Health Care Policy & Financing

FY 2019–20 PERFORMANCE PLAN

COLORADO
Department of Health Care
Policy & Financing

Contents

Colorado Department of Health Care Policy & Financing

Introduction

The Colorado Department of Health Care Policy & Financing's FY 2019–20 performance plan is our annual report on progress we are making in achieving our mission and supporting goals. It begins with an overview of our strategic framework and the performance measures we have selected to gauge progress, and it continues with a selection of strategic work and a summary of our operations. The audience for this report is the legislature and the people of Colorado, as well as Department staff.

Department Overview

The Department is the single Colorado state agency responsible for administering the Medicaid program (Title XIX of the Social Security Act) and the Children's Health Insurance Program (Title XXI of the Social Security Act). 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.

We serve Coloradans who are eligible for and/or enrolled in Medicaid and the Children's Health Insurance Program (CHIP), and those who receive services through the other programs described above. In serving these customers, we partner with medical, dental, behavioral health, and long-term services and supports providers; other state agencies; the Centers for Medicare & Medicaid Services (CMS); 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.

Colorado's Medicaid program receives approximately 59% of its funding from the federal government, and its CHIP program is approximately 79% federally funded.

Environmental Factors

One of the most critical factors impacting our Department is the escalating cost of health care in Colorado and across the nation. As a trusted health care expert, and in partnership with other health care thought leaders, the Department is focused on research, analytics, and reporting that identifies the drivers of rising costs and alternatives to address them. Below are some of the most prominent environmental factors the Department is focused on addressing.

- **Health care delivery system**: The participants in this delivery system – hospitals, physicians and other providers – are key stakeholders in our battle to control rising costs. The reduction in hospital charity care due to Colorado's low uninsured rate (6.5%) has increased hospital profit margins across the front range and in our resort communities. Excess earnings have been used to fuel the "arms race" for market share, construction, and the purchase of physicians and other hospitals. All of this contributes to rising costs. The Department has taken a strong leadership role to drive improvements in delivery system efficiency, quality, and affordability in response to these changing market characteristics. We are 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 procedure. In collaboration with the Attorney General's Office and the Colorado Hospital Association, we are also creating new alternate payment methodologies to be used by all payers to facilitate patient referrals to care centers of excellence. We are also implementing the Hospital Transformation Program to reward hospitals for changing the behaviors that are at the core of rising health care costs. Ultimately, our partnerships to help encourage the right care, at the right provider, in the right setting, and at the right price are critical to transforming Colorado's health care ecosystem.

- **Prescription drug costs**: The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid and all health plans. While we are able to consistently and diligently evolve our cost control initiatives to manage generic and brand name drugs, the Department – along with the country – is struggling to manage high-cost, specialty drugs. Specialty drugs represent only 1.5% of Colorado Medicaid's pharmacy claims but account for 40% of its total pharmacy spending – in line with the rest of the nation. Given that the cost of these medications has increased an average of 28.5% per year over the past six years (a total of 171%), addressing high cost drug costs through emerging policy – for both the state of Colorado and for Medicaid – is one of our most pressing priorities.

- **Health of the Medicaid population:** Addressing higher than average obesity, tobacco use, addiction, and behavioral health needs is a top opportunity for the Department. Our partnership with the Colorado Department of Public Health and Environment in addressing these opportunities is critical. Colorado Medicaid covers more than 40% of the births in the state, so our emerging focus on maternal health, prenatal care, and healthy outcomes is also paramount.

- **Changes to federal health care policy:** Medicaid is a state-federal financial partnership. About 59% of our funding comes from the federal government. Changes in eligibility definitions, benefit coverage policy, and federal financing available to the state of Colorado are critical environmental factors impacting our work. The Department closely monitors proposals by Congress and the White House that would impact Medicaid and CHIP policy, caseload, population health, or revenue and responds with appropriate strategic adjustments. We are increasing our compliance staff to manage increasing changes in guidance and expectations from our federal partners.

Major internal Department changes

We continue to implement structural changes to better manage the largest health plan in the state (Medicaid), improve service to members and stakeholders, improve our operational performance, promote executive accountability, enhance our ability to control costs and trends, and help our employees thrive. Changes recently implemented or underway include:

- **Medicaid cost control initiatives:** In addition to our Affordability Roadmap initiatives, we are focused on many other cost control initiatives such as: curbing fraud, waste, and abuse; evolving our Accountable Care Collaborative strategy; delivering care and services in community-based settings to our members who need long-term services and supports; data analytics, reporting and insights that help inform care support and programming strategy; and modernizing our medical claim edits and utilization management programs. Overall, there are more than 15 workstreams inside the Department focused on Medicaid claim trend management.

- **Care management, outreach, and support:** Over the last year, we have made significant investments in our analysis and reporting systems, which enable us to identify those members who are at the highest risk for complications. Reports are now produced by the Department to help our Regional Accountable Entities (RAEs) identify those members who would most benefit from support and care coordination to improve their health and better control the costs of their care. We are also partnering to improve the outreach programs used by the RAEs to more effectively improve member health and reduce claim costs.

- **New Cost Control and Quality Improvement Office:** Senate Bill (SB) 18-266, *Controlling Medicaid Costs*, provided funding to establish this new Department Office. The Office includes our analytics, reporting, and insights staff; quality analytics staff; clinical leadership (i.e. Chief Medical Officer, Chief Nursing Officer); cost control programming; and Regional Accountable Entity partnership. The Office has driven our analytics and insights – which are now driving our strategy – to a whole new level.

- **New Executive Leadership Team:** The Executive Leadership Team creates a higher level of accountability for health plan management by functional area (i.e. legal, human resources, eligibility, claims processing, member services, etc.) and business area (i.e. Medicaid, CHIP, pharmacy, etc.). This leadership team is responsible for managing the health plans and all offerings. The Executive Director employs a Strengths Based Leadership methodology to ensure the right experience and talent assume the positions that can maximize their capabilities and potential to improve Department performance.

- **Medicaid operations focus:** Department operations such as program eligibility, claims processing, member and provider call service centers, primary care (PCP) attribution, ID card production and distribution, and member and provider communications are spread across the Department under the management of a number of Executive Leadership Team members. The Executive Director has created a new Chief Operating Officer role to oversee Medicaid Operations with the goal of improving executive accountability, customer service, operations efficiency, and program implementation.

- **Vendor management:** While Medicaid is the largest health plan in the state, serving about 21% of Colorado's population, it is far smaller than commercial payers such as United Health Care which serves about 50 million Americans, or Anthem which serves about 40 million Americans. Where appropriate, smaller plans like ours utilize contractors in order to maximize the systems and expertise they can deliver. In round figures, the Department spends about 10 times more on vendor fees then it does on FTE (full-time equivalent) staff. In recognition of this, major changes have been implemented in our vendor management process to ensure we are paying the right price for the right service to the right partner, and that we are holding our vendor contractors accountable. We will continue to review where vendor partners should be replaced by staff, with a focus on enhancing and better controlling core capabilities.

Developing this Year's Performance Plan

To set the stage for our FY 2019–20 strategic plan, we conducted a series of studies and planning workshops over the past year. Our Executive Director led a process with staff to review internal factors – strengths and weaknesses – to identify emerging areas of focus. This included holding employee meetings to solicit input on internal operations, our strengths and weaknesses, as well as how to modernize our mission statement. To

identify our external opportunities and threats, we met with members, providers, payers, and elected officials. We also convened workgroups to identify projects and initiatives that would address areas of opportunity.

Strategic Framework

The Department is in the process of modernizing its mission and vision. All employees are engaged in this effort, along with our Member Experience Advisory Council. This work will be complete by the fall of 2019. The below represents our current mission and vision.

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

Health Care Affordability for Coloradans	Medicaid Cost Control	Member Health	Customer Service	Operational Excellence
Reduce the cost of care in Colorado	Ensure the right services for the right people at the right price	Improve member health	Improve service to members, care providers, and partners	Create compliant, efficient, and effective business practices that are person- and family-centered

Initiatives

Operations

Values

Our Core Values:

- **Person-Centeredness:** Adapting to the needs of those we serve is at the forefront of our strategic planning, operational enhancements, and priority management.

