



# Health Care Policy & Financing

FY 2017–18 PERFORMANCE PLAN



**COLORADO**  
Department of Health Care  
Policy & Financing

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Cover: Teresa (r) has been a member of Health First Colorado for most of her life. Anna became a member while studying biology and public health at the University of Colorado, Denver.

# Introduction

Welcome to the Department of Health Care Policy & Financing's FY 2017–18 performance plan, an annual report detailing 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.

We receive 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 for the state's executive branch. The Medicaid program receives approximately 60% 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 and/or enrolled in Medicaid and Child Health Plan *Plus*, and those who receive services through the other programs described above. Indirect customers (those that impact and are impacted by our work) include medical providers, partners such as non-profit entities and sister state agencies, the Centers for Medicare & Medicaid Services, groups that advocate for member populations, the Governor and the Legislature of the State of Colorado, service contractors, and entities that help eligible individuals apply for benefits. These entities include 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:

- Medicaid member population: shifts in their demographics and health
- Decisions of the Legislature of the State of Colorado
- Changes to federal health care policy
- Escalating health care costs

The most significant external factors currently include issues related to federal policy changes and health care costs.

**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 environmental factors impacting our business. At this time Congress and the Trump Administration are contemplating major changes to each of these areas of Medicaid policy.

**Health care costs** – Perhaps the most critical environmental factor impacting our business is the escalating cost of health care in the U.S. Along with other payers and influencers of the U.S. health care delivery system, we are working to contain costs and improve the quality and efficiency of care. The strategic policy initiatives described in this performance plan are designed to do just that: improve health outcomes, select and deliver evidence-based care, and eliminate payment for duplicative or unnecessary services.

## About This Performance Plan

The organization and narrative of this performance plan are as simple, concise, and customer-focused as possible, with the understanding that a key customer for this document is the Department itself.

The plan describes our long-range goals, strategic policy initiatives, strategies, and performance measures. Data reported for each performance measure includes historical actuals for the prior two fiscal years, as well as one- and three-year targets. Prior year performance is evaluated based on estimates for FY 2016–17, as actuals will not be available for all measures until 2018 as described below.

A glossary of acronyms and relevant terms is provided at the end of this document.

### A FEW FACTS ABOUT OUR REPORTING

**Performance Measures** – We are focused on objectives related to improving health, ensuring members receive quality care, implementing evidence-based policy, and financing services efficiently. In an effort to make our performance plan and goals meaningful, we use multiple measures to define success in achieving our strategic goals. This provides a more complete picture when evaluating progress toward the complex objectives of quality health care, improved member health outcomes, and cost-effective health care.

**The Data** – The availability of timely and relevant data presents challenges in creating an actionable performance plan. Some of the reporting in this plan relies on de-identified health data from medical claims that can take up to six months to be billed, validated, paid, and entered into an electronic system. These steps must be completed before claims information becomes reportable as data for performance measurement. This time period is referred to as *claims run-out* or *lag time*, and it inhibits the ability to use claims data timely. Similarly, some data sets come from third party reports, and are dependent on the third party’s processing and reporting times. To overcome these limitations, we maximize use of timely data from clinical sources as well as internal operational indicators (not included in the performance plan) to make intermediate course corrections when needed.

**Performance Graphics** – Most of the graphs and tables we use to display performance data include more than one performance measure. It’s important to note that this is not indicative of correlation or cause and effect relationships between measures. Graphs include more historical data than tables in order to provide more context.

## Strategic Management Process

The elements of our strategic framework (described below), are the creation of the entire agency. Our executive team defined our current strategic direction and priorities in 2015, and a framework of supporting strategies, programs, and performance measures was created by management and staff across the Department. Framework elements were revised by subject matter experts and solidified by managers and directors. Operational teams meet throughout the year to set quarterly and annual goals and ensure alignment of work with overarching agency strategy.

# Strategic Framework and Programs

This performance plan is constructed around a framework we generated through the process described above. Our six core values serve as its foundation, and four strategic policy initiatives support achievement of our long-range goals, mission, and vision.

## Performance Plan At a Glance

COLORADO  
 Department of Health Care  
 Policy & Financing

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

An organization's core values can't be 'set' or created; they must be discovered. By declaring these values, we are committed to aligning our actions with them.

**Person-Centeredness:** 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.



**Integrity:** We behave ethically, treat others with dignity and respect, and align our actions with our mission and vision.

**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. Must be accompanied by performance measures and strategies.



**Performance Measures:** These gauge the effectiveness of strategies to achieve strategic policy initiatives and long-range goals. Performance measures can be influenced by teams, and they are predictive of success or failure. They must meet “SMART” criteria and be expressed as “achieve X to Y by when” by comparing baseline or historical data to targets.



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













**Strategies:** High-impact action plans that must be successfully executed to achieve strategic policy initiatives.

### 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 AND PERFORMANCE MEASURES

Goal	Measures
 Improve health for low-income and vulnerable Coloradans	 # Physically unhealthy days per month  # Mentally unhealthy days per month
 Enhance the quality of life and community experience of individuals and families	 % New mothers receiving maternal depression screening  % Persons receiving HCBS services expressing social inclusion or connectedness to the community  % Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services
 Reduce the cost of health care in Colorado	 \$ Medicaid per-capita total cost of care  \$ Total costs avoided from ACC and Medicaid

## STRATEGIC POLICY INITIATIVES AND PERFORMANCE MEASURES













SPI	Definition	Measures
 1. Delivery Systems Innovation	Medicaid members can easily access and navigate needed and appropriate services	 % ACC members with an enhanced primary care medical provider
 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	 \$ Provider payments tied to quality or value through innovative payment methods
 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	 # Members in counties with a RCCO-LPHA* relationship
 4. Operational Excellence	We are a model for compliant, efficient and effective business practices that are person- and family-centered	 % Favorable responses to employee survey “we get work done more efficiently with less waste of money or other resources”


\*Regional Care Collaborative Organization-local public health agency


## STRATEGIES AND PERFORMANCE MEASURES


The Strategic Policy Initiatives (SPIs) above are achieved through corresponding strategies 1A through 4E below. Performance measures indicate progress in areas relevant to each strategy.

As is apparent below, there is extensive cross-functionality among most of these strategies and performance measures (that is, most of them support more than one SPI).

 <b>1. Delivery Systems Innovation</b>		
#	Strategy	Measures
1A	▶ Ensure robust management of Medicaid benefits	<ul style="list-style-type: none"> <li> # Benefits modified to align with new data, research, or evidence-based guidelines through Benefits Collaborative, policy modifications, or rule changes</li> </ul>
1B	▶ Expand network of providers serving Medicaid	<ul style="list-style-type: none"> <li> # Colorado providers serving Medicaid</li> <li> # Colorado primary care providers serving Medicaid</li> </ul>
1C	▶ Increase member engagement and health literacy	<ul style="list-style-type: none"> <li> % Nurse Advice Line calls referred to more appropriate level of care</li> <li> # PEAK App users</li> </ul>
1D	▶ Integrate primary care and behavioral health service delivery	<ul style="list-style-type: none"> <li> % New mothers receiving maternal depression screening</li> <li> # Members in practices that receive behavioral health integration incentives</li> </ul>
1E	▶ Make Long-Term Services and Supports easier to access and navigate	<ul style="list-style-type: none"> <li> # Community Living Advisory Group recommendations fully or partially implemented</li> <li> % Persons receiving HCBS services expressing social inclusion or connectedness to the community</li> <li> % Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services</li> </ul>
1F	▶ Strengthen the ability of the ACC to deliver coordinated care	<ul style="list-style-type: none"> <li> % ACC members with an enhanced primary care medical provider</li> </ul>

 <b>2. Tools of Transformation</b>		
#	Strategy	Measures
2A	▶ Expand the use of value-based purchasing methods	<ul style="list-style-type: none"> <li>▮ \$ Provider payments tied to quality or value through innovative payment methods</li> </ul>
2B	▶ Implement cost containment initiatives	<ul style="list-style-type: none"> <li>▮ \$ Total costs avoided from ACC and Medicaid</li> <li>▮ \$ Medicaid per-capita total cost of care</li> </ul>
2C	▶ Maximize use of health information technology and data analytics, aligning these efforts with the broader health care system	<ul style="list-style-type: none"> <li>▮ # Medicaid professionals demonstrating meaningful use of electronic health records</li> <li>▮ Providers with a quarterly report card; % of total Medicaid expenditures</li> <li>▮ # Primary care medical providers who log in to the SDAC/BIDM provider portal</li> </ul>

