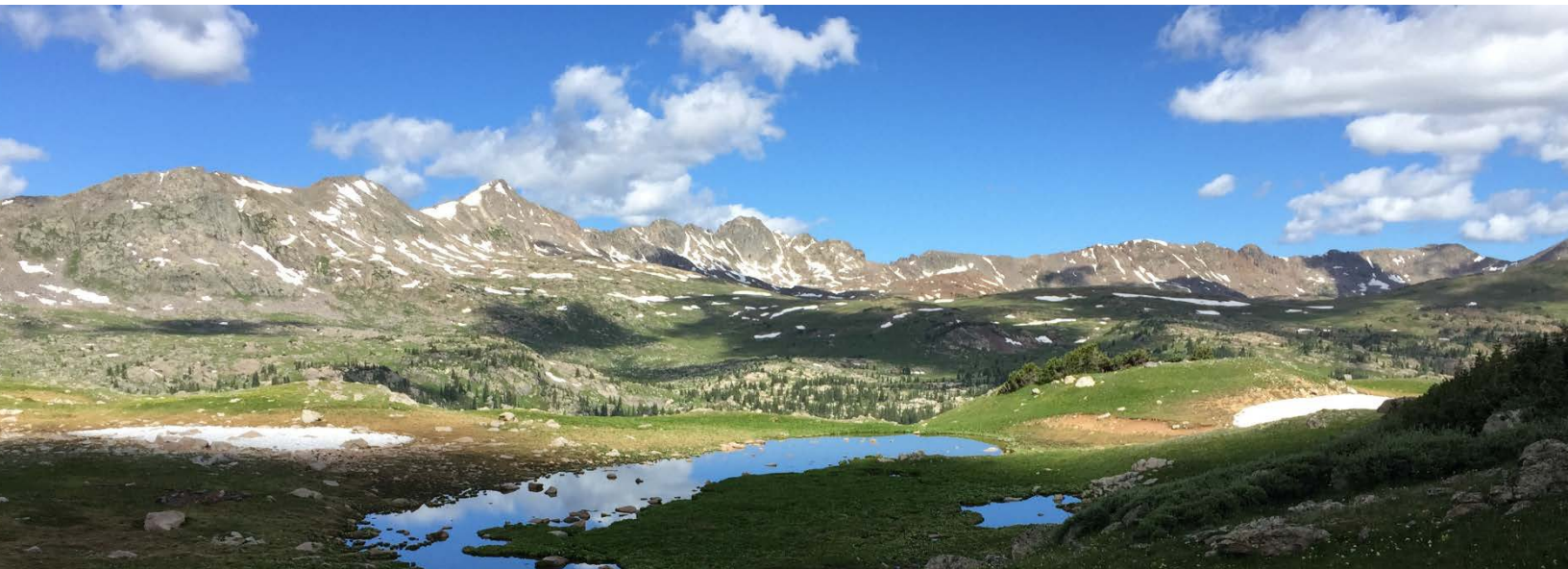# Health Care Policy & Financing

FY 2018–19 PERFORMANCE PLAN

COLORADO

Department of Health Care
Policy & Financing

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Contents

Introduction

The Department of Health Care Policy & Financing's FY 2018–19 performance plan is an annual report detailing priority efforts to achieve our mission, vision, and goals. This performance plan follows guidelines from the Governor's Office of State Planning and Budgeting, and complies with Colorado's State Measurement for Accountable, Responsive, and Transparent Government (SMART) Act.

The Department receives federal funding as the single Colorado state agency responsible for administering the Medicaid program (Title XIX) and the Child Health Insurance Program (Title XXI), known as Child Health Plan *Plus* (CHP+). Colorado's Medicaid program is known publicly as Health First Colorado. In addition to these programs, we administer the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, and the School Health Services Program. We also provide health care policy leadership – including cost control guidance – for the state's executive and legislative branches and to purchasers at large.

The Medicaid program receives approximately 59% of its funding from the federal government. The CHP+ program is approximately 88% federally funded.

Our Customers

Our direct customers include Coloradans who are eligible for and/or enrolled in Medicaid and Child Health Plan *Plus*, and those who receive services through the other programs described above.

Our Partners

Our partners include medical, dental, behavioral health, and long term services and supports providers; sister state agencies; the Centers for Medicare & Medicaid Services; groups that advocate for member populations; the Governor's Office and the Legislature of the State of Colorado; service contractors; expert consultants and advisors; various non-profit entities; commercial carriers; and entities that help eligible individuals apply for benefits such as Colorado counties, local government agencies, and medical assistance sites.

Factors that Influence Our Work

The work we do and the strategy that guides it are shaped by external factors both positive and negative. These include:

- Shifts in the demographics and health of the Medicaid population
- State and federal health care policy
- The economy
- Changes in the health care delivery system
- Escalating health care costs
- Health care innovations

The most significant external factors currently include increasing mental health and substance abuse needs as well as other population health needs of the Medicaid population; changes in the health care delivery system; issues related to state and federal policy changes; and rising healthcare costs.

Mental health and substance abuse – The impact of alcoholism in the Medicaid population, the opioid crisis, and the State's higher than average substance abuse disorder challenges have led to identification and execution of new Department initiatives intended to prevent and treat addiction.

Health of the Medicaid population – Obesity rates among adults in Medicaid (25.7%) are increasing in Colorado and remain flat for children (15.5%).[1] However, the higher than average obesity rates in the Medicaid population and the impact of obesity on chronic disease, combined with higher tobacco use among the lower income populations contribute to downstream health, cost, and quality of life impacts on Medicaid and CHP+ members. These population health attributes, combined with the mental health and substance abuse factors mentioned above, drive increasing priority in the management of population health programs, chronic condition management and outreach, the management of catastrophic claims/conditions, and the importance of physical and behavioral care management and delivery integration.

Health care delivery system – Rising health care costs are a pressing issue to consumers, employers, and other payers, including the Department. The Department is taking a leadership role to drive improvements in efficacy and quality with stronger focus and prioritization than it ever has. We are collaborating with stakeholders to deliver the right care, in the right setting, at the right time, at the right price across primary care, hospital, and pharmaceutical delivery systems. In addition, the Department is doing significant work to reform primary care delivery systems through the Accountable Care Collaborative and alternative payment methodologies.

Changes to federal health care policy – Medicaid is a state-federal partnership. Changes in eligibility definitions, benefit coverage policy and federal financing available to states are critical macro-environmental factors impacting our work. The Department closely monitors proposals by Congress and the Administration that would impact Medicaid and CHP+ policy, caseload, population health, or revenue and responds accordingly with appropriate strategic plan adjustments.

Health care costs – One of the most critical macro- and micro-environmental factors impacting our business is the escalating cost of health care in the U.S. and in Colorado. In partnership with other payers and influencers, we are working to identify alternatives and build consensus around the priority initiatives that will contain costs and improve the quality and efficiency of care delivery in the Medicaid program and within State policy to the benefit of consumers, employers, the State, and taxpayers. These initiatives include improvements in value-based and supplemental payments through changes in distribution of the Hospital Provider Fee,[2] and through the Hospital Transformation Program;[3] innovative tools to better manage care; delivering care and services in community-based settings; improvements in our data management and insights; advancing evidence-based medicine through utilization review and related care management programs; enhancements to our claims system and fraud unit; and renewed focus on the management of large claims. The strategic policy initiatives described in this performance plan fall within the framework of the bipartisan Health Care Blueprint[4] and pursue the Quadruple Aim[5].

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[1] Source: Colorado Dept of Public Health and Environment, 2016: https://www.colorado.gov/pacific/cdphe/vision-data-tool
[2] The Hospital Provider Fee is a state program involving an annual charge to hospitals that is matched by the federal government and redistributed to subsidize the cost of providing care to Colorado's uninsured and indigent populations.
[3] The Hospital Transformation Program is a Department initiative to connect hospitals to the Health Neighborhood (a network of Medicaid providers that support a member's health and wellness), and align hospital incentives with the goals of the Accountable Care Collaborative.
[4] The Health Care Blueprint is a bipartisan proposal to improve health care in the United States released by Governors Hickenlooper, Kasich, Walker, Wolf, and Sandoval on February 23, 2018.
[5] The Quadruple Aim, *improvement in population health, patient experience, per-capita cost and provider experience* is a framework for the delivery of high value care in the U.S.A.