- **Accountability:** We hold ourselves and our partners accountable to higher standards of performance, to meeting the complex needs of those we serve, and to prudently spending administrative and claim dollars. We accept responsibility for our actions, learn from our experiences, and inspire others to do the same.

- **Health Care Expertise, Credibility and Leadership:** As a trusted partner to legislators, Coloradans, members, and stakeholders, we produce fact-based reports and insights to inform effective health care policy to the benefit of Coloradans.

- **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. We invest in our employees to help them thrive.

- **Integrity:** We behave ethically, treat others with dignity and respect, and align our actions with our mission and vision.
- **Diversity:** We value diversity of thought, background and experience. This contributes to better decisions, programs, outcomes, and service to our customers.
- **Passion to Serve:** Department staff come to work each day to help our members rise and thrive. We manage our resources to ensure we can serve those who rely on our programs.

Strategic Elements and Associated Performance Measures

Strategic Elements

Pillars: Significant objectives for the current fiscal year. Destination oriented, achievable through strategic initiatives, and measurable by SMART performance measures.

Performance Measures: Gauge progress in achieving pillars. Performance measures can be influenced by business units, and are predictive of success or failure.

Pillars and Performance Measures

This section presents our five pillars and supporting performance measures.

Pillar	Definition	Measures of Success
1. Health Care Affordability for Coloradans	Reduce the cost of care in Colorado	Conduct extensive educational outreach to businesses, constituents and thought leaders about Colorado's Health Care Affordability Roadmap to identify the cost drivers and best practices in health care. Increase engagement in the Roadmap from 2,220 (2019) to 3,500 (2020).
		Develop a report by December 31, 2019 to inform effective prescription cost control policy.
		Implement a Colorado payer prescription tool by June 30, 2020 that results in lower prescription drug costs.
		Receive CMS approval for Colorado's Hospital Transformation Program (HTP), and implement the HTP by June 30, 2020.
		Implement no fewer than 10 HTP standards by June 30, 2020, that are focused on lowering hospital costs.
2. Medicaid Cost Control	Ensure the right services for the right people at the right price	Achieve $6,780 per member per year ($565 per member per month) in average annual Medicaid per-capita total cost of care, excluding all supplemental and other financing payments.

Pillar	Definition	Measures of Success
		Work with the Regional Accountable Entities (RAEs) to better manage the highest risk and highest cost Medicaid members. Identify the members who would benefit the most from RAE support, and identify the areas where Medicaid health care costs are rising by September 1, 2019. • Work with the RAEs to identify programs that will improve Medicaid member health and better control costs by March 1, 2020. • Conduct stakeholder feedback by May 15, 2020.
3. Member Health	Improve member health	Decrease the # of opioid pills dispensed among members who use the prescription drug benefit by 8%, from 8.11 to 7.46 by June 30, 2020. Develop a baseline risk score for every member and aggregate those scores to be used for future specific member risk score targets and State agency shared goals by June 30, 2020.
4. Customer Service	Improve service to members, care providers, and partners	Maintain provider call average speed of answer ≤ 61 seconds for FY 2019–20.
5. Operational Excellence	Create compliant, efficient, and effective business practices that are person- and family-centered	Complete contract management training for 100% of contract managers and executive team leaders by June 30, 2020.

A Word About Measures and Alignment

- 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 2018–19, as actuals will not be available for all measures until December 2019. A glossary of acronyms and relevant terms is provided at the end of this document.

Fulfilling the Governor's Health Goal for the State of Colorado

The Governor has appointed Lieutenant Governor Dianne Primavera as Director of the newly created Office of Saving People Money on Health Care. That office is helping to coordinate the work of Colorado state agencies that impact health care, including the Department of Health Care Policy & Financing.

The new office has set out 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.[1] The Department is a key player in achieving its action steps, as they align with Department workstreams focused on controlling Medicaid claim costs.

Pillars and Strategic Initiatives

This section presents our five pillars, each accompanied by a selection of initiatives representing transformative work underway to achieve the pillar. Many of the initiatives described in this section support more than one pillar; primary connections are emphasized in this report. Performance measures described in this section align with pillars.

Pillar 1: Health Care Affordability for Coloradans

To advance the Governor's vision for saving people money on health care, the Department created a Health Care Affordability Roadmap that identifies cost drivers and cost control policies to address them. The Roadmap is intended to inform the State's and Medicaid's affordability strategy. Likewise, Medicaid cost control findings and strategy are intended to inform the Roadmap. The roadmap includes strategies to:

1. constrain prices, especially hospital and prescription drugs,
2. champion alternative payment models,
3. align and strengthen data infrastructure,
4. maximize innovation, and
5. improve population health.

A list of Affordability Roadmap initiatives follows below.

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[1] https://www.colorado.gov/governor/news/gov-polis-unveils-roadmap-lowering-health-care-costs

Pharmacy solutions

- Shared Physician prescribing tool
- Manufacturer-carrier compensation (including rebates)
- Pharmacy pricing transparency
- Joining lawsuits – manufacturer price fixing, opioids
- The Department's prescription drug cost drivers and solutions report

Hospital solutions

- Hospital Transformation Program
- Financial transparency
- Hospital centers of excellence
- Alliance model, driving community reimbursements
- Analytics by hospital, for communities

Alternate Payment Methodologies

- Hospital Transformation Program
- Out of network reimbursements
- Prescription drug value-based contracting
- Value-based rewards
- Procedural bundles
- Total cost of care incentives, to Include prescription drugs

Shared Systems Priorities and Innovations

- All-Payer Claims Database affordability supports, including employer data
- TeleHealth, TeleMedicine and eConsults, broadband
- End-of-life planning
- Analytics: potentially avoidable costs/complications
- Universal coverage

Population Health Focus Areas

- Teen vaping, adult tobacco use
- Obesity
- Maternal health
- Addiction, including opioids
- Behavioral Health Task Force, executive order
- Suicide prevention
- Hospital transparency: Community Health Needs Assessments

Measure

This measure includes attendees at conferences/meetings with thought leaders where Executive Director Bimestefer or a Health Care Affordability Roadmap senior team member is presenting.

Increase # of Stakeholders Engaged in the Affordability Roadmap to 3,500 by June 30, 2020

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Marc	Apr	May
Actual	691	1,059	1,159	1,265	1,415	1,470	1,535	1,885	2,015	2,220	2,662
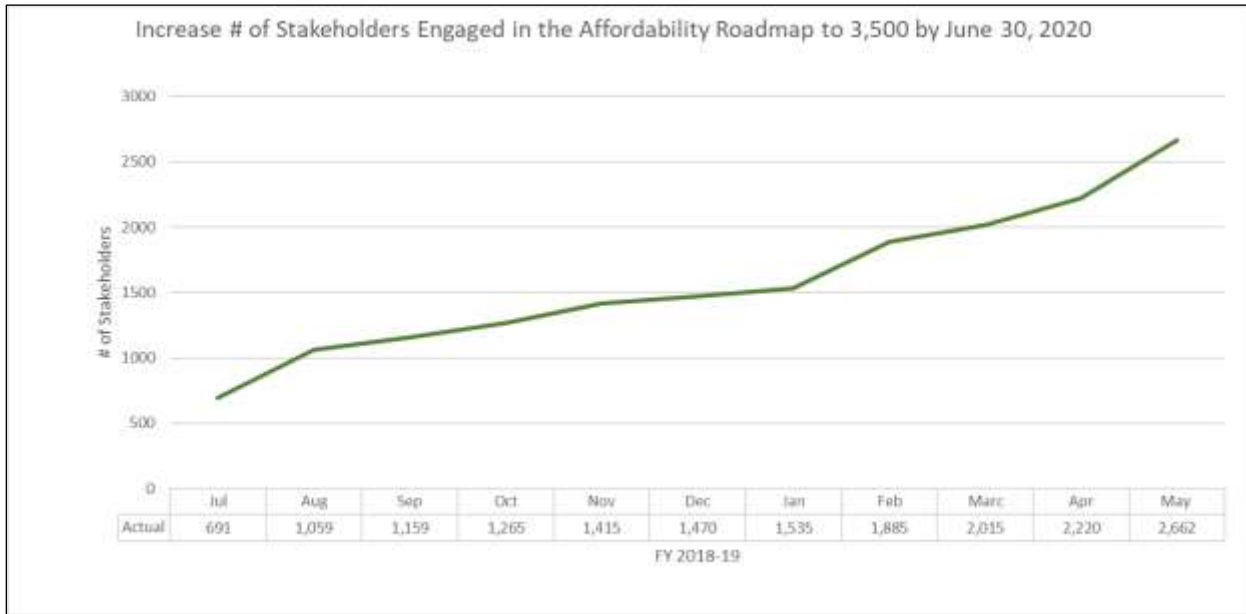
FY 2018-19

Performance Evaluation

During FY 2018–19 we exceeded the target of 1,000 with 2,662[2] for the fiscal year, and have set a target to reach 3,500 stakeholders by the close of FY 2019–20.