 <b>3. Partnerships to Improve Population Health</b>		
#	Strategy	Measures
3A	▶ Support statewide efforts to improve population health	<ul style="list-style-type: none"> <li>▮ # Members in counties with a RCCO-LPHA relationship</li> <li>▮ # Education activities developed by SIM targeted towards PCMPs and community partners</li> </ul>

 <b>4. Operational Excellence</b>		
#	Strategy	Measures
4A	▶ Enhance employee engagement and performance	<ul style="list-style-type: none"> <li>▮ % Favorable responses to employee survey “we get work done more efficiently with less waste of money or other resources”</li> <li>▮ % Employee retention for 36 months or more</li> </ul>
4B	▶ Improve efficiency of business processes	<ul style="list-style-type: none"> <li>▮ % Electronically submitted clean claims processed within 7 business days</li> <li>▮ % Providers notified of missing or incomplete enrollment information within 5 business days</li> <li>▮ % First call resolution by Member Contact Center</li> <li>▮ \$ Dollar equivalent of Lean efficiency gains</li> </ul>



#### 4. Operational Excellence

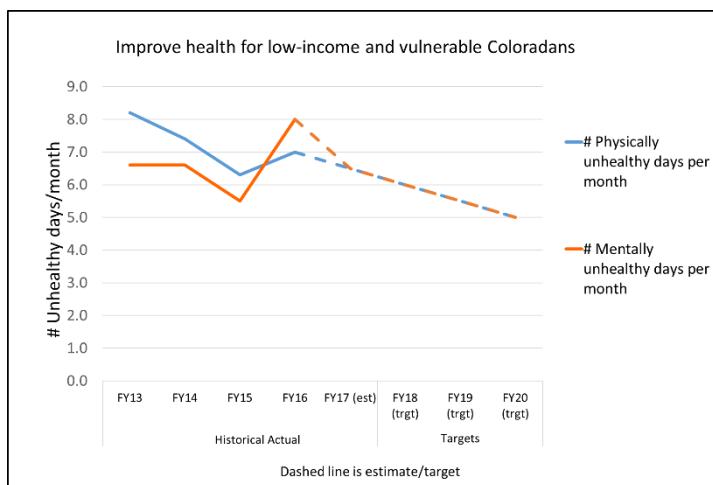
#	Strategy	Measures
4C	<ul style="list-style-type: none"> <li>▶ Instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change</li> </ul>	<ul style="list-style-type: none"> <li>▮ # Items vetted through person-centered advisory councils</li> <li>▮ % Persons receiving HCBS services with person-centered goals identified in their service plan</li> </ul>
4D	<ul style="list-style-type: none"> <li>▶ Promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures</li> </ul>	<ul style="list-style-type: none"> <li>▮ \$ Dollars recovered from over-payments to Medicaid providers</li> <li>▮ \$ Dollars recovered from third party liability</li> <li>▮ % Existing OSA audit recommendations resolved</li> </ul>
4E	<ul style="list-style-type: none"> <li>▶ Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently</li> </ul>	<ul style="list-style-type: none"> <li>▮ # Individuals enrolled in Medicaid/CHP+</li> <li>▮ % Eligibility determinations processed timely</li> <li>▮ % Real time eligibility applications</li> </ul>

# Section 1: Long-Range Goals

This section presents our long-range goals: achievements that will require at least three years of commitment to Strategic Policy Initiatives described in Section 2, and successful execution of Strategies described in Section 3.

## LONG-RANGE GOAL #1 IMPROVE HEALTH FOR LOW-INCOME AND VULNERABLE COLORADANS

We are committed to delivering a member-focused Medicaid program that improves health outcomes and member experience while delivering services in a cost-effective manner. This goal leverages proven



reforms to health care delivery models (such as care coordination and payment incentives) and advances in health information technology to improve member health and well-being.

Performance measures indicative of improved health over time include the number of physically and mentally unhealthy days per month reported by our members. Current reporting methods for these measures require Colorado-specific data to be extracted from the national Behavioral Risk Factor Surveillance System,

which surveys adults age 18–64 via telephone. Only 468 adults from Colorado responded to this question in FY 2015–16. Since total Medicaid and CHP+ membership is over 1.4 million, the spike shown in FY 2015–16 is not representative. We are researching the feasibility of adding a Colorado-specific survey to improve our ability to capture data on individual perceptions of physical and mental health.

Improve health for low-income and vulnerable Coloradans	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Physically unhealthy days per month	6.3	7.0	6.5	6.0	5.0
# Mentally unhealthy days per month	5.5	8.0	6.5	6.0	5.0

FY 2015-16 sample size did not meet confidence level required for statistical significance.

## LONG-RANGE GOAL #2 ENHANCE THE QUALITY OF LIFE AND COMMUNITY EXPERIENCE OF INDIVIDUALS AND FAMILIES

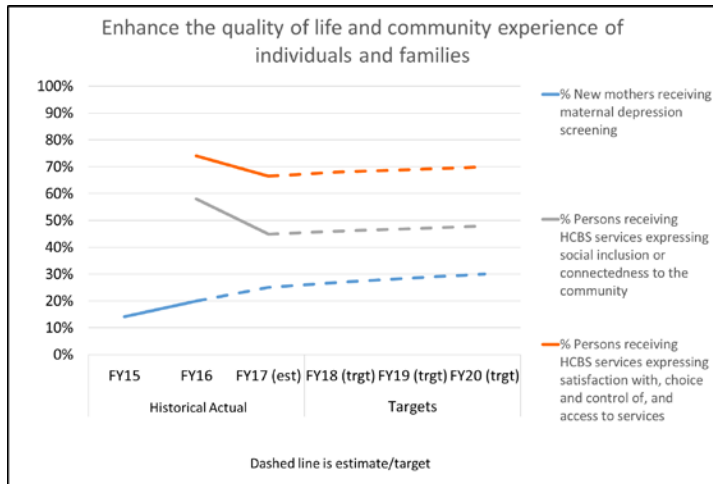
This long-range goal focuses on improving member experience through health interventions and care that improve conditions of daily life. A strong emphasis of this goal is helping members with complex medical needs get care when and where they need it, with a focus on care in the home and community.

By measuring maternal depression screenings among Medicaid members, and satisfaction rates among individuals receiving home and community based services, we can gauge progress toward enhancing quality of life and community experience.

We expect gradual improvement with all three measures shown below. The Accountable Care Collaborative (ACC) is working with primary care providers to encourage maternal depression screenings, and pediatricians are conducting them during well-child visits. In addition, a data sharing agreement with the Colorado Department of Public Health and Environment is informing policy in the statewide Pregnancy Related Depression Task Force—a cross sector and cross agency team that targets reducing stigma, increasing access, and building provider confidence in screening. In FY 2018–19, ACC Phase II initiatives to

join physical and behavioral health under one accountable entity will further embed best practices such as maternal depression screening and treating behavioral issues in the primary care setting.

Satisfaction scores among individuals receiving home and community based services (HCBS) are expected to increase as the long-term services and supports (LTSS) system shifts to being more person-centered. Activities driving this shift are described under Strategies 1E (p. 29) and 4C (p. 51).



Enhance the quality of life and community experience of individuals and families	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% New mothers receiving maternal depression screening <sup>1</sup>	14%	20%	25%	27%	30%
% Persons receiving HCBS services expressing social inclusion or connectedness to the community <sup>2</sup>	N/A	58%	45%	46%	48%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services <sup>2</sup>	N/A	74%	67%	68%	70%

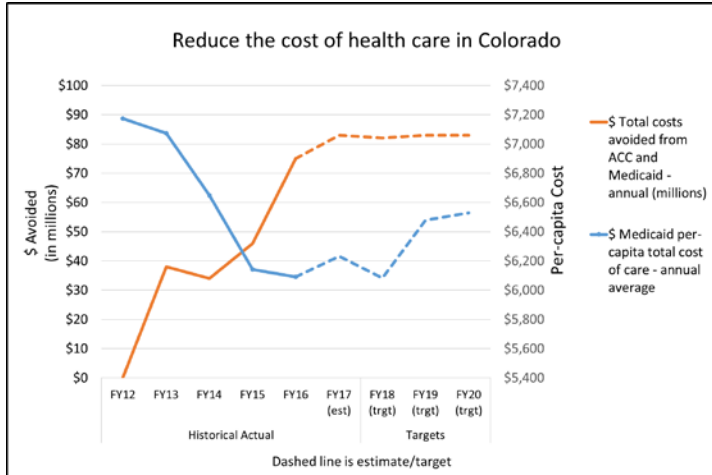
<sup>1</sup>Methodology adjusted in FY 2016–17 to include screenings not in the billing system. Historical data is restated.