About This Performance Plan

This plan presents our long-range goals, strategic policy initiatives (SPIs), performance measures, strategies and programs for achieving the SPIs. Data reported for each performance measure includes historical "actuals" for the prior two fiscal years, as well as one-, two-, and three-year targets where appropriate. Prior year performance is evaluated based on estimates for FY 2017–18, as actuals will not be available for all measures until December 2018. A glossary of acronyms and relevant terms is provided at the end of this document.

Revisions to Our Strategy

With the arrival of our new Executive Director, Kim Bimestefer, we have heightened our focus in various areas, including health care cost management that recognizes the 34% of the State budget that the Department consumes. In addition, we are improving accountability in managing our 390+ vendor partners and contracts. These contractors are key partners in how we operationalize the management of comparatively small health plans (1.3 million Medicaid members and 80,000 CHP+ members[6] versus national plans like United Health or Anthem which manage 40–50 million members). With the broader spectrum of performance measures we are now holding ourselves accountable to, we are driving renewed focus, transformation and improved accountability.

With Director Bimestefer's guidance, managers across the Department convened workgroups to develop strategic projects focused on "controlling claim costs in a member-friendly way". With the expansion of Medicaid in January 2014, the program added an estimated 429,000 members, driving pressure across our operations, including claims processing, customer- and provider service, enrollment, eligibility determination, and case management. With the stabilization of our operations in the years since Medicaid expansion, and the turnaround of our new claims processing system which struggled through 2017 and into early 2018, we can now focus more attention on claim cost control/trend management as well as vendor performance and return on investment within the administrative/operational component of our business. This renewed focus is clear in the establishment of new goals in the areas of annual per-capita claim target, administrative budget discipline, vendor management accountability, and cost control policy leadership for the State.

Strategic Framework

While our goals and strategies have changed and expanded under our new Executive Director, this performance plan continues to be constructed around a framework generated by our executive team and staff across the Department during 2016: our six core values serve as its foundation and four strategic policy initiatives support achievement of our long-range goals, mission, and vision.

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[6] Department of Health Care Policy and Financing FY 2017-18 Medicaid Premiums Expenditures and Caseload Report, June 2018.

Performance Plan At a Glance

VISION: Coloradans have integrated health care and enjoy physical, mental and social well-being

MISSION: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

LONG-RANGE GOALS

Improve health for low-income and vulnerable Coloradans

Enhance the quality of life and community experience of individuals and families

Reduce the cost of health care in Colorado

STRATEGIC POLICY INITIATIVES

1 Delivery Systems Innovation
Medicaid members can easily access and navigate needed and appropriate services

2 Tools of Transformation
The broader health care system is transformed by using levers in the Department's control such as maximizing the use of value-based payment reform and emerging health technologies

3 Partnerships to Improve Population Health
The health of low-income and vulnerable Coloradans improves through a balance of health and social programs made possible by partnerships

4 Operational Excellence
The Department is a model for compliant, efficient and effective business practices that are person- and family-centered

DEPARTMENT VALUES

Person-Centeredness · Accountability · Continuous Improvement · Employee Engagement · Integrity · Transparency

HCPF Strategic Framework Infographic

Our Core Values

By declaring these values, we are committing to aligning our actions with them.

Person-Centeredness and Customer Centricity: We respect and value the strengths, preferences, and contributions of employees, members, providers, and stakeholders by adapting and responding to individual needs.

Accountability: We accept responsibility for our actions, learn from our experiences, and inspire others to do the same.

Continuous Improvement: We evaluate our processes and systems, engage in creative problem-solving, and innovate solutions to work more efficiently and effectively.

Employee Engagement: We attract and retain talented people by creating a positive work environment and empowering them to shape our strategies and fulfill our mission, and we invest in them to help them thrive.

Integrity and Diversity: We behave ethically, treat others with dignity and respect, and align our actions with our mission and vision. We value diversity of thought, knowing that it helps us drive better decisions, programs and service to our members.

Transparency: We openly communicate decision making processes, clearly articulate roles and responsibilities, and create opportunities to inform and influence policy.

Strategic Elements and Associated Performance Measures

ELEMENTS

Long-Range Goals: Significant achievements requiring years of commitment to strategic policy initiatives and successful execution of strategies.

Strategic Policy Initiatives (SPIs): Significant objectives for the current fiscal year, destination oriented, achievable through strategic projects and programs, and measurable by SMART performance measures. The ideal number of SPIs is 3–5 per year.

Performance Measures: These gauge the effectiveness of strategic projects and programs in achieving strategic policy initiatives and long-range goals. Performance measures can be influenced by business units, and are predictive of success or failure.

FULFILLING THE GOVERNOR'S VISION

To achieve Governor Hickenlooper's vision of Colorado becoming the healthiest state in the nation, we contribute to his statewide health-related goals of *improving health care coverage, reducing the incidence of substance use disorder, reducing the impact of mental illness, and improving value in health care service delivery*.

We make progress by committing to the following long-range goals and strategic policy initiatives.

LONG RANGE GOALS

Improve health for low-income and vulnerable Coloradans

Enhance the quality of life and community experience of individuals and families

Reduce the cost of health care in Colorado

SPIs, Performance Measures, and Strategies

This section presents our four strategic policy initiatives, or SPIs, performance measures, and the strategies underway to achieve them.

PERFORMANCE MEASURES SUMMARY

SPI	Definition	Measures
1. Delivery Systems Innovation	Medicaid members can easily access and navigate needed and appropriate services	▯ Increase the # of Colorado providers serving Medicaid from 48,841 to 49,571 by June 30, 2019 ▯ Increase the # of Colorado primary care providers serving Medicaid from 22,838 to 23,177 by June 30, 2019 ▯ Reach 80% of hospitals and 100% of Regional Accountable Entities (RAEs) by June 30, 2019 with messaging that makes them aware of the new HCPF Prometheus tool to measure potentially avoidable costs ▯ Increase # of nursing facility members transitioned to home and community based settings through Colorado Choice Transitions
2. Tools of Transformation	The broader health care system is transformed by controlling costs in Medicaid	▯ The average cost per-capita for Medicaid for FY 2018–19 will be less than $6,951, adjusted by September 1, 2018 for legislative initiatives such as provider rate increases and new policy ▯ Increase total costs avoided from ACC[7] and Medicaid from $133 million last FY to $189 million this FY by June 30, 2019
3. Partnerships to Improve Population Health	The health of low-income and vulnerable Coloradans improves through a balance of collaborative population health and social programs	▯ Decrease the # of opioid pills dispensed among members who use the Rx benefit from 10.09 to 9.59 by June 30, 2019
4. Operational Excellence	We are a model for compliant, efficient, and effective business practices that are consumer centric, person- and family-centered	▯ Maintain provider call average speed of answer at <61 seconds ▯ Increase the % of targeted Medicaid households using the PEAK*Health* mobile app from 23% to 26.5% (15%) by June 30, 2019

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[7] Accountable Care Collaborative

SPIs and Strategies

SPI #1 DELIVERY SYSTEMS INNOVATION
Medicaid members can easily access and navigate needed and appropriate services