Supporting Initiatives

A selection of initiatives we are pursuing in support of our *Health Care Affordability for Coloradans* pillar follows below.

Rx Shared Provider Tool

During FY 2019–20, we will be implementing a tool that will provide physicians and other prescribers with insights allowing them to:

- compare the costs associated with prescription therapy alternatives specific to each patient's health plan, enabling physicians to be part of the cost control solution;
- use available information to assess the patient's risk of addiction before prescribing an opioid; and
- enable the physician to prescribe health plan programs to address the root of the patient's health or condition, empowering the physician to prescribe programs, not just pills.

The application will be easy for providers to access and use, embedded in the provider's electronic medical record system or available via a web portal. The tool will improve quality of care, improve member health

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[2] May 2019 total

outcomes, and provide information about efficacy and cost to reduce prescription drug expenditures for consumers, employers, the Department, and payers across Colorado.

Hospital Transformation Program

The HTP (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. While the program focuses on services provided to Medicaid members, favorable transformative behaviors incentivized by the program are expected to effect permanent hospital delivery system change related to cost and quality that will benefit consumers, employers and other payers across Colorado. Under the HTP, hospitals will be required to implement quality-based initiatives, improve clinical and operational efficiencies, and embark on community development projects to receive supplemental payments. A financial model together with a statewide framework of incentives for hospitals has been developed, subject to final CMS approval.

HTP quality-based incentives will require hospitals to be accountable for reducing avoidable inpatient and outpatient hospitalization, addressing the needs of vulnerable populations, improving the coordination of care for individuals with behavioral health and substance use needs, improving clinical and operational efficiency, and addressing population health and total cost of care.

Cost and Quality Assessment Tools

In FY 2018–19, the Department finished rolling out a suite of powerful cost and quality assessment capabilities to the seven Regional Accountable Entities (RAEs), as well as hospitals and Primary Care Medical Providers (PCMPs). These analytics tools enable the Department to identify potentially avoidable costs on member care provided by individual physicians, PCMPs, specialists and hospitals. This information enables providers to improve their referral patterns towards more cost-effective, higher quality physicians and hospitals, and allows hospitals to identify and self-correct inefficient, lower quality care delivery.

Hospital Centers of Excellence

The purpose of this initiative is to encourage hospitals, under the oversight of the Attorney General's Office in partnership with the Department, to collaborate to refer patients to the higher quality, lower cost site alternative (Center of Excellence) for specific and common procedures, such as delivery, hip/knee replacement, back surgery, colonoscopy, and specific heart procedures. This alternative payment methodology approach improves outcomes and lowers costs for patients, lowers costs for employers and other payers (thereby lowering insurance premiums), improves volume at Centers of Excellence providers, and rewards hospitals for referring care out of their site when it is in the best interest of the patient.

The Department will work with Primary Care Medical Providers and the Regional Accountable Entities to refer Medicaid members to these Centers of Excellence for treatment by service category. The ultimate goal is for Medicaid and commercial payers to facilitate this payment methodology, and for providers to collaborate to identify Centers of Excellence under agreed-upon parameters.

All-Payer Claims Database Reporting

The All-Payer Claims Database (APCD) is a valuable data collection resource. The APCD can help payers including Colorado's Medicaid program, Medicare, commercial health insurance, health care providers, and medical research institutions identify opportunities for efficiency, measure access to health care, and compare reimbursement rates by comparing their claims data to other health insurance providers in Colorado. Effective in FY 2019-20, we have secured additional budget dollars to fund emerging APCD priorities, such as improvements to cost and quality analytics, Health Care Affordability Roadmap reporting insights, and reporting support for self-funded employers.
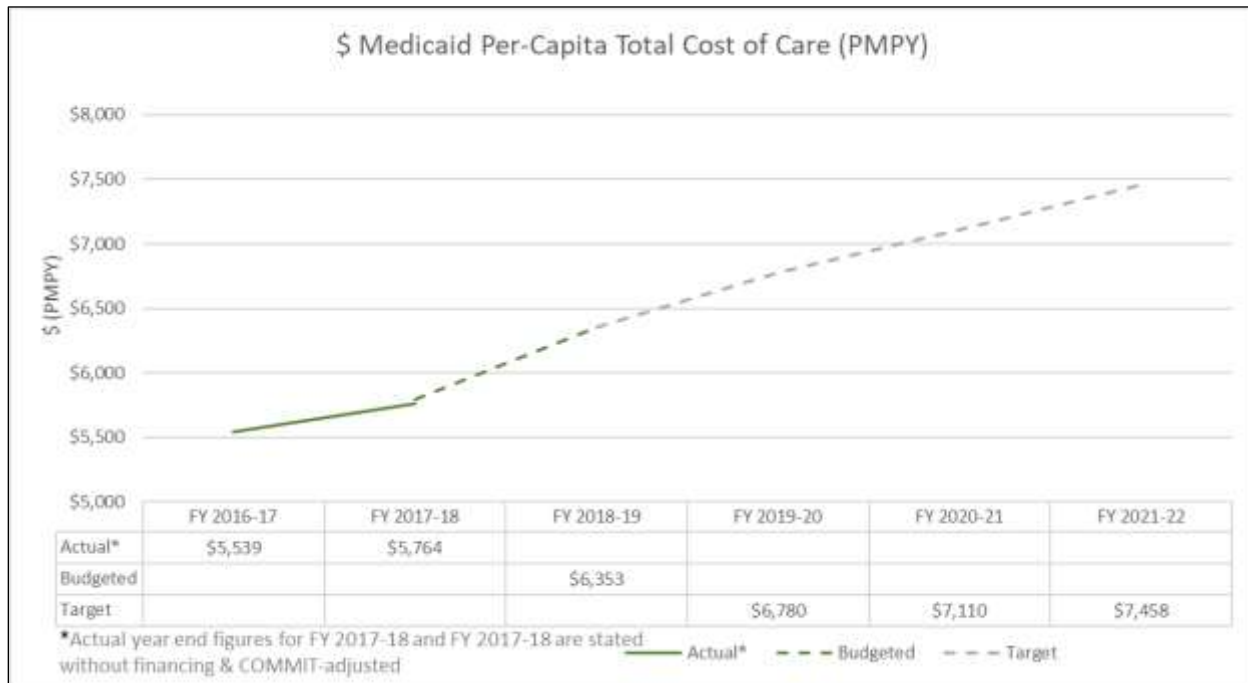
Pillar 2: Medicaid Cost Control

In addition to the Health Care Affordability Roadmap initiatives discussed above under Pillar 1, we are focused on many other cost control initiatives to better manage Medicaid expenditures, such as: curbing fraud, waste, and abuse; evolving our Accountable Care Collaborative strategy; delivering long-term services and supports to our members in community-based settings; data analytics, reporting, and insights that help inform care support and programming strategy; and modernizing our medical claim edits and utilization management programs. Overall, there are more than 15 workstreams inside the Department focused on Medicaid claim trend management.