<sup>2</sup>The Department utilizes the NCI-AD (Aging and Disabled) and NCI-IDD (Individuals with Developmental Disabilities) Consumer Surveys to assess this measure and began tracking results in FY 2015–16. Data reported is up to 18 months in arrears.

### LONG-RANGE GOAL #3 REDUCE THE COST OF HEALTH CARE IN COLORADO

This long-range goal focuses on efforts to provide care that is high quality and low cost. It is supported by work to slow the growth rate of per-capita costs while improving health outcomes. It is also supported by efforts to make internal business processes more efficient, and to reduce fraud, waste, and abuse in the Medicaid program. Two measures show progress toward reducing the cost of health care in Colorado: total costs avoided and Medicaid per-capita. Total costs avoided is a cumulative measure of prior year budget initiatives with savings, plus costs avoided from the Accountable Care Collaborative.

Since FY 2012–13, an estimated \$276 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 2017–18,



that figure is expected to be \$358 million. Medicaid per-capita is the annual average cost per member for total cost of care. Per-capita cost has decreased since FY 2012–13, and is expected to increase over the next few years with increased payments to hospitals and higher costs for community-based long term care and long term care provided through nursing facilities and the Program of All-inclusive Care for the Elderly.

Reduce the cost of health care in Colorado	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Medicaid per-capita total cost of care - annual average <sup>1</sup>	\$6,140	\$6,092	\$6,231	\$6,084	\$6,529
\$ Total costs avoided from ACC and Medicaid - annual (millions) <sup>2</sup>	\$46	\$75	\$83	\$82	\$83

<sup>1</sup> Measure uses a new methodology based on Exhibit Q from the Department’s annual budget request, reporting Title XIX (Medicaid) expenses only, where previously both Title XIX and Title XXI (CHP+) were included. In addition FY 2015–16 excludes additional hospital supplemental payments. All expenditures are restated.

<sup>2</sup> Measure restated to provide costs avoided per annum rather than life-to-date. ACC figures are based on FY 2016–17 Legislative Request for Information #3. Medicaid figures include annualized savings from prior year budget requests.

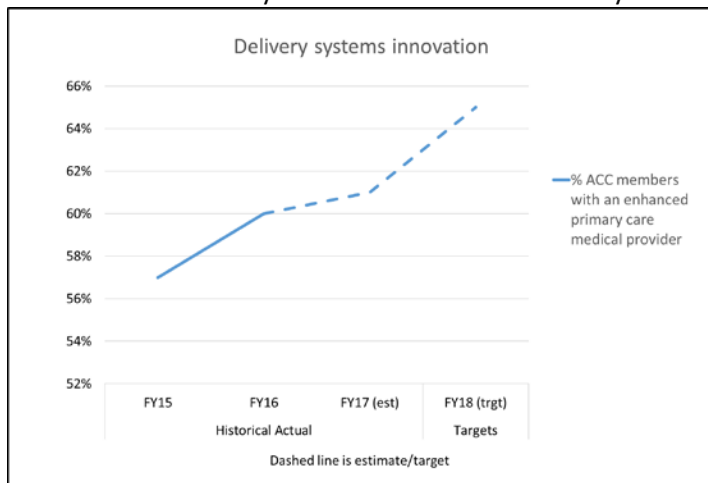


## Section 2: Strategic Policy Initiatives

Our four strategic policy initiatives, or SPIs, represent significant achievements that we expect to deliver through the strategies detailed in Section 3, below. The timeframe for accomplishing them is FY 2017–18. Each is accompanied by a performance measure representative of work accomplished through the SPI. Measures that align with one SPI often provide insight into the progress of others as well.

### SPI #1 DELIVERY SYSTEMS INNOVATION

Our development of improved health care delivery systems focuses on enabling members to easily access and navigate necessary 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



the integration of physical and behavioral health services. Although a combination of performance measures is necessary to gauge progress of delivery systems innovation, a representative measure is the percent of ACC members with an enhanced primary care medical provider. Efforts to enhance primary care services include incentivizing providers to offer evening and weekend hours, offering on-site behavioral health, and consultations via telephone and secure email.

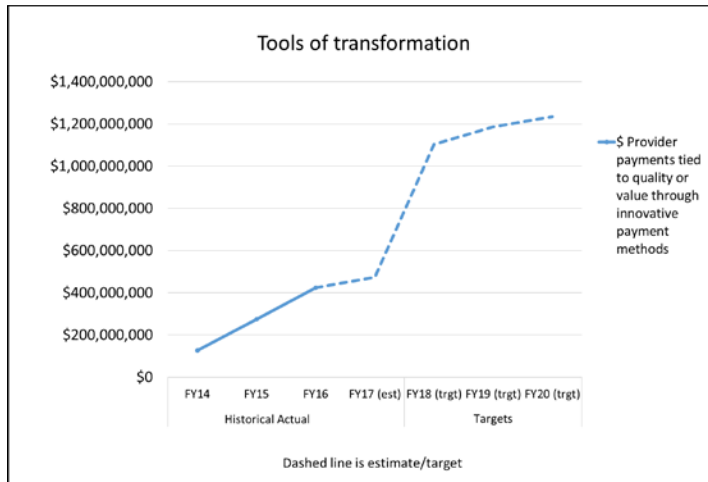
Delivery systems innovation	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% ACC members with an enhanced primary care medical provider	57%	60%	61%	65%	N/A

The enhanced primary care program will transition into a broader payment reform initiative in FY 2018-19; therefore, FY 2017-18 will be the final year for reporting this measure.

### SPI #2 TOOLS OF TRANSFORMATION

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.



A good measure of performance for this strategic policy initiative is the dollar amount of provider payments tied to quality or value through innovative payment methods. Since FY 2014-15, the dollar amount of these payments has nearly doubled, and is on track to double again by the end of FY 2017-18.

Tools of transformation	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Provider payments tied to quality or value through innovative payment methods	\$275,265,225	\$424,606,261	\$474,552,208	\$1,102,223,409	\$1,233,374,433

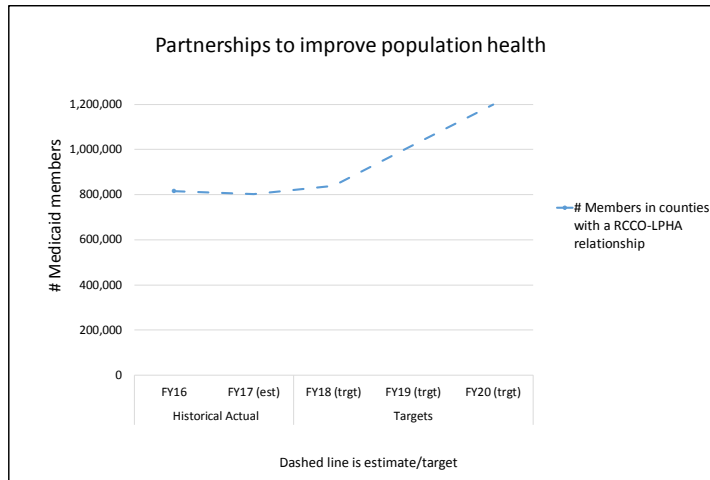
Historical data is restated to align with the Centers for Medicare & Medicaid Services standard definition for measuring value-based purchasing efforts.

### SPI #3 PARTNERSHIPS TO IMPROVE POPULATION HEALTH

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.

We are measuring progress toward this strategic policy initiative by the number of members in counties where the local public health agency (LPHA) is working with a Regional Care Collaborative Organization (RCCO) to provide community-based health supports. LPHAs conduct community needs assessments and have a well-developed understanding of the communities they serve. They also house, or can link to, essential community supports such as the Special Supplemental Nutrition Program for Women, Infants, and Children or the Health Care Program for Children and Youth with Special Health Care Needs.