A critical indicator of member access to services is the number of medical providers serving Medicaid. To support providers and increase enrollment, we are working with primary care provider associations to communicate resolution in our claims system transformation. We are also providing value-based payment opportunities to encourage physicians to provide services to Medicaid members.
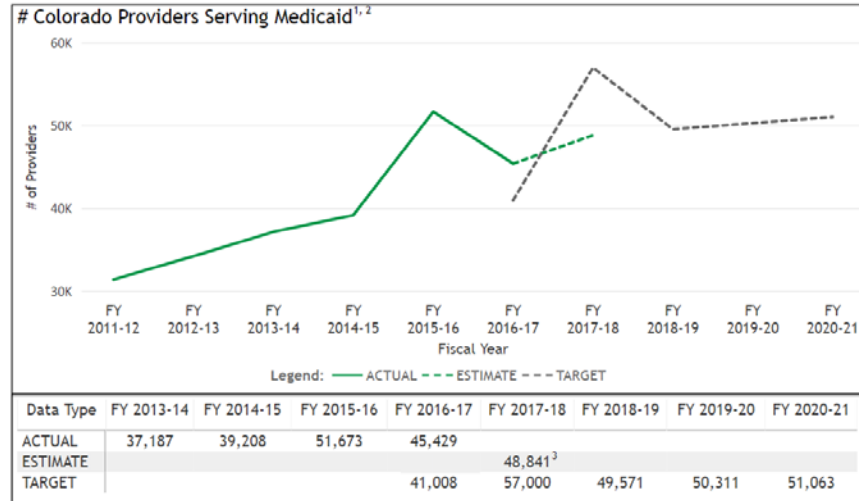
 # Colorado Providers Serving Medicaid[1,2]

Data Type	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	37,187	39,208	51,673	45,429				
ESTIMATE					48,841[3]			
TARGET				41,008	57,000	49,571	50,311	51,063

1 This measure restates prior years' reporting to include only providers within Colorado.
2 Number of providers include all providers (emergency, primary care, urgent care, etc.) with an active status, excluding those whom provide only specialty services (Neurology, urology, cardiology, etc.).
3 Actuals through March 2018.

In FY 2018-19, our focus is on innovating within existing delivery systems to improve quality of health care and control costs. Our goal is to reach 80% of hospitals and 100% of Regional Accountable Entities (RAEs) with messaging to drive awareness and enthusiasm around a new, sophisticated cost and quality tool called Prometheus that measures potentially avoidable costs by the end of FY 2018–19. The tool will be used to generate provider performance reviews and Hospital Quality Incentive Payments. It can also be used to help the Regional Accountable Entities identify opportunities for quality improvement and cost savings in patient management. It can further assist primary care medical homes in the establishment of more efficacious clinical pathways in the management of Medicaid members.

 # Colorado Primary Care Providers Serving Medicaid[1]

Data Type	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	18,822	20,151	23,145	21,398[2]				
ESTIMATE					22,838[2,3]			
TARGET				21,616	25,500	23,177	23,521	23,870
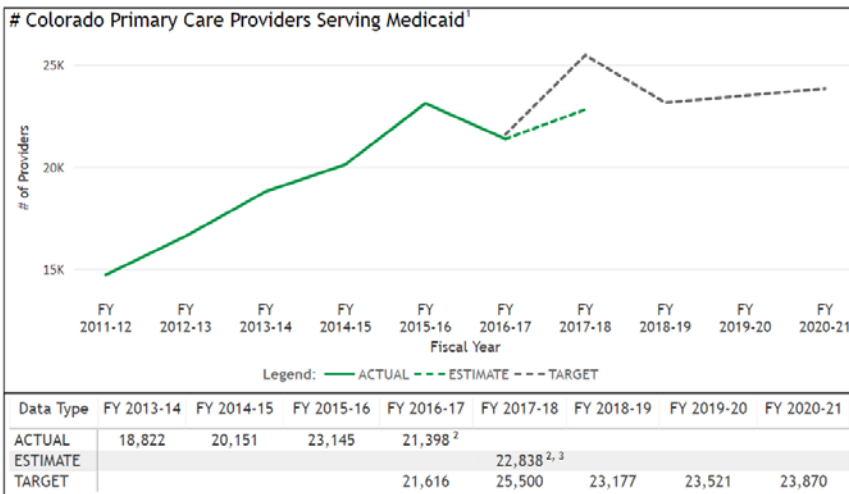
1 This measure restates prior years' reporting to include only primary care providers within Colorado.
2 Data corrected to remove duplication. Revised methodology includes Physicians, Osteopaths, Family/Pediatric Nurse Practitioners and Physician Assistants.
3 Actuals through March 2018.

The increase in provider enrollment during FY 2015–16 was partially due to federally mandated provider revalidation, which established more accurate and current enrollment information. The rate of growth in enrollment declined during the last quarter of FY 2016–17 due to a new system implementation, which disenrolled a large number of providers requiring them to reenroll the following fiscal year. We project modest growth going forward.

HOSPITAL REVIEW PROGRAM

In recognition that hospitals are responsible for about 30% of Colorado Medicaid spending and 10% of the State's budget, the Hospital Review Program provides inpatient utilization review through pre-admission certification and continued stay review using evidence-based guidelines.

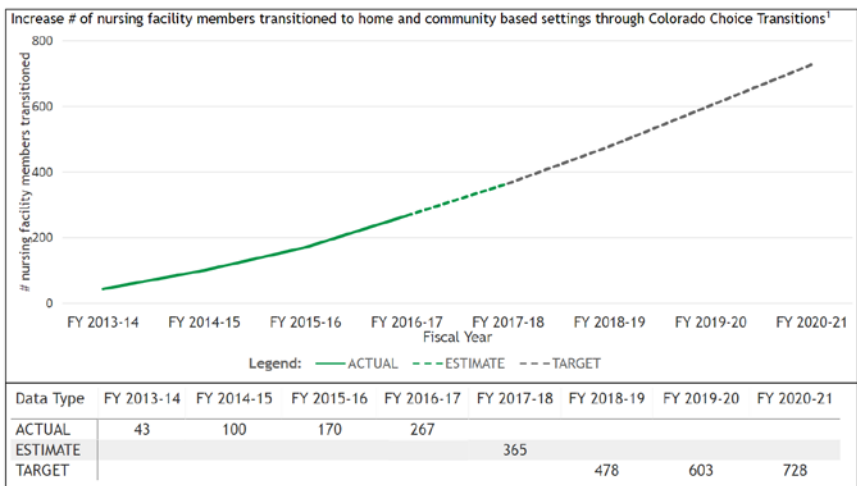Targeted for implementation on January 1, 2019, the program will notify the Regional Accountable Entities (RAEs)[8] of member diagnosis and treatment plans and highlight opportunities for discharge planning care coordination and case management of patients who are at risk for re-admission. The program will also allow the RAEs to invite patients who are "more coachable" due to a chronic disease exacerbation into population health and disease management programs. Last, it includes a complex claim, pre-payment review to ensure proper DRG[9] coding and claim adjudication/payment.

Overall, the Hospital Review Program provides a "commercial carrier catch-up opportunity" and is intended to ensure that Medicaid is paying for the right treatment, in the right setting, at the right time, and for the right price with the intent of better managing our most expensive benefit area.

COLORADO CHOICE TRANSITIONS

Since April 2013, the Department has participated in a federally-funded demonstration program in Colorado called Colorado Choice Transitions (CCT). CCT is designed to help transition Colorado Medicaid members out of long-term care facilities such as nursing homes into home and community-based settings. Members who have transitioned into the community using the CCT program report having a higher quality of life, better health outcomes, and a reduction in the total cost of their care to the state. As of December 2017, CCT produced a savings of more than $2.8 million, and as of June 2018, 361 members transitioned to the community.