Since the passage of Colorado's Senate Bill (SB) 18-266, *Controlling Medicaid Costs*, the Department has been focusing resources to meet the intent of the legislation and the affordability goals of Governor Polis. The Department's FY 2019–20 appropriations comprise fully one-third of the State's total operating budget, and the Department received more than 26% of the State's General Fund appropriations.[3] Most of the appropriations received by the Department are for the purpose of operating the State's Medicaid program. As such, it is critical that the Department demonstrate sound stewardship of the financial resources that have been allocated to its programs.

Measure

Per member per year FY 2019-20 claim cost, not including supplemental financing payments, will not exceed $6,780.

$ Medicaid Per-Capita Total Cost of Care (PMPY)

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Actual*	$5,539	$5,764				
Budgeted			$6,353			
Target				$6,780	$7,110	$7,458

*Actual year end figures for FY 2017-18 and FY 2017-18 are stated without financing & COMMIT-adjusted

—— Actual*   – – – Budgeted   – – – Target

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[3] Joint Budget Committee FY 2019-20 Long Bill narrative; http://leg.colorado.gov/sites/default/files/19lbnarrative.pdf

Performance evaluation

FY 2017-18 is understated due to complications associated with our transition to a new MMIS[4] claims system in March 2017. As a result, claims payments in FY 2018-19 were higher, reflecting provider payment corrections and delayed claims payment catch-up.

This measure experiences normal monthly fluctuation due to caseload, billing, and other factors. Medicaid per-capita total cost of care is partly a function of the demographics of Medicaid caseload. Less expensive members tend to churn off Medicaid at a higher rate than more expensive members during improving economic times, which could inflate per-capita cost over time.

Supporting Initiatives

A selection of the initiatives we are pursuing to control costs in Colorado's Medicaid program follows below.

Accountable Care Collaborative Evolution

The Accountable Care Collaborative (ACC) continues to integrate behavioral and physical health care coordination, strengthen care support, and improve overall health among Medicaid members.

We have identified an opportunity for additional refinement, including a more efficient allocation of ACC capitated payments. Specifically, we are collaborating with our Federally Qualified Health Centers, Primary Care Medical Providers (PCMPs), and Regional Accountable Entities (RAEs) to consider adjusting their requirement to track down members who are churning in and out of the Medicaid program, and redirecting those efforts toward members who clearly need RAE and PCMP assistance. We are also working with these essential partners to develop programs to improve member health and better control costs.

RAE Cost Collaborative

The Regional Accountable Entities formed the Cost Collaborative to provide a forum to develop key success factors and evidence-based, best-practice recommendations to support better outcomes, improved quality, and lower costs. In FY 2018–19, the Cost Collaborative developed a statewide approach to clinically stratify the population and define the performance pool metrics for FY 2018–19. Cost Collaborative focus initiatives for FY 2019–20 are:

- refining key performance indicators and creating performance pool metrics for FY 2019–20 that focus on outcomes,
- implementing chronic condition management and complex care management programs that effectively address the needs of our most vulnerable populations while also supporting upstream health management, and
- introducing cost and health outcome metrics to track RAE performance and guide continuous improvement.

Provider Cost and Quality Variation Reports

Variation in health care delivery, costs, and outcomes is a critical factor in the quality of care members receive and the cost of the Medicaid program as a whole. Cost and Quality Variation Reports use claims data and

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[4] medicaid management information system

insights to analyze and display variation in costs and health outcomes across providers in our health care delivery systems. The goal of the program is to identify the highest quality, most cost-effective care sites for members.

Two reports have been created: A hospital report measuring variation in procedures, surgeries, and aftercare, and a Federally Qualified Health Center (FQHC) report, created in consultation with the Colorado Community Health Network and individual health centers to gather feedback, hear concerns, and refine how FQHCs are measured. A primary care report is expected to be completed, and a Regional Accountable Entity/Primary Care Medical Provider report is also being designed.

Long-Term Care, Direct Care Workforce

The aging and older adult community is growing faster than any other segment of Colorado's population. The demand for direct care workers is increasing rapidly at a pace that will far outgrow supply without active and intentional intervention. Recruiting new workers into the field, as well as retaining those who currently work in direct care positions, is challenging because of the low wages, limited-to-no benefits, and high physical and emotional demands that characterize these jobs. Some reports indicate a turnover rate in this workforce of over 75%.

Failure to proactively address this workforce shortfall will result in increased costs for aging adults and their families, inappropriate placement of individuals in long-term care facilities, over-medicating, social exclusion, reduced quality of life, and significantly worse health outcomes.

The Department is leading the effort to increase and stabilize the direct care workforce for all individuals who require these long-term care services. The strategies and priorities to meet this critical need are:

- identifying challenges facing the direct care workforce and their employers and eliciting recommendations for changes to current policies and programs,
- creating a Training Advisory Committee to examine best practices and efforts around direct care workforce training and career advancement,
- implementing wage pass-through legislation[5] that requires specific wage increases through Department rate increases, and
- coordinating all state-level efforts and identifying key areas for collaboration and partnership across the Colorado Departments of: Regulatory Agencies, Public Health & Environment, Labor and Employment, Higher Education, Education, Health Care Policy & Financing, and the new Office of Saving People Money on Health Care.

Member Health Risk Stratification

The Department developed a tool to clinically stratify our member population to identify members who are most vulnerable and in need of care coordination and other support from the Regional Accountable Entities (RAEs). The goal is to improve member health outcomes and reduce the costs of care. Beginning in FY 2019-20,

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[5] House Bill (HB) 18-1407, Access to Disability Services and Stable Workforce, and Senate Bill (SB) 19-238, Improve Wages and Accountability for Home Care Workers

the RAEs will use the clinical risk stratification tool to more effectively focus their care and condition management efforts.

Additionally, the Department calculated current and prospective risk scores for each member using DCG (diagnostic cost group) risk methodology provided by IBM Watson Health, which houses our data analytics portal. The risk score methodology requires enhancement to improve the predictive value of key influencers, such as the presence of behavioral health diagnoses, and populations including children and individuals with disabilities. These enhancements to the baseline scores will be completed by December 2019.

Evolving ACC Strategy

The Department has taken significant steps with the integration of physical and behavioral health to improve health outcomes and bend the cost curve. We now have the opportunity to refine and focus the program to target high-cost populations in need of additional support. With less than 5% of members contributing over 50% of our claim costs, a focused approach for managing care will result in lower costs and improved outcomes. The seven Regional Accountable Entities (RAEs) will be required to utilize best-in-class programs and tools, reducing variation in the services they provide to members and providers. We are working with the RAEs to ensure consistent programs and tools are in place to address the identified health care needs of these members.

Controlling Prescription Drug Costs

We seek to provide a quality pharmacy benefit in the most cost-effective way. Increases in the costs of medications, especially specialty drugs, are a significant challenge for Colorado's Medicaid program and all other payers as well. In our program, 1.25% of our claims are for specialty drugs that are so expensive that they consume 40% of our prescription drug spending (before rebates).