The RCCOs are encouraged to partner with LPHAs to share information and understanding about community needs as well as available resources. These partnerships are essential to expanding the reach of health care and health interventions such as preventive services supporting physical and behavioral health.



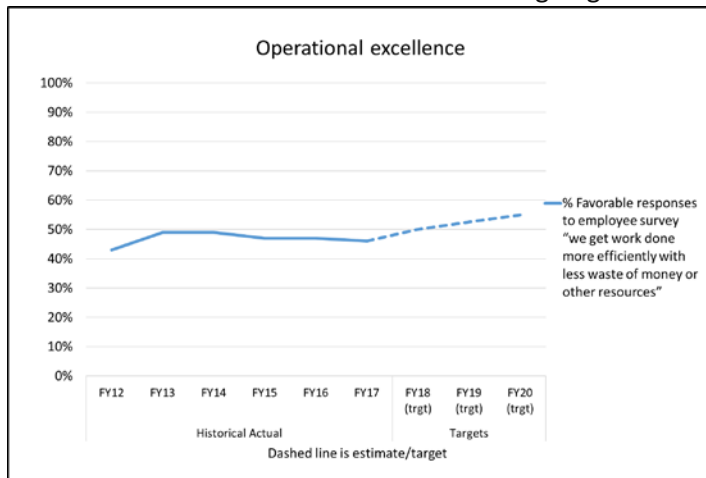
Measuring the number of members in a county with a RCCO-LPHA relationship reflects the enhanced capacity of the county to provide effective community-clinical linkages. To date there are an estimated 801,643 members in such counties. We expect this number to approach the total number of Medicaid members by FY 2019–20 as additional partnerships are formed with funding appropriated for this purpose.<sup>1</sup>

Partnerships to improve population health	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Members in counties with a RCCO-LPHA relationship	N/A	814,606	801,643	840,000	1,200,000

\*RCCO – Regional Care Collaborative Organization; LPHA – local public health agency

## SPI #4 OPERATIONAL EXCELLENCE

We aim to be 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. To measure operational excellence, we are focusing on employee perception of efficiency. Current year results are from the Department's 2017 internal survey. The percentage of employees reporting increased efficiency within the Department dropped 1% in FY 2016–17. We are committed to ongoing efforts to improve operational efficiency and employee engagement as described in Section 3.

Operational excellence	Historical Actual			1 and 3 Yr Target	
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2019-20
% Favorable responses to employee survey "we get work done more efficiently with less waste of money or other resources"	47%	47%	46%	50%	55%

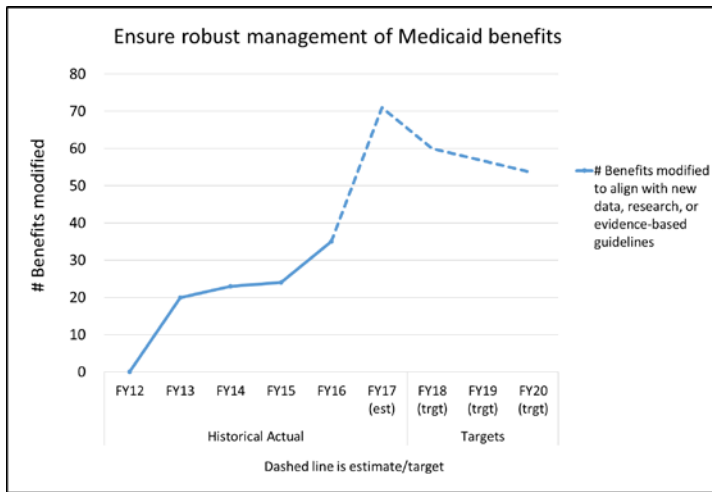
<sup>1</sup> Budget request R-12 (FY 2017–18), "Local Public Health Agency Partnerships." Spending authority is contingent on receiving federal approval.

# Section 3: Strategies and Programs

This section presents our 15 strategies, or high-level action plans for FY 2017–18. Each is accompanied by a selection of programs representing transformative work underway to achieve the strategy. Many of the programs described in this section contribute support to more than one strategy; primary connections are emphasized in this report.

## SPI #1 DELIVERY SYSTEMS INNOVATION

### STRATEGY #1A ENSURE ROBUST MANAGEMENT OF MEDICAID BENEFITS



Benefits management refers to a range of functions aimed at balancing member access to high quality and appropriate care with considerations of program cost. Safeguarding access, continuity and quality of care is a critical element of benefits management. The programs described below focus on ensuring that covered services are high quality and person-centered, limited to those that are necessary and effective, and that provider payment rates are set at actuarially sound, sustainable levels.

A representative measure of progress with this strategy is the number of benefits modified each year to align with new data, research, or evidence-based guidelines. This number has steadily increased with focused efforts to review and modify benefits, and is expected to taper off reflecting a steadier state in staying current with new data and evidence.

Ensure robust management of Medicaid benefits	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Benefits modified to align with new data, research, or evidence-based guidelines	24	35	71	60	54

Benefits modified excludes pharmacy benefit modifications.

The following programs assist in supporting our strategy to ensure robust management of Medicaid benefits.

#### BENEFIT POLICY ENFORCEMENT

Enforcing proper use of benefits and identifying potential areas for improvement and fiscal stewardship are critical to managing benefit utilization. We operate two internal reporting mechanisms to support this requirement.

Management reports created for each benefit track member utilization and Department expenditures for related services and programs. Information collected in the reports assists in identifying areas for benefit improvement and fiscal stewardship. Beginning in 2018, the new Colorado interChange claims

management system will enable us to supplement the reports with additional demographic information for analysis and improvement of member access to services and programs.

The Benefit Policy Inventory (BPI) is designed to support proper use of benefits. This program catalogues all policies pertaining to individual fee-for-service benefits, correlates each benefit with information about enforcement methods and policy compliance levels, and provides a framework to track the effectiveness of each. The BPI is being rolled out in four phases. The catalogue was assembled and benefit enforcement methods added during 2016 and 2017. The compliance and analysis capability components are expected to be completed during FY 2018–19. The system will be continually maintained by benefit managers to be responsive to the changing nature of benefit policy.

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## BENEFITS COLLABORATIVE

To support our strategy of ensuring robust management of Medicaid benefits, we routinely review new data, research, and evidence-based guidelines to ensure that covered services are current and appropriate for provision of quality health care.

One mechanism for achieving this is through the public Benefits Collaborative process, which applies person-centered principles to the design and revision of Colorado Medicaid covered services. The Benefits Collaborative seeks to define coverage that

- is based on the best available clinical evidence and best practices,
- outlines the appropriate amount, scope and duration of Medicaid services,
- is cost-effective and sets reasonable limits upon services, and
- promotes the health and functioning of Medicaid members.

Coverage policies established through the Benefits Collaborative are re-examined every three years.

In addition to ensuring responsible allocation of taxpayer dollars and promoting member health, clearly defined coverage provides guidance for service providers and increases member understanding of their benefits.

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## PHARMACY BENEFITS MANAGEMENT

All policy decisions related to clinical criteria and coverage standards regarding the Department's pharmacy benefit include evidence-based processes. In addition, we review applicable federal and state laws and regulations whenever making policy decisions, clinical or not. We also consider the impact on our providers and members whenever we look to make a change.

For example, there are 37 classes of drugs on our Preferred Drug List (PDL), which comprises hundreds of drugs. Every class undergoes an extensive annual clinical review to determine what is a preferred or non-preferred drug. The clinical review is based on evidence-based processes and is coupled with a financial analysis to determine the most cost-effective approach while ensuring quality is maintained. There are also a number of drugs that are placed on prior authorization outside of the PDL process. Whenever a drug is added or prior authorization criteria change, we review applicable clinical information and use an evidence-based process to determine the criteria. All prior authorization reviews are based on criteria established by these evidence-based processes.

In addition, we are a member of the Drug Effectiveness Review Project (DERP)<sup>2</sup>, which provides analysis on the relative quality of clinical information and shares evidence-based policy information with states. We consult this information when making clinical decisions.

Our pharmacy reimbursement rate-setting is based on actual costs to our providers and is updated regularly as follows: On a monthly basis, we receive invoices from selected Colorado pharmacies, and our vendor uses this information to calculate an average acquisition cost. On a weekly basis we use another pricing statistic, wholesale acquisition cost, to validate our rates and determine whether changes are needed. If a provider believes a reimbursement rate is incorrect, they can submit an inquiry along with their invoice to back up their request. Our vendor compares the submitted price to available pricing information to determine if the rate needs to be changed.