Increase # of nursing facility members transitioned to home and community based settings through Colorado Choice Transitions[1]

Data Type	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	43	100	170	267				
ESTIMATE					365			
TARGET						478	603	728

1 Data is cumulative

With federal funding for the demonstration ending in 2019, the Legislature passed House Bill 18-1326,[10] directing the Department to implement successful services to support additional transitions to community based settings.
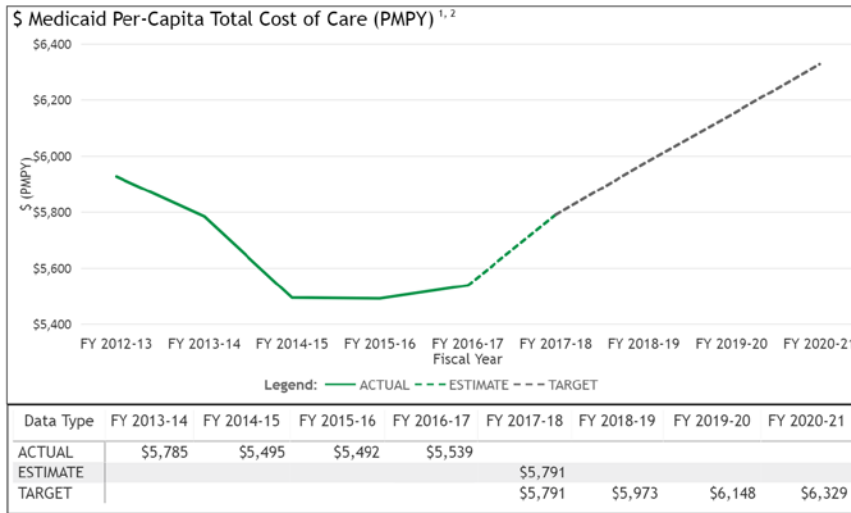
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[8] The seven Regional Accountable Entities or RAEs administrate the Accountable Care Collaborative health care delivery system. Each of the seven is responsible for managing physical and behavioral health care for its members.
[9] Diagnosis Related Group (DRG) is a claim coding system used to classify hospital cases
[10] *Support for Transition from Institutional Settings*

SPI #2 TOOLS OF TRANSFORMATION
The broader health care system is transformed by controlling costs in Medicaid

$ Medicaid Per-Capita Total Cost of Care (PMPY) [1, 2]

Data Type	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	$5,785	$5,495	$5,492	$5,539				
ESTIMATE					$5,791			
TARGET					$5,791	$5,973	$6,148	$6,329

1 FY 2020-21 is based on an estimated per capita trend and is not an official budget projection.
2 Methodology change to exclude all hospital supplemental payments and adjust delayed payments from COMMIT in FY 2016-17 and FY 2017-18. All data restated.

In FY 2016–17, Medicaid per-capita expenditures were lower than orginally estimated due to complications associated with our transition to a new MMIS[11] system in March 2017. As a result, claims payments in FY 2017–18 were higher than normal reflecting provider payment corrections and delayed claims payment catch-up. FY 2018–19 per-capita cost of care is expected to normalize.

$ Total costs avoided from ACC and Medicaid (in millions)

Data Type	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	$46	$75	$118				
ESTIMATE				$133			
TARGET			$62	$82	$189	$296	$298
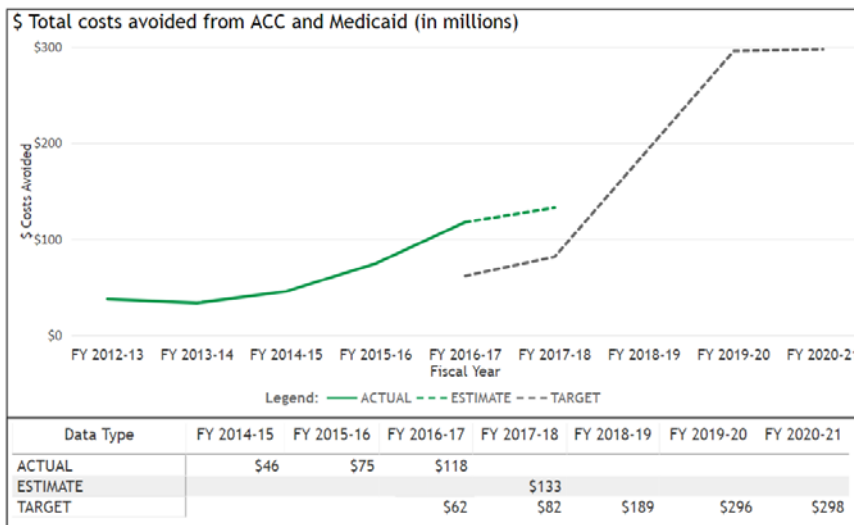
Total costs avoided is an annual measure of estimated savings from prior year budget initiatives, plus costs avoided from the Accountable Care Collaborative. Since FY 2012–13, approximately $444 million in costs has been avoided by improving care coordination and reducing payment for unnecessary, duplicative, and less effective services. By the end of FY 2018–19 that figure is expected to exceed $632 million.

TOTAL MEDICAL COST AND CLAIM MANAGEMENT OFFICE

Senate Bill 18–266, the Deparament's Cost Containment bill, included funding for a new office inside the Department intended to focus exclusively on claim cost control innovation and trend management. This may include innovations in value based payments and related alternative payment methodologies, managed pharmacy, delivery system innovations, utilization review and large case management, population health advances, long term cost-control planning and policy guidance for employer and consumer stakeholders.

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[11] Medicaid Management Information System

This coordinated team will maximize other Medicaid and commercial carrier best-in-class cost control programs in combination with big data insights newly available through IBM Watson Health, which will complete the critical portions of our Business Intelligence and Data Management system by January 1, 2019. The team will collaborate with healthcare experts and industry stakeholders to implement impactful cost control strategy for the benefit of consumers, employers, taxpayers, the Department, the State, and our local economy.

HEALTH CARE COST CONTROL ROADMAP

The Department will lead a collaborative process to devise a 3–5+ year Cost Control Roadmap for the State of Colorado. The Roadmap is intended to frame policy and drive actions that reduce health care prices to the benefit of employers, consumers, and other payers, and will identify drivers of healthcare costs/prices as well as options to significantly and favorably impact those drivers to the benefit of consumers, employers, and other payers. The Roadmap will be comprehensive and will cover major areas impacting health care utilization, costs, and outcomes including

- provider practice patterns and changing norms;
- members such as seniors, individuals in rural areas, and children;
- opportunity areas for innovation with a special focus on employing local businesses to solve challenges to the benefit of our state's economy;
- benefit areas such as hospital, primary care and pharmacy;
- value-based payments and other alternate payment methodologies; and
- lifestyle and population health influencers such as tobacco use, addiction, and excess weight.

The Cost Control Roadmap will be framed by expert healthcare thought leaders and refined by stakeholders such as medical care providers, business chambers, consumer advocates and union leaders, and legislators. Based on the Roadmap's inclusive approach, the Department has set a goal that by the close of FY 2018–19, the number of thought leaders, industry influencers, and stakeholders who are aware of, engaged to develop, or support the execution of the Roadmap will exceed 1,000 individuals. In the years to come, the goals associated with the Roadmap will evolve from engagement to implementation of initiatives through cost/price impact.

ACCOUNTABLE CARE COLLABORATIVE, PHASE II

The Accountable Care Collaborative (ACC) is the health care delivery system for Medicaid in Colorado. The program is designed improve member health and control costs. The next iteration of the ACC began July 1, 2018 and seeks to leverage the proven successes of Colorado Medicaid's programs to enhance the member and provider experience.

The objectives of Phase II are:

- Join physical and behavioral health under one accountable entity
- Strengthen coordination of services by advancing team-based care and Health Neighborhoods
- Promote member choice and engagement
- Pay providers for the increased value they deliver
- Ensure greater accountability and transparency

Development ACC Phase II began in 2014 and included stakeholder, advocate and provider input and leveraged learnings from evaluations of the program. Phase II is built on four key concepts:

Increasing Coordination between Physical and Behavioral Health Care: The Department will contract with one Regional Accountable Entity (RAE) that is responsible for coordinating both physical and behavioral health for its enrolled members. The state will be divided in to seven regions. The regional entities will perform the duties previously held by the Regional Care Collaborative Organizations and Behavioral Health Organization prior to July 1, 2018. The RAEs will also be responsible for:

- Developing a network of Primary Care Medical Providers (PCMPs) to serve as medical home providers for their members,
- Developing a contracted statewide network of behavioral health providers,
- Administering the Department's capitated behavioral health benefit,
- Onboarding and activating members,
- Promoting the enrolled population's health and functioning, and
- Coordinating care across disparate providers, social, educational, justice, and other community agencies to address complex member needs that span multiple agencies and jurisdictions.