Current tools we use to control drug costs include a preferred drug list (PDL),[6] prior authorization, quantity limits, review of member drug utilization, and value-based contracts. We will also be releasing a comprehensive prescription drug report in calendar year 2019 that will help inform cost control policy for Medicaid and other payers.
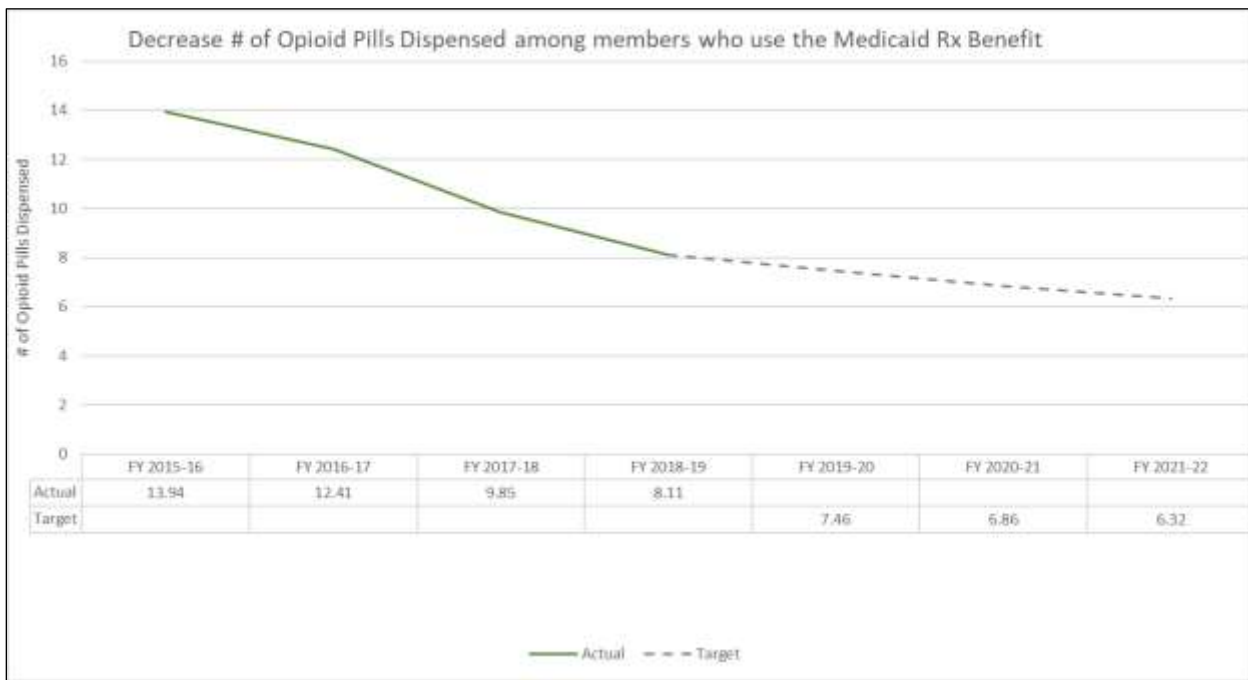
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[6] Our PDL is developed based on safety, effectiveness, and clinical outcomes from classes of medications where there are multiple drug alternatives available and supplemental rebates from drug companies.

Pillar 3: Member Health

The opioid crisis has been declared a national emergency by the Trump Administration. Its impact has devastated families across the nation, and Colorado is no exception. Our Pharmacy Office has been leading the State in crafting and implementing policies that battle overprescribing, thereby reducing the chance of patient addiction in the Medicaid and CHIP populations.

Measure

Decrease the number of opioid pills dispensed among members who use the prescription drug benefit by 8%, from 8.11[7] to 7.46 per member per month by the end of FY 2019-20.

Decrease # of Opioid Pills Dispensed among members who use the Medicaid Rx Benefit

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Actual	13.94	12.41	9.85	8.11			
Target					7.46	6.86	6.32

Performance evaluation

The Department is tracking both the number of members taking opioids as well as the pills prescribed to Medicaid patients. For this goal, the pills prescribed is the chosen metric. FY 2019-20, FY 2020–21 and FY 2021–22 are draft targets and will be evaluated to ensure they are clinically appropriate.

Supporting Initiatives

A selection of the initiatives we are pursuing to improve member health follows below.

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[7] Actuals represent a point in time during the fiscal year (June) except FY 2018-19 which is from March 2019, the latest data available.

Opioid Strategy

The impact of the opioid epidemic in Colorado makes reducing the amount prescribed to Medicaid members a priority in our member health strategy. We have taken numerous actions, which resulted in reducing the number of opioid pills prescribed by 50% over the past five years while ensuring appropriate access to pain management.

- Short-acting opioids have been added to our Preferred Drug List.
- Our Morphine Milligram Equivalent (MME) limit began at 300 and has been reduced in increments of 50 over the past few years.
- We have implemented stricter limits on opioids for dental procedures.
- We have a pain specialist who provides consultations to help manage pain and opioid use.

Given the increased risk of adverse events with concurrent use of opioids and benzodiazepines, a type of sedative prescribed for anxiety or to help with insomnia, the Department is looking at an initiative to more tightly monitor the concurrent use of opioids and benzodiazepines. (More than 30% of overdoses involving opioids also involve benzodiazepines.[8])

Informing Opioid Use Disorder Services with Data

A data analytics project focused on opiate use disorder care in the state that was completed in 2018 has provided powerful insights regarding development of policies and programs focused on services for these members, such as:

- improving strategies for managing maternal opioid misuse and babies born with neonatal abstinence syndrome,
- helping obstetric and pediatric practices that want to better integrate substance use disorder (SUD) care into their clinics, and
- informing design of the residential SUD benefit starting July 2020.

Data resources emerging from the project are being shared with behavioral health initiatives across the Department. The project was initiated by a Centers for Medicare and Medicaid Services (CMS) Innovative Accelerator Program grant awarded in 2018. The grant provided data analytics assistance and supported 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).

Tax-Exempt Hospital Accountability

Medicaid members will benefit from recent legislation[9] requiring hospitals that are tax-exempt due to nonprofit status to improve the transparency of their annual community health needs assessments (CHNAs). These assessments are required to help the federal government measure the investments tax-exempt hospitals are making in their local communities, an obligation of their tax-exempt status. This bill will help communities

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[9] National Institute on Drug Abuse
[9] House Bill (HB) 19-1320, Hospital Community Benefit Accountability

dialogue with their local hospitals to ensure that their investments truly improve the health of the community, including the health of Medicaid members.

Residential and Inpatient Substance Use Disorder Treatment

Provisions of a 2018 law passed by the Colorado legislature enable the Department to provide inpatient and residential treatment, including withdrawal management, to members suffering from substance use disorders (SUD). In preparation for making these services available, the Department is applying for a waiver[10] to gain approval for federal funding. Simultaneously we are preparing to make the benefit available to members in July 2020. All Medicaid members will be eligible, and those who need it will be able to access the services through their Regional Accountable Entity, which will manage the benefit.

There is currently a restriction on federal payment of these services.[11] With the recent opioid crisis the federal government has acknowledged the need for residential and inpatient services for individuals with advanced addiction. Individuals in need of these services will be treated in residential settings and then stepped down to community-based services as they make progress in treatment. Opening up these higher levels of care as covered services will allow us to complete the continuum of SUD services available to our members. In the future, SUD services will range from early intervention, outpatient, residential, inpatient to recovery support services.