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## MEDICAID AND CHP+ MANAGED CARE CONTRACT MANAGEMENT

Focusing on contract management processes and tracking key performance indicators in our managed care contracts helps us ensure adequate access to and continuity and quality of care.

In FY 2016–17, we focused on driving performance in managed care contract management. We continue to use a contracts management knowledge center to support greater understanding of processes and program activities. We also aligned contracts to facilitate tracking and performance monitoring, and closely analyzed key performance indicators (KPIs) including Coverage of Services, Access and Availability, and Network Adequacy.

In FY 2017–18, we will continue to track performance on the KPIs, work with the managed care plans to ensure that members receive the care and support they need, and review contracts with an eye toward clarifying expectations, incentivizing performance and delivering better services to members. We will continue to build on the contracts management knowledge center to facilitate greater access to progress and performance. In addition, we will work with the plans to ensure compliance with the new managed care regulations, help them complete their parity analysis, and monitor and support strategies to improve EPSDT<sup>3</sup> rates.

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## DENTAQUEST PERFORMANCE MANAGEMENT

DentaQuest performance management has enabled us to improve and confirm effectiveness in multiple areas, including expansion of our dental provider network. We added an adult dental benefit in FY 2014–15, and contracted with DentaQuest to administer dental benefits for children and adults. DentaQuest uses an administrative services organization (ASO) delivery model, and sets annual performance goals focused on areas in need of improvement. This has enabled DentaQuest to meet our goals of establishing a robust dental network and reducing dental-related emergency department visits.

DentaQuest's annual performance goal for FY 2016–17 was to measure dental care outcomes, with the purpose of ensuring that increased access to preventive and restorative dental care has had a positive impact on members' overall health (reduced diabetic-related episodes, pre-term deliveries, etc.).<sup>4</sup> In approaching the final two years of the DentaQuest contract, we have begun evaluating data to set

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<sup>2</sup> Run by the Center for Evidence-Based Policy, DERP is a partnership of state Medicaid and public pharmacy programs. DERP produces comparative, evidence-based reports to assist policymakers and other decision-makers with drug coverage decisions.

<sup>3</sup> Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the pediatric component of Medicaid.

<sup>4</sup> Performance goal outcomes are evaluated in the subsequent FY to account for claims run-out.

appropriate performance goals. This work will continue into FY 2017–18, and is expected to offer flexibility to set goals based on areas in need of improvement as the program matures. Department staff are in active discussions with the American Dental Association (ADA) to explore measures to confirm the value of offering a dental benefit to Medicaid members, in particular adults (as this is currently an optional benefit). We have provided dental network data to the ADA to assist in their efforts to measure the value of the dental benefit. We have also been approached by the Heller School for Social Policy and Management at Brandeis University for similar work.

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## UTILIZATION MANAGEMENT

The ColoradoPAR Program for utilization management (UM) promotes robust management of Medicaid benefits by establishing guidelines to help ensure members receive the right services and supports at the right time and for the appropriate duration. The program improves quality of care and contains costs by reducing unnecessary and duplicative services. eQHealth Solutions, our UM vendor, reviews prior authorization requests (PARs) to determine if services are medically necessary according to established criteria and guidelines.

During FY 2016–17, we continued our focus on streamlining processes for providers and working with eQHealth Solutions to improve the PAR process through a data-driven, evidence-based approach. During the next year, the Department will work with eQHealth Solutions to achieve initiatives outlined in its annual UM plan. These include

- refining PAR processes,
- increasing provider outreach and education, and
- optimizing PAR-related processes in our new Colorado interChange claims management system to include more specialized benefit criteria and align prior authorization with payment.

These initiatives will decrease inappropriate utilization of benefits, improve provider satisfaction and ease, and promote continuity of member care. We expect to see utilization and cost reductions as collaboration, process efficiencies, program alignment, and policy enforcement increase.

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## HCBS PROGRAM EVALUATION

An important focus of our efforts to improve benefits management this year will be continuing to evaluate the Home and Community Based Services (HCBS) program for policy and rule changes needed under the 11 HCBS waivers.

The HCBS waiver program is Medicaid’s long-term care community alternative to serving eligible persons in an institution. Through HCBS waivers, individuals at risk of being placed in an institution can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Over the past year, we worked to implement several large-scale rule and policy changes related to our HCBS programs (Single Entry Point, Non-Emergency Medical Transportation, Consumer-Directed Attendant Support Services (CDASS), Home Modification). This work continues, and will be a priority during FY 2017–18 as we seek alignment and efficiency in our HCBS programs.

Examples of HCBS program evaluation and improvements during FY 2016–17 include

- a regulatory efficiency review to determine changes needed to remove burdensome requirements, and ensure clarity and alignment with several HCBS waivers and benefits;
- a study of the viability and potential alignment of waiver benefits through the implementation of a Community First Choice option;
- continued work to develop a redesigned waiver for adults with intellectual and developmental disabilities (I/DD) (for a description of this work, see page 30); and
- a rollout of the Cross-System Response for Behavioral Health Crises Pilot Program evaluation and actuarial study. This work will enable us to analyze and evaluate HCBS waiver and Medicaid State Plan benefits to identify gaps in services for adults and children with I/DD and co-occurring mental health diagnoses.

We will continue these efforts in FY 2017–18, as well as evaluate the benefits, health outcomes, and costs associated with consumer-directed service delivery options for HCBS.

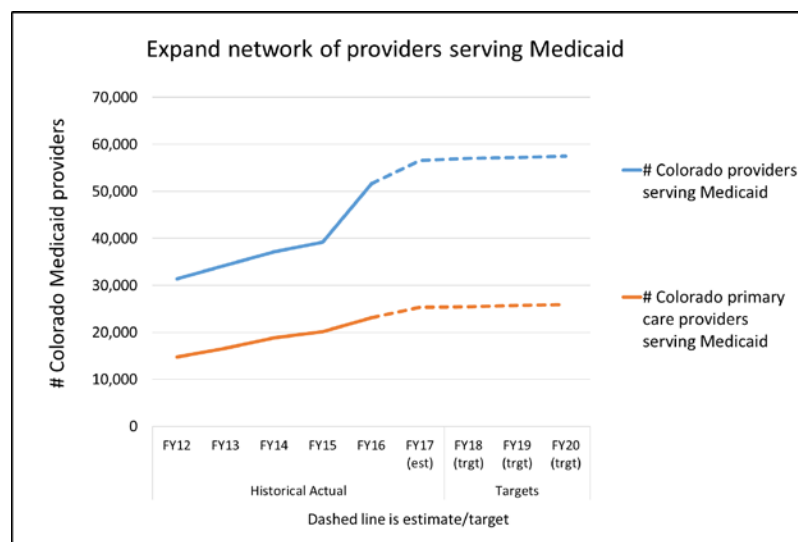
### QUALITY INDICATOR SURVEY – PERFORMANCE MEASURES REDESIGN

Another important effort supporting our strategy for ensuring robust management of Medicaid benefits is the Quality Indicator Survey for performance measures redesign. Our goal is to meet federal requirements for having systems in place to measure, improve performance, and provide assurances of quality for the Home and Community Based Services (HCBS) waivers.

Over the past year we have reviewed all performance measures and redesigned several of them to provide quality data to improve services provided to enrolled participants. We are currently working to incorporate the new measures into all waivers.

### STRATEGY #1B EXPAND THE NETWORK OF PROVIDERS SERVING MEDICAID

Our ultimate aim for this strategy is to improve member access to care. Increasing the number of providers and physicians serving Colorado Medicaid is an important way to achieve this. To gauge progress with this



strategy we are measuring the number of health care providers serving the Medicaid population. This number has increased since FY 2014–15 from 39 thousand to an estimated 56 thousand. Among these, approximately half are primary care providers.



The increase in provider enrollment during FY 2016–17 was partially due to the federally mandated provider revalidation project, which established more accurate and current enrollment information. The rate of growth in enrollment slowed during the last quarter of FY 2016–17, and we project modest growth going forward.

Expand network of providers serving Medicaid	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Colorado providers serving Medicaid	39,208	51,673	56,611	57,000	57,500
# Colorado primary care providers serving Medicaid	20,151	23,145	25,322	25,500	25,900

The following programs assist in supporting our strategy to expand the network of providers serving Medicaid.

