. Program Improvement Advisory Committee (PIAC)

Established in 2012, the PIAC is the Department's primary means to solicit guidance and recommendations from community members for improvement of the Accountable Care Collaborative. Membership includes Medicaid members, physical and behavioral health providers, LTSS providers, RAEs, oral health providers, local advocacy organizations, and member advocates. Meetings were open to the public.

With the change to the second iteration of the Accountable Care Collaborative, the PIAC was focused in FY 2018-19 on "forming and norming" with the incorporation of new committee members, selecting committee co-chairs, re-establishing operating procedures such as charters and by-laws, and setting up subcommittees. The PIAC established the following subcommittees to provide more detailed guidance on future activities: behavioral health integration strategies, provider and community experience, and performance measurement and member engagement.

B. Regional Program Improvement Advisory Committees and Member Advisory Councils

Each RAE established a regional performance 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 RAEs understand the unique needs within their community and design and implement solutions that best addressed the needs. The regional committees focused on issues such as care coordination efforts, member support services, RAE performance review, and establishing polices for distributing earned Pay-for-Performance Program payments.

All the RAEs formed advisory councils specifically for Medicaid members, which met quarterly. Member advisory councils have focused on understanding the member's perspective regarding how they access health care services in order to drive changes on policy and program decisions as well as member communications.

VIII. FY 2019-2020 Strategies

The Department has taken a significant step to improve health outcomes and bend the cost curve by joining the administration of physical health and behavioral health under the RAEs. Effectively leveraging this infrastructure in tandem with other Department initiatives will begin to generate greater improvements in member health, member experience, and cost containment. Below are some initiatives that will move the program and Department forward in improving the affordability of Medicaid in future years.

A. Statewide Approach to Addressing Member Health

With the implementation of the Department's new statewide approach and Clinical Risk Stratification Dashboard, the Department now has the opportunity to refine and focus the Accountable Care Collaborative to target members with complex health needs and identified high-cost conditions. The RAEs will be required to utilize best-in-class programs and tools to address the identified health care needs of these members. The Department will support the RAEs in implementing the plans they developed as part of the KPIs and Performance Pool to guide their work, particularly:

- Strategies to integrate PROMETHEUS into the RAEs' program management to address potentially avoidable costs.
- Plans to increase the percentage of members with complex health needs receiving care coordination and demonstrate a return on investment.
- Tactics for leveraging regional programs to address the Department's identified top chronic conditions.

The Department continues to work with the RAEs to improve the Clinical Risk Stratification Dashboard to best support their interventions. The Department's current risk score methodology requires enhancements to improve the predictive value of key influencers, such as the presence of behavioral health diagnoses, and for specific populations, such as children and individuals with disabilities. These enhancements will be completed in FY 2019-20.

The Department will monitor RAE performance and guide continuous improvement regarding the targeted populations and chronic conditions by introducing cost and additional health outcome metrics into the program. With fewer than 5 percent of members contributing over 50 percent of claim costs, a focused approach for managing care should result in lower costs and improved outcomes.

B. Prescription Drug Costs

The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid and all health plans. The Department diligently utilizes cost control initiatives to manage generic and brand name drugs such as a preferred drug

list, prior authorization requirements, quantity limits, review of member drug utilization, and value-based contracts.

The Department is working with other payers in Colorado to implement a pharmacy prescribing tool during FY 2019-20. The tool is being designed to enable physicians and other prescribers to:

- Compare the costs associated with alternate prescription therapies;
- Assess a patient's risk of addiction, based on existing information, prior to prescribing an opioid; and
- Prescribe program alternatives and supplements to drug therapy in order to address the root cause of the member's health condition.

By making it easier for prescribers to identify alternative therapies, the Department and other payers hope to improve the quality of care and reduce prescription drug expenditures for the Department, consumers, employers, and payers throughout Colorado.

C. Provider Cost and Quality Variation Reports

Variation in health care delivery and costs significantly impacts the cost of the Medicaid program and the quality of care members receive. In an effort to identify the highest quality, most cost-effective care sites for members and the RAEs, the Department has begun to create Cost and Quality Variation Reports. These reports use claims data to analyze and display variation in costs and health outcomes across similar provider types. Two reports have been created:

- Hospital report measuring variation in procedures, surgeries, and aftercare
- Federally Qualified Health Center Report

The Department is preparing a report on primary care providers for FY 2019-20, with a specific report on PCMPs to assist the RAEs in managing their PCMPs and deploying practice transformation resources.

D. Residential and Inpatient Substance Use Disorder Treatment

The Department is working to implement House Bill 18-1136 which adds residential and inpatient substance use disorder services to Medicaid's covered benefits. While not a cost-containment strategy, the addition of these services

will ensure members needing treatment for a substance use disorder have access to the full continuum of care available in the state.

The Department has applied to the Centers for Medicare & Medicaid Services to implement a Section 1115 Substance Use Disorder Demonstration Waiver. The proposed demonstration will complete the service continuum for Medicaid members by authorizing the state to draw down a federal match on inpatient and residential services, including withdrawal management, delivered in Institutions for Mental Diseases (IMD). If approved, the RAEs will have primary responsibility for administering the new benefit to complement the current substance use disorder early intervention, outpatient treatment, and recovery services available to members.

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