Mandatory Enrollment: In Phase II of the ACC, all full-benefit members (excluding members enrolled in Program for All-Inclusive Care for the Elderly / PACE) will be mandatorily enrolled in the ACC and immediately connected with a Primary Care Medical Provider (PCMP) or, if eligible, into one of the two limited managed care capitation initiatives. Mandatory enrollment gives members access to support from their RAE and the provider network upon Department approval.

Attribution by Geographic Location of Primary Care Medical Provider Site: Attribution is the method used to enroll members in their medical home (referred to as a PCMP). The geographic location of a member's attributed PCMP will determine a member's RAE assignment. Members can continue to choose their PCMP.

Value-based Payment: The Department seeks to improve tools and strategies that ensure accountability for the full range of services provided to members and the total cost of care. The RAEs will be held accountable by the Department for improved health outcomes and cost efficiencies by tying a greater proportion of their administrative payments to quality-based measures. The Department will continue to pay physical providers directly for the clinical services they offer in a way that promotes value. A capitation payment methodology will be retained for core behavioral health services that will be paid directly to the RAEs.

ACC Savings alone in FY 2018–19 is projected to be $145,824,407. For additional information on ACC Phase II, visit: CO.gov/HCPF/ACCPhase2.

PROVIDER COST AND QUALITY TOOLS

Beginning in fall, 2018, the Department will be rolling out a suite of powerful cost and quality assessment capabilities to the seven Regional Accountable Entities (RAEs)[12] as well as hospitals and Primary Care Medical Home providers (PCMHs). This new Prometheus tool enables us to identify potentially avoidable costs on member care, individual physicians, PCMHs, specialists and hospitals. Ultimately, this tool enables providers to improve their referral patterns towards more cost effective, higher quality physicians and hospitals, enables hospitals to identify and self-correct inefficient, lower quality care delivery or affiliated providers, allows RAEs to target members for care management, enables the Department to direct members seeking provider locator services to higher performing providers, and more. The Department has estimated $10 million in savings in its claims forecast

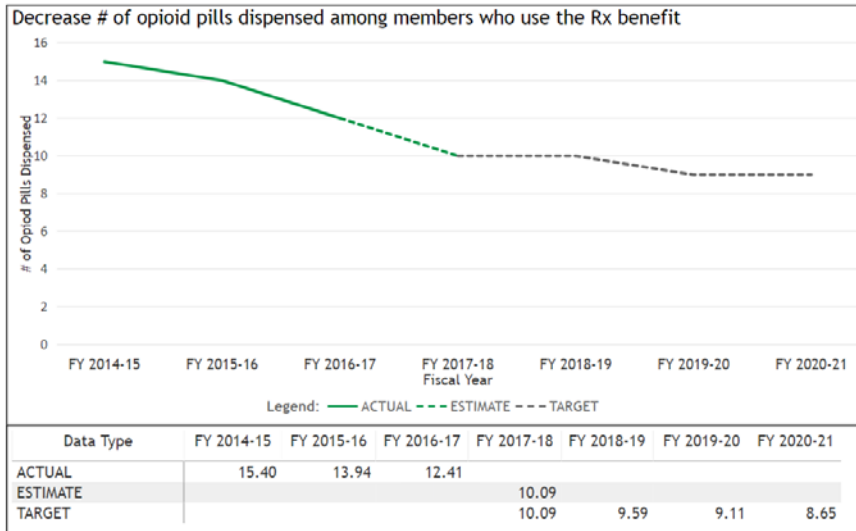---

[12] The Regional Accountable Entities or RAEs manage the Accountable Care Collaborative health care delivery system. Each of the seven is responsible for coordinating physical and behavioral health for enrolled members.

for FY 2018–19 due to implementation of Prometheus. To support adoption, during June-December 2018, we will deploy a robust user engagement campaign to inform and provide technical information to RAEs, hospitals, and other providers about these tools, and how using them can yield additional supplemental payments.

SPI #3 PARTNERSHIPS TO IMPROVE POPULATION HEALTH
The health of low-income and vulnerable Coloradans improves through a balance of health and social programs

Data Type	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	15.40	13.94	12.41				
ESTIMATE				10.09			
TARGET				10.09	9.59	9.11	8.65

At its peak, the opioid epidemic, which drove far too many opioids into the marketplace, included enough narcotic pain killers to have about one full bottle of addictive pain killers in every household in America. To reverse this trend, the U.S. health care delivery system and policy makers implemented countermeasures including new prescribing guidelines, scorecards to evaluate prescribers and their practice patterns against the norms, and databases to host patient utilization patterns.

The Department has been a leader in all of these areas, including performance results. Stemming from a number of efforts, both the number of opioid pills dispensed to Colorado Medicaid members and the number of members taking opioids have fallen more than 30% in the aggregate over the last three years. Going forward, our goal is to decrease the number of opioid pills dispensed per member per month in the pharmacy program 5% by the end of FY 2018–19.

REDUCING OPIOID AMOUNTS PRESCRIBED TO PREVENT ADDICTION

We will continue to adjust our prescribing policies during FY 2018–19, having reduced the number of opioid pills prescribed by 30% over the past three years. Our goal for all adjustments is to reduce the number of opioid pills available to members while ensuring appropriate access for pain management. As of July 1, 2018, we added short-acting opioids to our Preferred Drug List and will measure the impact of this addition during FY 2018–19 to determine need for further adjustments. Two additional adjustments will be investigated in tandem with appropriate stakeholder input processes: We will consider a further decrease to the Morphine Milligram Equivalent (MME) limit, and work toward reducing the maximum supply of opioids for dental procedures.

ADDRESSING THE CHALLENGES OF OPIOID MISUSE

Opioid use is a serious problem in Colorado and across the nation. Among other sources, we are utilizing data analytics assistance provided through a CMS Innovative Accelerator Program grant to gain a better understanding of how the opioid crisis is impacting Colorado Medicaid members. The grant is supporting efforts to streamline data sharing with our substance use disorder care management partner, the Office of Behavioral Health at the Colorado Department of Human Services (CDHS). The goal for both agencies is to establish a holistic picture of opiate use disorder care in the state to support development of policies and programs that meet our goals of controlling costs and better coordinating member services.
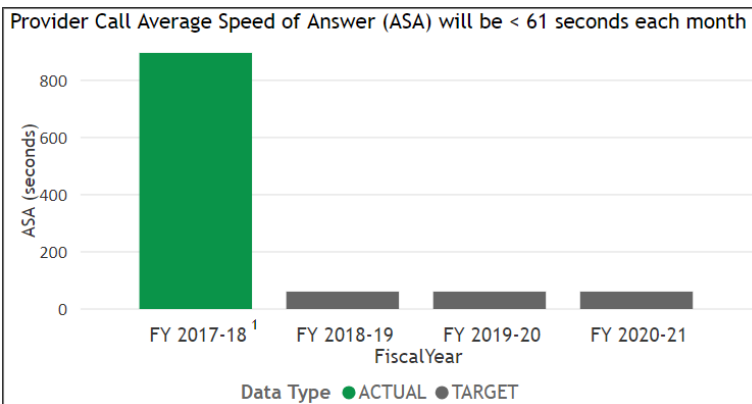
In tandem with this effort, the Department is supporting the *Lift the Label* campaign, which was rolled out in May of 2018 by CDHS. While the bulk of initiatives above focus on opioid addiction prevention by reducing inappropriate prescribing patterns, the *Lift the Label* campaign is designed to address those who are already addicted to opioids. The core of the campaign is designed to remove the stigma associated with addiction and to encourage individuals to seek help if they need it instead of struggling in silence, untreated.