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### ACCESS TO CARE

A primary focus of the Department is to ensure that members have adequate access to care so that they receive services from appropriate providers, including transportation, as needed. Access to needed services helps to ensure that members receive the right services at the right time. To ensure our members have adequate access to care, we are working to impact three variables:

- Member health needs
- Availability of services to meet member needs
- Member utilization of needed services

Member health needs are being addressed through a number of Department programs. The Medicaid Nurse Advice Line (NAL) serves as one mechanism to improve access to care. Members may call 24 hours a day to receive medical advice to help determine the appropriate level of care (e.g., home care, emergent care, or physician follow-up) based on reported symptoms and conditions. Members may also call to receive advice and education related to chronic medical conditions, such as diabetes. NAL staff refer members to appropriate Medicaid, Department, state, and community resources (e.g., Nurse Family Partnership) based on their needs, which helps bridge gaps related to health care and social determinants of health. The NAL shares data with Regional Care Collaborative Organizations to help support coordinated care and primary care physician follow-up (see page 23).

The ColoradoPAR Utilization Management Program and Medicaid member appeals and policy staff work directly with providers and members on a case-by-case basis to direct them to appropriate services based on member needs. For example, if members do not meet criteria for one service, they will be directed to a more appropriate service to best meet their needs (see page 18).

Department staff, with stakeholder input, develop policies to expand access to care with consideration to provider requirements (e.g., provider types that can render services, prior authorization requirements, limitations), reimbursement, member quality of care, and regional factors. More specifically, the Benefits Collaborative, the Department’s formal stakeholder engagement process to define benefits, uses a person-centered, collaborative approach when creating or revising benefits. In addition to supporting access to care, the Benefits Collaborative supports Strategy #1A, *ensure robust management of Medicaid benefits* (see page 15).

Another way access to services is impacted is by how much providers are paid. Federal law requires state medical assistance programs to ensure payments are consistent with efficiency, economy and quality of care, and sufficient to enlist enough providers so that care and services are available.<sup>5</sup> This means, in part, ensuring compensation is adequate across payers, provider types, and health care delivery sites. When provider payment rates are reduced or restructured, we use an access monitoring program to ensure access is not diminished. In cases where access is diminished, corrective action such as a payment increase is taken to reduce barriers to provider enrollment. In addition, we conduct recurring provider rate reviews analyzing utilization, access, and quality, and rate comparison by service. In response to payment rate review findings, strategies are developed to ensure payments are sound, and recommendations are provided to the Joint Budget Committee each November.

Both availability of services and member utilization of needed services are impacted when a member lacks access to transportation in a non-emergency situation. For this reason, non-emergent medical transportation (NEMT) to and from Medicaid services is a mandatory State Plan benefit offered to all Medicaid members. The Department recently took steps to improve access to, and quality of, NEMT services. In November 2014, we contracted with a new NEMT provider, Total Transit, to service nine counties on the Front Range. To support retention of NEMT service providers, we applied a targeted rate increase to a number of transportation services in addition to the 0.5% across-the-board provider rate increase effective July 2015. We supported legislation which became effective July 1, 2016 to increase the number of qualified NEMT providers by reducing licensing barriers.

Most recently, we provided recommendations to evaluate and improve NEMT, emergent medical transportation, and physician-administered drugs access based on stakeholder feedback and data analysis in the Medicaid Provider Rate Review process.

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## PRIMARY CARE MEDICAL PROVIDER OUTREACH & ENROLLMENT FOR THE ACC

Because primary care is critical to preventive health and wellness, our goal for the Primary Care Medical Provider Outreach and Enrollment program is to increase the number of providers available as primary care medical providers (PCMPs). While we have made steady progress since the Accountable Care Collaborative (ACC) was implemented in 2011, there is still opportunity for improvement. Important targets for this work are

- providers that are not PCMPs but are providing care to ACC-enrolled individuals,
- providers serving as the medical home for individuals enrolled in the ACC's Medicare-Medicaid Enrollee demonstration program,
- rural health centers, and
- community mental health centers (CMHCs) that provide integrated physical and behavioral health care.

Approximately half of the rural health centers are PCMPs. In FY 2017–18 we will target those not serving as PCMPs through outreach at rural health center events and strengthen engagement facilitated through provider associations. In FY 2017–18, we will also reach out to CMHCs providing integrated health services to encourage them to sign up as PCMPs. These outreach efforts are important for increasing access to care, and strengthening the provider network in advance of the next phase of the Accountable Care Collaborative.

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<sup>5</sup> Equal access provision in Section 1902(a)(30)(A) of the Social Security Act, amended 2015 in 42 C.F.R. §447.

To support these outreach and enrollment efforts, we have implemented several strategies to increase financial incentives for PCMPs, including the enhanced PCMP initiative. This initiative allows primary care practices that meet at least five out of nine “enhanced” service factors to receive an additional \$.50 per member per month. Enhanced service factors include member offerings such as evening or weekend hours, telephone or secure electronic message consultations, and access to onsite behavioral health specialists. Payment incentives are also offered to primary care practices participating in SIM. (For a description of the SIM Practice Transformation program, see p. 27.)

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## PROVIDER RELATIONS ENHANCEMENT

Provider relations is critical to expanding our network and retaining providers already serving Colorado Medicaid, and focuses on ensuring the Colorado Medicaid provider network is adequate and comprehensive, with sufficient physical, behavioral, dental, and long-term services. Ongoing provider relations work includes outreach, recruitment/retention, enrollment support, and communications.

Beginning in September 2015, we began supporting providers in complying with new federally mandated provider screening/revalidation regulations. Completion of this provider revalidation process was scheduled for February 2017, but is ongoing for a small percentage of providers that did not complete the process on time.

During FY 2017–18, we will continue our support for providers during the transition to the Colorado interChange system and work to improve provider communications, identify and remove/reduce barriers to Medicaid participation, and expand and improve relationships between Medicaid and the provider community. This work will include development of provider communications and trainings to support post interChange-launch activities and system or policy changes, development of reporting to support targeted provider outreach, and assessment of access to care for Medicaid members across the state.

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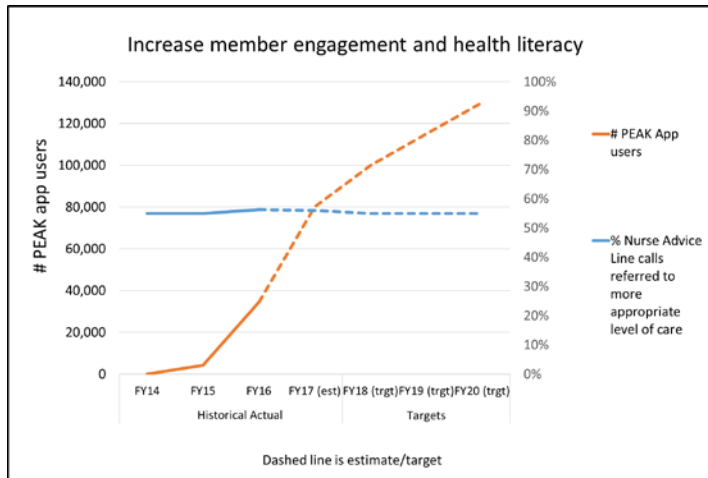
## EXTERNAL RELATIONS

External relations efforts support all our strategies, but place emphasis on our strategy to expand the network of providers serving Medicaid. This is due to the importance of developing messaging to help providers understand changes related to the provider revalidation project and implementation of COMMIT and related IT components in Spring, 2017. (For more about COMMIT, see page 43.)

## STRATEGY #1C INCREASE MEMBER ENGAGEMENT AND HEALTH LITERACY

This strategy supports efforts to engage members in their health and health care decision making with the goals of promoting wise use of services and improving health and well-being.

Although a combination of performance measures is necessary to gauge progress with member engagement and health literacy, we have selected two representative measures: number of PEAKHealth App users and percent of Nurse Advice Line calls referred to a more appropriate level of care.



The PEAKHealth App was launched in December 2014, and the number of users is expected to reach 80,000 by July 2017. Our goal is to achieve 130,000 users by FY 2019–20. The Nurse Advice Line has been steadily referring 55% of its callers to more appropriate levels of care. For example, to a primary care physician instead of an emergency department, or if conditions appear emergent, to visit an emergency department instead of waiting for an appointment.