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[10] Allowing the Federal government to "Waive" requirements of the IMD exclusion so that Colorado's Medicaid program is able to pay for these services for its members.
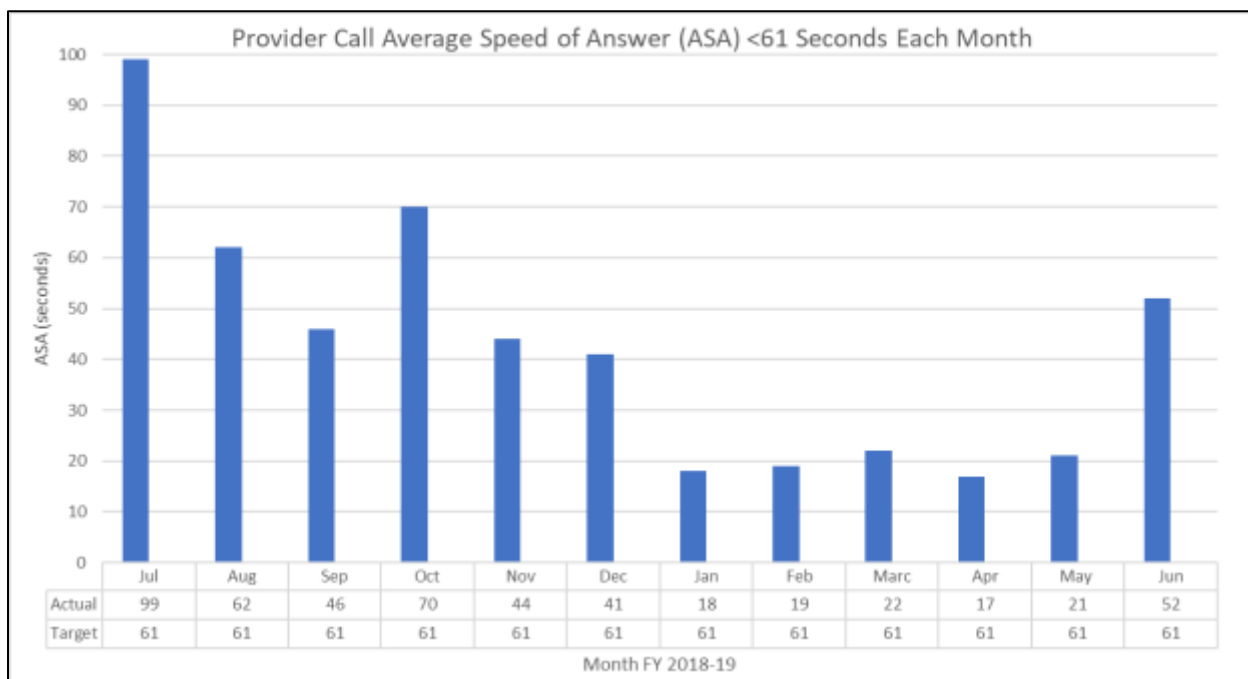
[11] The federal Institutions for Mental Diseases (IMD) Exclusion, enacted in 1965, prohibited use of federal funds to pay for services provided to individuals in mental health and substance use disorder residential treatment facilities larger than sixteen beds.

Pillar 4: Customer Service

Our focus for this pillar is on improving service to our members and providers to reach levels that parallel that of the private or commercial sector. This requires focus, alignment, and accountability, given that the administrative resources inside the Department represent about 4.5% of our budget. In contrast, administrative resources available to commercial payers average 13.5% of their premium dollars,[12] a percentage in ratio to a much larger revenue and membership base. For example, the largest carriers in the industry – United Healthcare, Anthem and Aetna – serve approximately 50 million, 40 million, and 30 million members respectively across the United States. This allows them to spread administration investments and expenses – such as claim processing, call center, digital tools, ID card production, member communications, and related systems – over a much larger revenue base. Colorado's state-based Medicaid program doesn't have such economies of scale. While Medicaid is indeed the largest health plan in the state, it serves only 1.3 million people. That means we have to be diligent and thoughtful in finding ways to do more with less across all our operations in order to match the service levels associated with commercial payers.

Measure

Average Speed of Answer (sometimes called ASA) of telephone calls coming into our provider service center from Medicaid providers.

Provider Call Average Speed of Answer (ASA) <61 Seconds Each Month

Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Marc	Apr	May	Jun
Actual	99	62	46	70	44	41	18	19	22	17	21	52
Target	61	61	61	61	61	61	61	61	61	61	61	61

Month FY 2018-19

Performance evaluation

For FY 2018–19, the Provider Call Center achieved an average speed of answer of 43 seconds. This metric is critical to our members as well. If providers are not well served by our Department and our vendor contractors,

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[12] AHIP (The America's Health Insurance Plans association)

providers are less likely to choose to serve Medicaid members. The good news is the panel of providers serving Medicaid members grew every month of FY 2018-19.

Supporting Initiatives

A selection of the initiatives underway to advance our Customer Service pillar are below.

Improving Service for Our Providers

Since implementing the Colorado interChange systems that replaced our legacy Medicaid Management Information System (MMIS) in March 2017, we have dedicated significant resources to improving customer service to our providers. This includes Customer Service Representative (CSR) training, new CSR call management tools, more supervisor training, and analytics to identify what system enhancements are needed to address provider issues. The new system was built and is operated by a contractor that also serves as the Colorado Medicaid fiscal agent, paying fee-for-service claims to our providers.

Provider Service Improvement Initiatives

Focus areas for current and recently completed provider service improvement initiatives include reducing provider customer service call answer time, improving call quality and service level agreements, further reducing suspended and aging claims, and improving Department staff internal coordination to provide information required by the contractor.

Maintaining an Average Speed of Answer (ASA) of Less than 61 Seconds

Over the past year, the Department has managed the contractor to make continual improvements in their Provider Call Center to address wait time issues that existed after the launch of the new Medicaid Management Information System (MMIS) in March 2017. Since that time, the contractor has focused on meeting service level agreements (SLAs) in this area and has committed additional resources and focus to ensure calls are answered in less than 61 seconds. Through FY 2018–19, the Provider Call Center achieved an average speed of answer of 43 seconds. During the next year, we will continue to focus on this very important metric, holding the contractor accountable for maintaining adequate staffing, providing training and feedback to agents, and identifying and implementing process improvements to gain increased efficiency.

Improving Call Quality

During FY 2019–20, we will be focusing on the quality of the interaction providers have with our contractor's Provider Call Center with the goal of transitioning calls from simple transactions to quality interactions that deliver providers meaningful service that satisfies their needs. Action items we will implement include:

- strategic meetings with Provider Call Center leaders to identify and address areas of concern,
- routine call calibration sessions with the contractor to ensure expectations are clear and are being met,
- examination and adjustment of the call-quality scoring process to ensure alignment with expectations,
- identifying changes and improvements to the call center script to drive service improvements, and
- implementation of additional targeted training on soft-skills, claim processing and adjudication and program-specific requirements for call center agents.

We are also working on ways to obtain provider feedback on the level of service they are receiving through provider surveys.

Revising Performance Measures in Current Service Level Agreements

The original contract contained 26 Service Level Agreements (SLAs), each with an associated monthly quality measurement payment. Many of those SLAs were achievable with little or no effort by the contractor, or they did not measure performance that was meaningful to the Department. Development of new meaningful SLAs has been completed. A contract amendment holding the contractor accountable to the 20 new SLAs is expected to be executed early in FY 2019–20.

Reduce Suspended and Aged Claim Volume

One component of improving the provider customer experience is reducing the number of days suspended claims age before they are worked by staff and adjudicated, which results in faster claim payment and/or claim decision for the provider. The number of claims suspended for questions was reduced by 32% between January and June, 2019.

Department staff regularly meet with contractor claims operations leadership to review and discuss:

- claim edit processing instructions to ensure they are correct, clear and concise so claims can be quickly and accurately worked,
- changes to the manual claims process to improve efficiency,
- initiation of a claims review process by which aging claims are identified, with root causes for aging determined and addressed, and
- reporting and tracking of aging suspended claims to ensure accountability.

Redesign of Transmittal Workflow and Approval Process

The Department processes over 180 transmittals per month. These transmittals provide instruction to the contractor to make configuration adjustments to the Colorado interChange (claims system) that impact provider rates, mass adjustments to previously processed claims, and lump sum provider payments.

A pilot project has been initiated to promote tighter control over the transmittal submission process and share details with leaders across the Department of those transmittals that are high-risk. To further reduce errors in our processes, we are piloting an e-clearance process in our Health Programs Office that requires a division director to approve all transmittal requests prior to submission to ensure there are no negative downstream impacts to other areas of the Department or external stakeholders.

Pillar 5: Operational Excellence

During FY 2018–19, we have taken on a substantial amount of project work intended to improve operational excellence in areas including state and federal compliance, member call center service, primary care provider attribution, eligibility accuracy and county partnerships, executive accountability, project and priority management, strategic plan documentation, and measurement and execution.

Measure

Complete contract management training for 100% of contract managers and executive team leaders by June 30, 2020.

Performance Evaluation

While the Department consumes about one third of the State's total funds and about 26% of the State's General Fund, it does not employ nearly as many FTE (full-time equivalent) employees as other Colorado state agencies. In fact, the Department spends roughly 10 times more on vendor partner contracts than FTE. This is because it is more cost effective for smaller health plans like Colorado Medicaid or CHIP to hire a contractor that has the systems required to perform a specific health plan function than to invest in the required FTE, IT systems and infrastructure. Although we are re-evaluating this practice to consider returning to FTE where the current outsourcing practice has become more costly or an impediment to modernization and efficiencies, the preponderance of contractors over FTE will continue.