IMPROVING ACCESS TO SUBSTANCE USE DISORDER SERVICES

The Substance Use Disorder treatment bill (HB 18–1136) was signed by the Governor on June 6, 2018. The bill requires the Department to pursue a federal waiver[13] for coverage for inpatient residential substance use disorder treatment. The waiver will strengthen the continuum of behavioral health benefits in the Colorado Medicaid program. The Department will work with stakeholders and substance use disorder experts to design the benefit during the next year.

SPI #4 OPERATIONAL EXCELLENCE
We are a model for compliant, efficient and effective business practices that are person- and family-centered

Provider Call Average Speed of Answer (ASA) will be < 61 seconds each month

Data Type	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	896			
TARGET		61	61	61

1 Available data for FY 2017-18 limited to March 2017 - December 2017 due to major system change with COMMIT. Performance adversely impacted by higher call volumes.

Provider call average speed of answer will be <61 seconds each month in support of improved service to providers – the most critical partners in serving the needs of our Medicaid population.

This focus recognizes the many program implementations in process for FY 2018–19 and the need to provide strong service to our providers in order to support them. These new programs include ACC Phase II RAE implementation (July 1, 2018), Hospital Review (January 1, 2019), ClaimXten (July 1, 2019), External Visit Verification (January 1, 2019), and a variety of new utilization review and prior authorizations (January 1, 2019).

PROVIDER SERVICES CALL CENTER

The Department's provider services call center vendor has implemented improvements focused on benefitting providers in need of assistance. These include new training modules, quality monitoring, and additional staff to ensure provider calls are answered efficiently and effectively. Our agreement with the vendor includes a performance standard of <61 seconds for answering phone calls. Setting this standard represents an ambitious goal due to implementation of significant changes to the Accountable Care Collaborative and our enhanced focus on claims cost controls beginning July 1, 2018. We will be adding additional, stronger call center metrics by October 2018. These include how long calls are on hold, and how many are resolved the first time a provider calls.
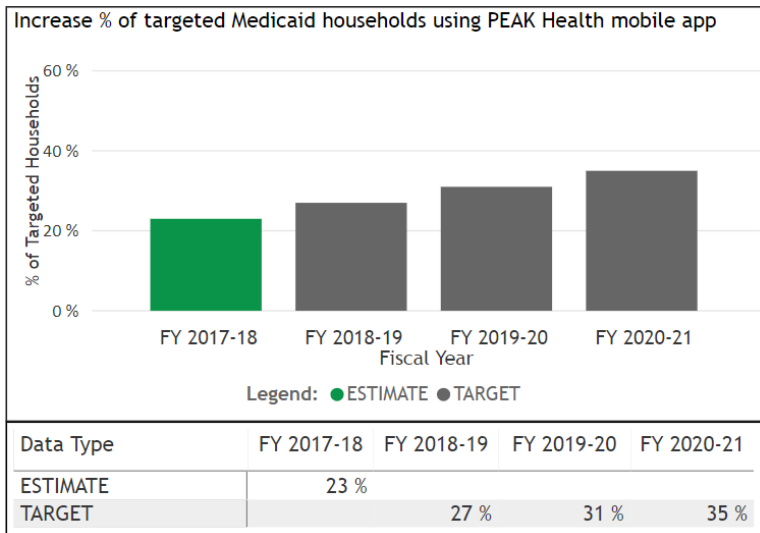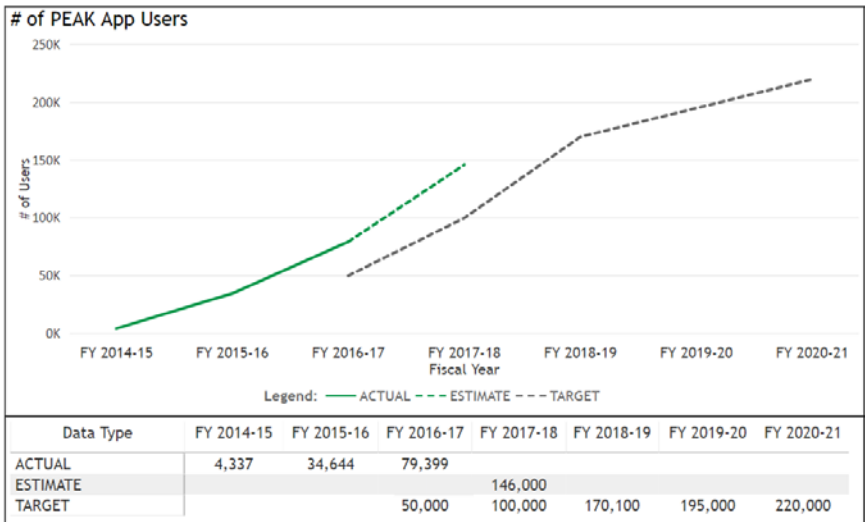
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[13] The waiver will allow Colorado Medicaid to cover residential and inpatient substance use disorder services for persons who meet need requirements defined by nationally recognized, evidence-based level of care criteria.

PEAK*HEALTH* APP OPTIMIZATION

The free PEAK*Health* app was created to simplify and improve member experience accessing and updating account information. It leverages members' preferred means of accessing online information – through their mobile phone. During FY 2018–19, we will be working with RTD to provide public transit special discount cards for certain populations through the mobile app. In the graphic to the left, *targeted households* include all households enrolled in Medicaid, minus those in eligibility categories that are unable to manage benefits using a mobile app, such as individuals in long term care settings.

Data Type	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ACTUAL	4,337	34,644	79,399				
ESTIMATE				146,000			
TARGET			50,000	100,000	170,100	195,000	220,000

Data Type	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ESTIMATE	23 %			
TARGET		27 %	31 %	35 %

PROCUREMENT AND CONTRACTS PROCESS IMPROVEMENT

We are increasing the efficiency and performance of our vendor partners through improvements in our procurement, contracting, and training practices. The Department acts as a small health plan, delivering health benefit services to 1.2 million in Colorado. This membership figure is dwarfed by larger commercial payers such

as United Health Group and Anthem, which together serve about 90 million nationally. The Department's administration of benefit services is facilitated through relationships with about 395 vendor partners. Operational enhancements are in the areas of:

- Executive review of procurement necessity to ensure alignment with Department goals and priorities
- Expert assistance with RFP decision criteria
- Integration with other related Department pursuits
- Request for Proposal and contract discipline focused on vendor accountability, expectations, service level agreements, and termination provisions
- Contract manager assignments and training
- New contract management content and execution oversight

ADMINISTRATION BUDGET MANAGEMENT DISCIPLINE AND ACCOUNTABILITY

This fiscal year and going forward, the Department will have a formal goal of managing operations within its Administrative budget allocation. This is defined as the monies that finance full- and part-time staff and vendor partner contracts necessary to administer programs under the Department's authority such as Medicaid and CHP+. Department leadership, in cooperation with our Finance Office, will ensure budgets are communicated to and managed by office directors and managers. This renewed emphasis on budget discipline and accountability aligns with the procurement and contracts focus discussed above, and requires continual improvement and responsibility for performance by functional area, as well as return on investment from vendor partners.

This allocation and separation enables the Department to more clearly track and communicate the importance of investing in claim cost control programs to better manage Medicaid claim costs and trends. The Administrative budget ($335.4 million) is less than 4% of our overall budget of $10.1 billion.

FY 2018-19 Total Administration		
	Total Funds	General Fund
Total HCPF Appropriation	$10,130,526,763	$2,891,689,537
HCPF Admin	$335,389,423	$84,686,455
Percent of Total	**3.31%**	**2.93%**
HCPF Personal Services	$46,768,516	$16,268,121
Percent of Total	**0.46%**	**0.56%**

Compared to commercial carriers and far larger health plans, this Administrative allocation is incredibly low, reflecting a significant opportunity to increase claim cost control and quality improvement programs and innovations. Overall, this will enable us to achieve significant reductions in the much larger claim cost allocation of $9.79 billion.