Increase member engagement and health literacy	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% Nurse Advice Line calls referred to more appropriate level of care	55%	56%	56%	55%	55%
# PEAK App users	4,337	34,644	80,000	100,000	130,000

The following programs assist in supporting our strategy to increase member engagement and health literacy.

### NURSE ADVICE LINE

The Nurse Advice Line (NAL) engages members in their health and health care decision making by offering free around-the-clock access to medical information and advice and assisting callers in identifying the most appropriate level of care based on their individual health care needs.

The NAL promotes appropriate use of services and coordinated care. It refers members to their local Regional Care Collaborative Organization (RCCO) and/or to other appropriate services, such as the Nurse Family Partnership. Daily data feeds of NAL caller information are transmitted to the caller’s RCCO to encourage care coordination and greater follow-up with the caller’s primary physicians. Member adoption of the service has been encouraging. Calls to the NAL increased from roughly 18,000 in FY 2014–15 to 34,500 in FY 2016–17.

A recent NAL adherence study found that approximately half of callers who had planned to go to the emergency department received advice to seek a lower level of care, and that 73 percent complied with that recommendation.<sup>6</sup> During FY 2017–18, our plans include continuing to study caller behavior so we can support members to make the best care choice, and increase member use of the NAL service. Based on the positive findings of the adherence study, we will continue efforts to increase the number of callers to the NAL. Our plans also include increased collaboration with RCCOs to support care coordination efforts, as well as other community programs that are a viable resource for callers.

<sup>6</sup> The study reviewed six months of NAL calls received during late 2015 through early 2016.

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## MEMBER PORTAL

The Web-based member portal advances our strategy of increasing member engagement and health literacy by connecting members to the new Colorado interChange system. The portal delivers important functions for members such as the ability to update personal information and search for a provider, as well as access coverage, appeals, and claims information.

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## PEAKHEALTH APP

The *PEAKHealth* mobile application increases member engagement and health literacy by allowing members to keep their information up to date, find a doctor, and access important health information from their phone. Design and updates of the free app focus on member engagement objectives including enabling members to find what they need, when and how they need it, and minimizing the effort required.

The app saw more than 100% increase in new users from FY 2015–16 to FY 2016–17. Use has increased steadily, from 10,000 in August 2015 to 73,000 separate individuals as of April 30, 2017, when it was being used on average 900 times a day. By July 1, 2017 we estimate 80,000 users. A popular feature has continued to be View My Medical Card, enabling members to show their Health First Colorado card to providers and pharmacies from their phone. To date, the feature to review case information has been accessed over 500,000 times.

The Department has partnered with many of its contractors to help promote and advertise advantages of the app. While we recognize that this grass roots strategy has yielded a steady adoption, a more targeted strategy can rapidly increase awareness and adoption.

New features planned for FY 2017–18 continue to align with member engagement objectives. A personalized content for health plans and population health management feature will provide specific and relevant information for users. Announcements of new benefits and a fast and easy way to schedule non-emergent medical transportation will also be added.

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## HEALTHY COMMUNITIES EVALUATION RECOMMENDATIONS

Healthy Communities is a statewide program administered at the local level by 26 local public health agencies serving all children (birth through age 20) and pregnant women on Medicaid and CHP+. Nearly 100 family health coordinators across these sites deliver member and community outreach, application assistance, member orientation and navigation services, provider and community resource referrals, member health education, and administrative case management.

In FY 2014–15, the Department commissioned an evaluation of the Healthy Communities program and identified recommendations to eliminate duplication of work and to better align Healthy Communities activities with EPSDT wellness visit participation outcomes.<sup>7,8</sup> The evaluation recommended focusing program resources on those age groups with the highest number of eligible children and with the greatest need for improvement (ages 6–9, 10–14, 15–18). It further recommended that to make the most impact on state performance, improving performance in the top 12 (of 64) counties by program population would affect 85% of eligible children.

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<sup>7</sup> Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the pediatric component of Medicaid.

<sup>8</sup> Upleaf. (2015). *Healthy Communities evaluation project final report and program recommendations*. (Annex C: EPSDT Outcomes Mapping & Analysis). Evergreen, Colorado: Elizabeth Beachy, MHS.

In FY 2016–17, program efforts focused on developing workflows, processes and scripting language to improve interactions with members and developing strategies to improve ESPDT rates. The program has also begun incorporating Medicaid claims data into its member relationship management system to enable family health coordinators to better prioritize and follow up on children who have not had a well-check during the previous year.

In FY 2017–18, we will continue to focus on improving data management to enable contractors to better analyze and monitor performance. We will also focus on implementing strategies that enable better collaboration with RCCOs and make the biggest impact on improving EPSDT rates.

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## MEMBER ENGAGEMENT

Our goal for the Member Engagement program is to infuse policy, programs, and operations with an understanding of how members engage with, participate in, use, and respond to the Medicaid and CHP+ health care system. One outcome of member engagement is better health for members at lower cost. For example, we know that successfully finding a provider can be the difference between an office visit and an emergency room visit.

A centerpiece of member engagement efforts during FY 2016–17 was *PEAKHealth*, a mobile app launched in December 2014.<sup>9</sup> The app was designed to meet growing demand from members for better access to their health coverage information.

During FY 2016–17, we focused member engagement work on appropriate use of care. In FY 2017–18, we plan to continue deepening member engagement through trusted, clear, and easy-to-access information and tools. For example, streamlining and consolidating member handbooks and offering them in more widely accepted formats. In FY 2017–18 members will, for the first time, have online access to a searchable, printable, comprehensive member handbook that includes videos and content personalized to the member’s household.

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## MEMBER COMMUNICATIONS

Improving communications with members is another way we are advancing our strategy to increase member engagement and health literacy. The first phase of this work focused on improving our operations and member communications. Consistent and understandable communications can build trust, which can foster member engagement. The first phase was completed during FY 2016–17, and focused on testing language with members to revise four prominent eligibility notices. During this phase, we worked with a vendor to gather member communication best practices and shared them with other partners and state agencies.

This work will continue during FY 2017–18 with the goal of revising additional correspondence to incorporate feedback from member testing and plain language best practices.

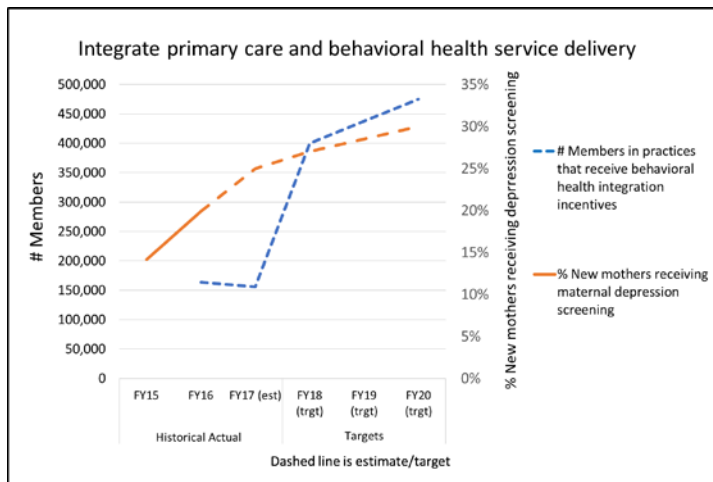
## STRATEGY #1D INTEGRATE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICE DELIVERY

Behavioral health care delivery systems (including mental health and substance use disorder) are often entirely separate and excluded from the physical health system, resulting in substandard care and

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<sup>9</sup> See page 24 for more about the *PEAKHealth* App.

increased costs.<sup>10</sup> In addressing the problem of behavioral and physical health care segregation, we have integrated substance use disorder and behavioral health care, and are piloting an integrated physical and behavioral health delivery model through the Colorado State Innovation Model Practice Transformation project, described below.



To gauge progress with this strategy we are measuring the percent of new mothers receiving maternal depression screening, and the number of members in practices that receive financial incentives to integrate physical and behavioral health services. Both measures are on track and expected to trend upward due to the efforts described below.

Integrate primary care and behavioral health service delivery	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% New mothers receiving maternal depression screening <sup>1</sup>	14%	20%	25%	27%	30%
# Members in practices that receive behavioral health integration incentives	0	163,770	155,500	400,000	475,000

<sup>1</sup>Methodology adjusted in FY 2016–17 to include screenings not in the billing system. Historical data is restated.