FY 2019-20 Total Administration (Long Bill/SB 19-207 and FY 2019 Special Bills) as of 5/14/19		
Item	Total Funds	General Fund
Total HCPF Appropriation	$10,689,061,864	$3,151,370,264
HCPF Admin	$436,961,708	$106,804,528
Percent of Total	4.09%	3.39%
HCPF Personal Services	$42,211,043	$15,157,362
Percent of Total	0.39%	0.48%
FTE	545.6	

The Department has contracts with more than 350 vendors, which perform the majority of health plan functions on our behalf, consuming about 90% of our administrative dollars. With this volume of partnerships, proper vendor management is paramount to yield the right service, for the right price, at the right service levels and the right return on investment. This goal is intended to drive the proper operational actions to achieve that intention.

Supporting Initiatives

A selection of initiatives currently underway to advance our *Operational Excellence* pillar follow below.

Administration Budget Management Discipline and Accountability

Department budget allocations include 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 CHIP. In advancing our Operational Excellence pillar, this allocation aims to more clearly track and communicate investment in cost control programs to better manage Medicaid claim costs and trends.

Contract Management

In FY 2018–19, we set and achieved the goal of transferring accountability and oversight for each of our 350+ vendor contracts to a member of our Executive Leadership Team (ELT), with each ELT member assuming accountability for their functional area, regardless if that function was performed by Department staff or a contractor.

This year, we are building on that foundation, improving our vendor contracting and oversight process through a three-pronged approach.

- First, we have incorporated a new set of tools that will ensure the content of our contracts creates strong vendor accountability and alignment of financial incentives with desired functional performance. Among these tools is a checklist for contract managers to ensure use of best practices to hold our vendors accountable.

- Second, before Executive Director contract execution, the ELT member with oversight of the functional area is required to sign off on this form, indicating that best-practices were followed to ensure a strong vendor contract.

- Third, we are mandating new and more robust training for contract managers and ELT staff. The training focuses on improving vendor contractor oversight skills and contract performance and on maximizing use of the newly available contract management tools.

Together, these three focus areas will increase the quality of the work performed, reduce delays resulting from rework of vendor deliverables, improve execution on cost control and other key strategies, and ensure that our members, providers, and stakeholders receive quality services from our vendors without increasing costs for the State.
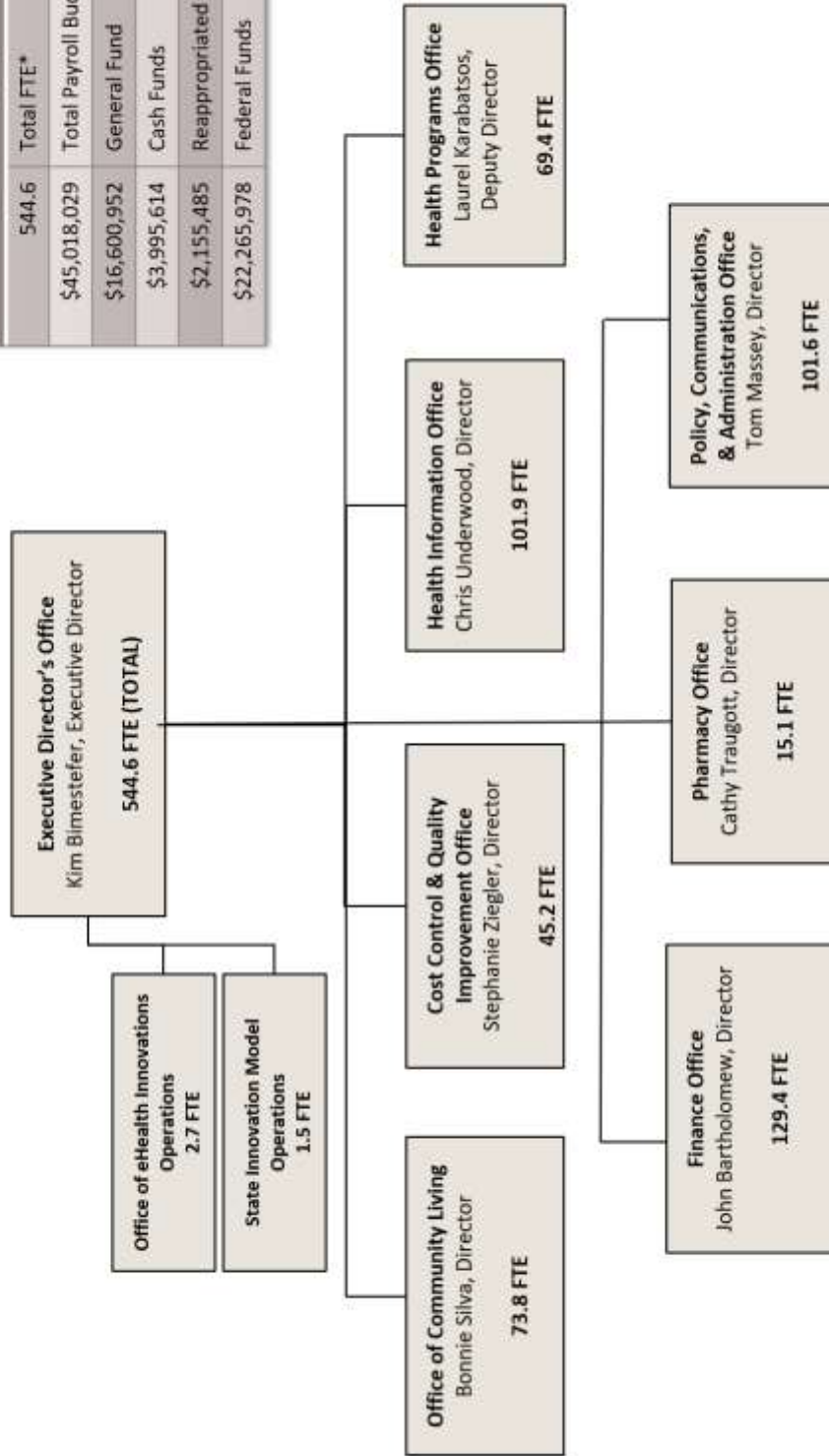
Integrated Performance Management Program

The Department is further enhancing operational excellence through its integrated performance management (IPM) program. The IPM program helps internal teams develop strategy, focus their operations, and make continuous improvements. It provides them with tailored facilitation and training in Lean for the purpose of setting and achieving goals and improving performance. This process enables clearer direction and purpose for teams that want to sharpen their focus and develop a blueprint for the future. Through this program, teams outline a proactive strategy that serves as a roadmap for where they are going and how they are going to get there.

Operational planning through the IPM program allows teams to identify and overcome barriers to achieving their goals, and sets them up for continued success. They evaluate how their resources are being used and make changes necessary to achieve their mission. Through operational planning, teams map their day-to-day functions to monitor and improve performance, and use data to identify problems and develop solutions.

FY 2019-20 Organizational Chart & Payroll Budget

Total Department FTE & Budget Summary (based on FY 2019-20 spending authority, including the Long Bill SB 19-207 and Special Bill appropriations)	
Total FTE*	544.6
Total Payroll Budget*	$45,018,029
General Fund	$16,600,952
Cash Funds	$3,995,614
Reappropriated Funds	$2,155,485
Federal Funds	$22,265,978

Executive Director's Office
Kim Bimestefer, Executive Director
544.6 FTE (TOTAL)

Office of eHealth Innovations Operations
2.7 FTE

State Innovation Model Operations
1.5 FTE

Health Programs Office
Laurel Karabatsos, Deputy Director
69.4 FTE

Health Information Office
Chris Underwood, Director
101.9 FTE

Cost Control & Quality Improvement Office
Stephanie Ziegler, Director
45.2 FTE

Office of Community Living
Bonnie Silva, Director
73.8 FTE

Policy, Communications, & Administration Office
Tom Massey, Director
101.6 FTE

Pharmacy Office
Cathy Traugott, Director
15.1 FTE

Finance Office
John Bartholomew, Director
129.4 FTE

*The Department's FY 2019-20 Spending Authority of $10.7 billion cannot be broken down by organizational unit because medical services for Medicaid members are provided through inter-office efforts. The total payroll budget is $45,018,029 of the total FY 2019-20 spending authority.