The Department is confident it can do this well and in collaboration with stakeholders, advocates, providers, the Governor's Office and expert advisers to the benefit of Medicaid and CHP+ members, the State and taxpayers.

INTEGRATED PERFORMANCE MANAGEMENT PROGRAM

This program provides structure and expertise to support the Department in achieving operational excellence through strategic planning, performance management, performance measurement, and Lean. Program staff provide training, facilitation, and coaching workshops to cross-functional teams and individual business units, with the goal of supporting the agency in achieving continuous improvement throughout its operational processes and organizational culture. We are integrating strategy with operations and Lean using a three-tiered approach that strengthens teamwork across all levels of the organization and ensures team operations are aligned with and driving success towards strategic goals.

Organizational Chart

FY 2018-19 Organizational Chart & Payroll Budget

Executive Director's Office
Kim Bimestefer, Executive Director
2.5 FTE
$385,648 Budget

Office of Community Living
Gretchen Hammer, Director
69.3 FTE
$6,647,229 Budget

Health Programs Office
Gretchen Hammer, Director
68.7 FTE
$6,403,494 Budget

Finance Office
John Bartholomew, Director
116.0 FTE
$11,763,803 Budget

Health Information Office
Chris Underwood, Director
104.1 FTE
$9,891,504 Budget

Client & Clinical Care Office
Judy Zerzan, Director
37.1 FTE
$3,826,376 Budget

Policy, Communications, & Administration Office
Tom Massey, Director
103.2 FTE
$8,514,206 Budget

Cost Control Office
Stephanie Ziegler, Director
5.4 FTE
$501,109 Budget

The Department's FY 2018-19 spending authority of $10.1 billion cannot be broken down by organizational unit because medical services for Medicaid members are provided through inter-office efforts. For this reason, dollar amounts listed in the organizational chart reflect only payroll appropriations from the Long Bill and Special Bills.

Department Description

Executive Director's Office

Kim Bimestefer was appointed Executive Director of the Department effective January 8, 2018. The Executive Director is responsible for setting the strategic direction of the Department, defining its vision and mission, and ensuring the Department operates in an efficient and effective manner. The Executive Director creates alignment between Department initiatives and the priorities of the Governor's Administration to ensure our state meets the Governor's vision of Colorado becoming the healthiest state in the nation. Areas of responsibility for the Executive Director include general governance and financial accountability of the Department and building relationships with partners within and outside of state government.

Health Programs Office

The Health Programs Office oversees Colorado's Medicaid and Child Health Plan *Plus* acute care physical and behavioral health programs including the Accountable Care Collaborative (ACC) program. The Office manages benefit policy development and oversight and key operational functions including utilization management, benefit coverage appeals, and federal and state compliance activities.

Health Information Office

The Health Information Office develops, implements, and maintains the Department's Health Information Technology (HIT) and related Information Technology (IT) infrastructure, while coordinating with the Governor's Office of Information Technology and other stakeholders on HIT and IT projects that impact the Department. Major responsibilities of the Health Information Office include enhancing and maintaining the Department's health care claims payment system or MMIS, member eligibility system (Colorado Benefits Management System or CBMS), Business Intelligence Data Management System (BIDM), and supporting Department operations related to claims processing and member eligibility.

Client and Clinical Care Office

The Client and Clinical Care Office provides clinical expertise and advising regarding Department services, programs, policy, and performance. The Office's functions are as follows: Oversees access to medication for Medicaid clients; establishes standards for analysis of data utilized in Department decision making; provides data and analytical services inside the Department and externally to stakeholders, partners, and others who request it; and conducts and coordinates performance improvement activities supporting care and services delivered by Colorado Medicaid and Child Health Plan *Plus*.

Finance Office

The Finance Office is responsible for the financial and risk management operations of the Department. Its divisions and functions are as follows: The Budget Division presents and defends our budgetary needs to Colorado executive and legislative authorities and monitors our caseload and expenditures throughout the fiscal year. The Controller Division oversees the Department's accounting functions. The Rates and Payment Reform Section is responsible for monitoring, developing, and implementing rates for payments to providers, including value-based payments and managed care rate setting. The Special Financing Division administers funding to qualified medical providers who serve low-income Coloradans and researches methods for leveraging federal funds and funds from other

sources to offset the expenditure of state General Fund dollars. The Audits and Compliance Division assists in ensuring Department compliance with state and federal law, identifies and recovers improper payments to providers, and conducts preliminary investigations of fraud. The CFO is responsible and accountable for our financial data and reporting, and for use of data analytics to define value and measure quality with regard to Department operations. The CFO develops our financial and operational strategy, and generates actionable analytics tied to that strategy.

Policy, Communications, and Administration Office

The Policy, Communications, and Administration Office manages Department functions associated with government affairs, communication and media relations, member services, legal affairs, grant-funding, and internal operations. It provides leadership and guidance regarding external communication and relations, legal affairs, organizational development, and strategy. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press.

Office of Community Living

The Office of Community Living oversees Colorado Medicaid's long-term services and supports programs. The Office manages efforts to transform Colorado's long-term services and supports system into a person-centered system that ensures responsiveness, flexibility, accountability, and person-centered supports for all eligible persons.

Total Medical Cost and Claim Management Office

The Medicaid Cost Containment bill[14] requires the establishment of a new office focused on controlling claim costs and trends beginning July 1, 2018. The Office is to include a director reporting to the Department's Executive Director, and six additional staff to start. The Department expects to fill the director position by the end of July 2018. The Office may focus on health care delivery efficiencies, tools to assist providers in evaluating cost and quality associated with their clinical pathways, Regional Accountable Entity care management, population health management performance results and program efficacy, data insights that identify opportunities for further cost-control strategies, value-based and other alternative payment methodologies, pharmacy guidance and expertise, utilization review program results and vendor performance, innovations in health care, and the 3–5 year cost control roadmap and its recommended approaches.

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[14] Colorado Senate Bill 18–266, passed in May, 2018.

FY 2017–18 Performance Evaluation

Q3 FY 2017–18 (APRIL 2018)

Strategic Policy Initiatives

The Department of Health Care Policy and Financing identified several strategic policy initiatives, or SPIs, to be accomplished in FY 2017-18 as part of its annual performance plan. Due to data sources with reporting lag time, data is available at varying intervals. Alphabetical footnotes beneath each table describe performance; numeric footnotes provide technical information. Additional detail about the Department's SPIs is available in the FY 2017-18 Department Performance Plan.

SPI 1: Delivery Systems Innovation: Medicaid members can easily access and navigate needed and appropriate services

Work supporting this SPI focuses on strengthening delivery systems such as the Accountable Care Collaborative (ACC), Behavioral Health Organizations, and Home and Community Based Services for the Elderly and Disabled. In addition, we are working to increase integration of physical and behavioral health services.

Performance Measures	FY17 YE	FY18 Q3	1-Year Goal
% ACC members with an enhanced primary care medical provider [a]	57%	55%	65%
# Benefits modified to align with new data, research, or evidence-based guidelines [b]	102	271	60
# Colorado providers serving Medicaid [c, d]	45,429 [1]	48,841 [1]	57,000
# Colorado primary care providers serving Medicaid [c, d]	21,398 [1, 2]	22,838 [1, 2]	25,500
% Nurse Advice Line calls referred to more appropriate level of care	50%	60% [3]	55%
# PEAK App users	79,399	128,301	100,000
% New mothers receiving maternal depression screening [e]	25%	27%	27%
# Members in practices that receive behavioral health integration incentives [f]	155,500	136,651	400,000
# Community Living Advisory Group recommendations fully or partially implemented	18	23	21
% Persons receiving HCBS services expressing social inclusion or connectedness to the community	45%	N/A [4]	46%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services	67%	N/A [4]	68%

1 This measure restates prior years' reporting to include only providers within Colorado.
2 Data corrected to remove duplication. Revised methodology includes Physicians, Osteopaths, Family/Pediatric Nurse Practitioners and Physician Assistants.
3 Data lagging—updated through December 2017.
4 Data not yet available.

[a] The decline in ACC members attributed to a PCMP is likely due to provider revalidation and implementation of the new interChange. The Department is working with RCCOs to ensure members are appropriately attributed to a PCMP, and will continue assisting providers in becoming certified as enhanced PCMPs.
[b] The increase in benefits modified is primarily due to benefits modified within the Federal Waiver Renewal related to Community Mental Health Supports in Oct 2017. These changes relate to a five-year cycle and are a unique situation.
[c] Results show steady growth from FY 2016-17 to Q1 FY 2017-18.
[d] Provider enrollment methodology was updated in March 2017 due to launch of Commit and BIDM. Historical data restated.
[e] Methodology adjusted in FY 2016-17 to include screenings not in the billing system. Historical data restated.
[f] Fluctuation is primarily a function of SIM cohort timing. SIM Cohort 1 practices received fiscal support during their active engagement (March 2016-March 2018). SIM Cohort 2 began in Sept. 2017. Numbers are higher when cohorts overlap. The SIM office is working towards program sustainability and promotes continuation of efforts.

SPI 2: Tools of Transformation: The broader health care system is transformed by using levers in our control such as maximizing the use of value-based payment reform and emerging health technologies

Medicaid, like Medicare, is an influential payer and policy maker nationwide. This makes it possible to use levers within our control to impact the broader health care system. For example, by implementing provider payment incentives to improve health outcomes in the Accountable Care Collaborative, we align with other payers in Colorado to use and improve upon these incentives. The same applies to the use of advanced health information technology and data analytics to improve quality and continuity of care. Work supporting this SPI focuses on increasing the impact of Colorado Medicaid investments and innovations to transform the broader health care system.

Performance Measures	FY17 YE	FY18 Q3	1-Year Goal
$ Provider payments tied to quality or value through innovative payment methods	$447,025,667	$688,328,200 [1]	$1,102,223,409
$ Total costs avoided from ACC and Medicaid (in millions) [a]	$118	$133 [2]	$82
$ Medicaid per-capita total cost of care [b, c]	$5,902	$6,928 [2]	$6,084
Providers with a quarterly report card; % of expenditures	24%	26% [1]	26%
# Primary care providers who log in to SDAC/BIDM portal	661	745 [3]	645

1 Data lagging—updated through Feb 2017.
2 Annual estimate. Data not yet available.
3 SDAC—State Data Analytics Contractor; BIDM – Business Intelligence and Data Management system.

SPI 3: Partnerships to Improve Population Health: The health of low-income and vulnerable Coloradans improves through a balance of health and social programs made possible by partnerships

The Department seeks to improve the health and well-being of Coloradans served by the Medicaid program and of the population as a whole. Appropriate health care must be complemented by addressing additional determinants of health – social, economic, and geographic among them. This SPI focuses on our efforts to advance community-based health supports in partnership with entities including other state agencies, local public health organizations, non-profits, health care providers, and community centers.

Performance Measures	FY17 YE	FY18 Q3	1-Year Goal
# Members in counties with a RCCO-LPHA relationship [a]	846,355	782,685 [1, 2]	840,000
# SIM education activities targeted toward PCMPs and community partners	26	32 [3, 4]	33

1 Estimate. Data available annually in November.
2 RCCO – Regional Care Collaborative Organization; LPHA – local public health agency.
3 SIM – State Innovation Model project for physical/behavioral health integration and payment reform; PCMPs – primary care medical providers.
4 Data lagging—updated through Dec 2017.

[a] The decline is due to decreased Medicaid member enrollment and is expected to increase once ACC Phase II is fully implemented in July 1, 2018.

SPI 4: Operational Excellence: We are a model for compliant, efficient and effective business practices that are person- and family-centered

To achieve this SPI we are redesigning our information technology infrastructure, improving data analytics capacity, advancing a culture of continuous improvement, and nurturing a well-trained, satisfied workforce.

Performance Measures	FY17 YE	FY18 Q3	1-Year Goal
% Favorable responses to employee survey "We get work done more efficiently…"	46%	54%	50%
% Employee retention for 36 months or more	58%	58%	50%

Performance Measures	FY17 YE	FY18 Q3	1-Year Goal
% Electronically submitted clean claims processed within 7 business days	98%	99%	95%
% Providers notified of missing or incomplete enrollment information within 5 business days	95% [1]	100%	100%
$ Dollar equivalent of Lean efficiency gains (cumulative) [a]	$479,057	$ 535,002 [2]	$658,512
% First call resolution by Member Contact Center [b]	89%	85%	90%
# Items vetted through person-centered advisory councils	59	58	50
% Persons receiving HCBS services with person-centered goals identified in their service plan	54%	55% [1]	55%
$ Dollars recovered from overpayments to providers	$6,662,965	$10,821,503	$10,000,000
$ Dollars recovered from third party liability [c]	$72,058,987	$35,624,124 [1]	$77,000,000
% Existing Office of State Auditor recommendations resolved	N/A [3]	N/A [3]	N/A [3]
# Individuals enrolled in Medicaid/CHP+	1,411,157	1,379,106	1,483,524
% Eligibility determinations processed timely	98%	96%	98%
% Real time eligibility (RTE) applications [d]	55%	63%	62%

1 Estimate. Data not yet available.
2 Data corrected
3 Audit recommendations data unavailable due to malfunctioning database

[a] Based primarily on estimated savings from one department-wide project, Travel Approvals. Reduction in savings is due to a reduction in staff travel.
[b] The MCC lost several tenured and experienced staff in Q2. Additionally, the Dept. implemented a billing process change that drove additional call backs from members.
[c] The lack of recoveries is due to System issues (the implementation of interChange and BIDM). Functionality needed to collect full recoveries is expected to be fully implemented by FYE 2017-18 and the Department anticipates increased recoveries in FY 2018-19.
[d] Data reflects all applications submitted that receive an RTE determination. Not every application is eligible for an RTE determination.

Glossary

ACC — The Accountable Care Collaborative is the health care delivery system for Medicaid in Colorado and is designed to affordably optimize member health, functioning, and self-sufficiency. Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) that serve as medical homes work together in collaboration with other health providers and members to optimize the delivery of outcomes-based, cost-effective health care services.

Accountable Care Collaborative – See ACC

BIDM — Business Intelligence and Data Management system

Capitation — provider payment arrangement based on the number of enrolled individuals assigned to the provider, per period of time, whether or not those individuals seek care

Centers for Medicare & Medicaid Services — See CMS.

CHP+ — Child Health Plan *Plus*. A low-cost health insurance program for uninsured Colorado children under age 19 and prenatal women whose families earn too much to qualify for Medicaid but cannot afford private insurance.

CMS — The Centers for Medicare & Medicaid Services, the federal agency overseeing the Medicaid program. CMS works in partnership with state governments to administer the Medicaid and the State Child Health Insurance programs.

FY — fiscal year. The State of Colorado's fiscal year is July 1-June 30.

HCPF — Colorado Department of Health Care Policy & Financing

Health Neighborhood – A network of Medicaid providers that support a member's health and wellness.

Medical Home — An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers, and, where appropriate, the member's family.

MMIS — Medicaid Management Information System; the hardware, software, and business process workflows that processes the Department's medical claims and payments. Additional functions include provider enrollment and management, certain member management functions, and analytics and reporting.

PEAK — Program Eligibility Application Kit

Regional Accountable Entity (RAE) —The ACC health care delivery system is administrated by seven Regional Accountable Entities. The Regional Accountable Entities or RAEs manage the Accountable Care Collaborative health care delivery system. Each of the seven is responsible for coordinating physical and behavioral health for its enrolled members and supporting network providers.

Medicaid State Plan — An agreement between a state and the federal government describing how that state administers its Medicaid and CHP+ programs. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

Waiver – A program that sets aside Medicaid State Plan requirements in order to provide a specific member population with needed services.