Office Descriptions

Executive Director's Office

Kim Bimestefer was appointed Executive Director of the Department effective January 8, 2018 and was reappointed by Governor Polis to this position. The Executive Director is responsible for setting the strategic direction of the Department, defining its vision, mission, and annual goals, leading the Department to achieve its vision, mission and goals, leading the Department's and influencing the state's health care affordability efforts, and ensuring the Department operates in an efficient and effective manner. The Executive Director creates alignment between Department initiatives and collaborates with other State Departments to achieve the health care agenda of the Governor.

Health Programs Office

The Health Programs Office oversees Colorado's Medicaid and CHIP acute care physical and behavioral health programs. The Office manages benefit policy development and oversight and is responsible for key functions including benefit coverage appeals, federal and state compliance activities, and the Accountable Care Collaborative.

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, the Office of eHealth Innovation (OeHI) and other stakeholders on Health IT and IT projects that impact the Department. Major responsibilities of the Health Information Office include enhancing and maintaining the Department's IT infrastructure and data flow as they impact its health care claims payment system (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.

Cost Control & Quality Improvement Office

The Cost Control & Quality Improvement Office has five major areas of accountability. The office provides all Medicaid data insights, utilization and reporting as well as Executive Leadership Team dashboard reporting for the Medicaid health plan. It houses clinical staff and expertise regarding Department services, programs, policy, and performance. It oversees Colorado Medicaid's cost control programs and strategic evolution. It oversees health care quality measurement for the Department. Finally, the Office works with the Executive Director to review Affordability Roadmap strategy for the state of Colorado.

Office of Community Living

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

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 (PACE, managed care organizations, behavioral health care capitation, etc.). 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. One significant responsibility is the administration of the CHASE fee. 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 strategy, financial data and reporting, and for use of data analytics to define value and measure quality with regard to Department operations.

Pharmacy Office

The Pharmacy Office oversees access to medications and durable medical equipment for Medicaid fee-for-service and Medicare-Medicaid enrollees. The Office is responsible for ensuring clinically appropriate and cost-effective use of medications. Focus areas include the Colorado Preferred Drug List Program, drug-utilization analysis and input from the Colorado Drug Utilization Review Board, value-based contracting, prescription drug affordability policy for the State and Medicaid, reimbursement strategy and contracting including rebate contracting. The Office handles all pharmacy-related appeals and administers the Rx Review Program (drug therapy counseling sessions for Medicaid members). The Office also manages the Pharmacy Benefit Management System (PBMS), the adjudication system that processes the point-of-sale pharmacy claims, and the contract with the Pharmacy Benefit Management vendor. Additional responsibilities include collecting federal and supplemental drug rebates from pharmaceutical manufacturers, ensuring pharmacy benefit compliance with federal and state statutes and regulations, and providing pharmacy benefits information and assistance to members, pharmacies, and prescribers.

Policy, Communications, and Administration Office

The Policy, Communications, and Administration Office manages Department functions associated with the legislative agenda, government affairs, communication and media relations, legal affairs, and human resources and workforce development. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press.

FY 2018–19 Performance Evaluation

FY 2018–19 Performance Evaluation

Q4 FY 2018–19 (July 2019)

Strategic Policy Initiatives

The Department of Health Care Policy and Financing identified several strategic policy initiatives, or SPIs, to be accomplished in FY 2018-19 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 2018-19 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 innovating within existing delivery systems to improve quality of health care and control costs. For example, the Hospital Review Program notifies the Regional Accountable Entities of member diagnosis and treatment plans to highlight opportunities for discharge planning and care coordination.

Performance Measures	FY18 YE	FY 19 Q4	1-Year Goal
# Colorado providers serving Medicaid	48,841	56,269	49,571
# Colorado primary care providers serving Medicaid	22,838	25,095	23,177
# Nursing facility members transitioned to home and community based settings through Colorado Choice Transitions	393	533	478

SPI 2: Tools of Transformation: The broader health care system is transformed by controlling costs in Medicaid

One of the most critical 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 build consensus around priority initiatives that will contain costs and improve the quality and efficiency of care delivery in the Medicaid program and within State policy. For example, in the Accountable Care Collaborative we have implemented cost and quality assessment capabilities to improve quality and continuity of care while controlling costs. Work supporting this SPI focuses on increasing the impact of Colorado Medicaid investments and innovations to transform the broader health care system.

Performance Measures	FY18 YE	FY 19 Q4	1-Year Goal
% Hospitals reached with messaging that makes them aware of the new HCPF Prometheus tool [a]	N/A [1]	100%	80%
% Regional Accountable Entities (RAEs) reached with messaging that makes them aware of the new HCPF Prometheus tool	N/A [1]	100%	100%
$ Medicaid per-capita total cost of care (PMPY) [b]	$5,791	$5,973 [2]	$5,973
$ Total costs avoided from ACC and Medicaid (in millions) [c]	$44	$115 [2]	$189

1 Data not available.
2 Estimate. Data not yet available.

[a] All hospitals have received individualized dashboards.
[b] PMPY—per member per year
[c] Restated FY 2017-18 YE after calculating final costs related to implementing the value-based payment initiative for Enhanced Ambulatory Patient Groups.

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

The Department seeks to improve the health and well-being of Coloradans served by the Medicaid program. Appropriate health care must be complemented by addressing chronic disease, mental health and substance abuse. For example, we are undertaking Department initiatives intended to prevent and treat addiction in response to the State's higher than average substance abuse disorder challenges.

Performance Measures	FY18 YE	FY 19 Q4	1-Year Goal
Decrease # opioid pills dispensed among members who use the Rx benefit	10.09	8.23[1]	9.59

1 Data lagging—updated through April 2019.

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 improving the cost-efficiency of our operations, strengthening services to our providers, and completing systems changes that improve member experience.

Performance Measures	FY18 YE	FY 19 Q4	1-Year Goal
Provider call average speed of answer (ASA) in seconds [a]	896 [1]	30[2]	61
# of PEAK app users	141,312	227,214	170,100
% targeted Medicaid households using PEAKHealth mobile app	22.4%	36%	26.5%
$ HCPF expenditures – Administration	$ 264,469,312	$68,845,943	$335,389,423

1 March–December 2017 average.
2 Average of April through June 2019.

[a] FY 2017-18 was high due to the implementation of a new MMIS claims system, which caused increased provider calls.

Glossary

Accountable Care Collaborative (ACC) — 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.

All-Payer Claims Database (APCD) — A statewide information repository that collects health insurance claims information from health care payers. APCDs exist in multiple states and are designed to inform cost containment and quality improvement efforts.

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

CHIP — The Children's Health Insurance Plan. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

CIVHC — The Center for Improving Value in Health Care, a not-for-profit organization that manages Colorado's All-Payer Claims Database (APCD) under the direction of the Department and the APCD Advisory Committee, which is appointed by the Department's Executive Director.

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.

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, analytics, and reporting repository, and the Prescription Drug Benefit Management System.

Primary Care Medical Provider (PCMP) — A primary care provider contracted with a RAE to participate in the ACC as a medical home.

Regional Accountable Entity (RAE) —The ACC health care delivery system is administrated by seven Regional Accountable Entities or RAEs, which also contract the ACC's behavioral health care delivery system. Each of the seven is responsible for coordinating physical and behavioral health for its enrolled members and supporting care coordination.

Medicaid State Plan — An agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs. The state plan sets out groups of individuals to be covered, services provided, provider reimbursement methodologies, and related administrative activities.

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