The following programs assist in supporting our strategy to integrate primary care and behavioral health service delivery.

## MATERNAL DEPRESSION SCREENING

Untreated postpartum depression negatively impacts the health and well-being of mothers and their families. Coordinated care and integrated physical and behavioral health services are central in our efforts to achieve early intervention and treatment.

The Accountable Care Collaborative (ACC) is working with primary care providers to encourage screening and prevention services such as information on nutrition, vaccinations, and depression screenings, as seen in the adult depression screening key performance indicator. Several of our Regional Care Collaborative Organizations have also identified maternal mental health as a target area and have specialized care coordination for this population. In addition, a significant number of pediatricians are utilizing this option to screen for maternal depression at well-child visits.

Prevention strategies help providers identify problems before they turn into serious complications. To increase the number of new mothers screened for depression, during FY 2016–17 we partnered with the Colorado Department of Public Health and Environment in a data sharing agreement focused on improving maternal depression screenings and referrals. The data is being used to inform policy in the

<sup>10</sup> Nardone, M., Snyder, S., & Paradise, J. (2014). Integrating physical and behavioral health care: promising medicaid models. *Washington, DC: Kaiser Commission on Medicaid and the Uninsured.*

statewide pregnancy related depression strategy being developed by the Pregnancy Related Depression Task Force—a cross sector and cross agency team that targets reducing stigma, increasing access, and building provider confidence in screening.

During FY 2018–19, ACC Phase II initiatives to join physical and behavioral health under one accountable entity will further embed best practices such as maternal depression screening and treating behavioral issues in the primary care setting.

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## SIM PRACTICE TRANSFORMATION

Accountable Care Collaborative (ACC) participation in the Colorado State Innovation Model (SIM) is a central component of the Department’s behavioral and physical health integration strategy.

The goal for SIM, which is funded by a grant from the Center for Medicare & Medicaid Innovation, is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems. An integral focus of this goal is to pay for value, not volume (using value-based payment structures), for 80% of Colorado residents by 2019.

Through SIM, the Regional Care Collaborative Organizations are making payments to selected primary care medical practices to help them integrate physical and behavioral health care and move along SIM’s 10 Building Blocks of High-Performing Primary Care. The Department is providing financial and administrative oversight for SIM, and has placed key staff in each of the eight SIM workgroups to ensure continuity of SIM support and facilitate alignment and synergy with the ACC. The department also serves as a payer supporting Medicaid practices participating in SIM.

From February 2016-February 2018, we will be supporting SIM’s goal of recruiting 400 primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care. To do so, SIM is collaborating with ACC providers to implement models of integrated care with the objective of providing consumers access to behavioral and physical health care services in coordinated systems of care.

Through the involvement of ACC primary care practices, the department is receiving benefits of SIM practice transformation. Benefits include SIM-funded education for Medicaid providers that supports practice integration and transformation, and connection between communities and practices. These and other aspects of our participation in SIM are helping us prepare providers to integrate physical and behavioral health in FY 2018–19 when the new ACC contract begins (See ACC Phase II, page 34).

During FY 2016–17, SIM engaged 92 practice sites, 88 of which are active members of the ACC program. These practices have more than 900 providers and serve more than 300,000 beneficiaries. There are 21 pediatric practices and nine practices that serve children and adults.

The SIM office completed an application process to engage a second round of practice sites (cohort 2) and is preparing to bring on an additional 165 practices during FY 2017–18. The applicant pool included a robust percentage of pediatric practices and it is anticipated that between 15–20% of the practices in cohort 2 will be pediatric, thus ensuring our maternal depression screening metric stays on track. Additionally, the second cohort will have a direct effect on the number of Medicaid members in practices that integrate behavioral and physical health care. The application to participate in the third cohort of SIM will be released during the fall/winter of 2017. These practices will kick-off participation in FY 2018–19. Given the continued progress of SIM, and success of the project in supporting integrated behavioral health, including screening and follow-up for maternal depression, this strategy remains on track.



After passing the one-year implementation mark, SIM continues to report small successes from practice team members, who are receiving thank you letters from patients, and hearing positive feedback from care team members, who report higher job satisfaction because of their ability to provide whole-person care, which makes a difference in patients' lives.

"We think it's the best way to deliver good care," says Brian Gablehouse, MD, of Peak Pediatrics, a SIM cohort 1 practice.

The initiative is also helping providers collect, report and analyze data in actionable ways that help them succeed in value-based payment models, and provide the type of whole-person care that improves patient outcomes. The team is preparing for cohort 2 with a refined set of milestones and a focused approach to practice transformation that will help practices improve quality while containing costs.

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## BEHAVIORAL HEALTH

The Community Behavioral Health Services program, which is operated by four Behavioral Health Organizations (BHOs) in five geographical regions statewide, provides comprehensive mental health and substance use disorder (SUD) services to Medicaid-enrolled Coloradans. Multiple efforts involving the program and the Accountable Care Collaborative (ACC) are advancing our work to integrate behavioral and primary health care service delivery.

Following integration of SUD benefits into the BHOs early in 2014, treatment initiation for SUD has increased 47%, and treatment for SUD 38%. During FY 2016–17, we extended treatment delivered by the BHOs by

- optimizing treatment for substance-use dependent members who use the emergency department;
- increasing the number of foster care children receiving assessments and services by 5%, and working with state and county partners to increase services; and
- working with state and county partners to increase services and care coordination for members transitioning back to the community from the criminal justice system.

To support this extended treatment initiative, we engaged the BHOs in strategic planning and attended community meetings and meetings with sister agencies to identify opportunities to align it with existing initiatives. In the development of an incentive program for the BHOs, we tied their strategic plans to a monetary incentive, which will be implemented during FY 2017–18.

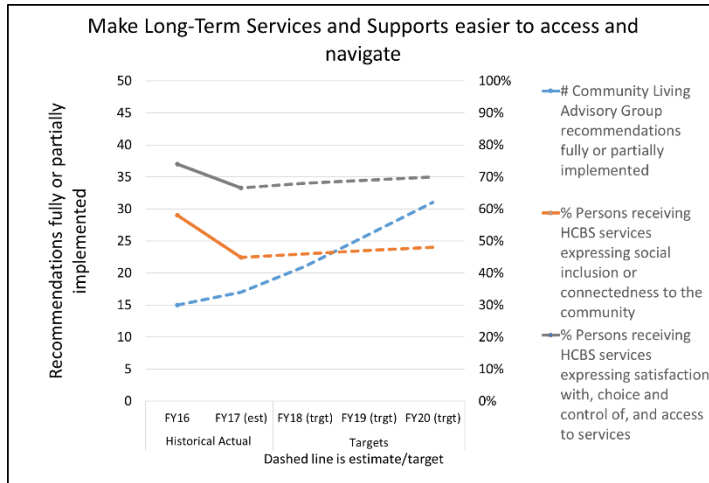
Also in FY 2016–17, we added language to our BHO contracts creating incentives for providing short-term non-chronic behavioral health services in a primary care setting by

- allowing up to six short-term non-chronic behavioral health services to be performed in a primary care setting without the extra paperwork requirement of the Colorado Client Assessment Record form, and
- allowing primary care practitioners to provide evaluation and management services for members with presenting behavioral health diagnoses without the requirement of joining a BHO provider network.

We are collaborating with ACC providers during 2017–18 to develop models of integrated care with the objective of providing access to coordinated behavioral and physical health care services in one location. Further integration of behavioral and physical health care will take place when we launch ACC Phase II in FY 2018–19.

## STRATEGY #1E MAKE LONG-TERM SERVICES AND SUPPORTS EASIER TO ACCESS AND NAVIGATE

Colorado has begun a large-scale effort to transform its delivery system for long-term services and supports (LTSS). Efforts focus on increasing ease of access, simplifying processes, expanding services, and reducing administrative burden. Programs supporting this strategy focus on simplifying Colorado Medicaid home and community-based services (HCBS) waivers for older Coloradans and persons with disabilities, and developing infrastructure to transition members from long-term care facilities to community-based settings.



Three performance measures gauge success of this strategy: the number of Community Living Advisory Group (CLAG) recommendations implemented, and two measures related to the satisfaction of individuals receiving HCBS.

We expect improvement in satisfaction scores as the LTSS system shifts to being more person-centered. With respect to CLAG recommendations implemented, details will be included in our November 2017 report to the legislature.

Make Long-Term Services and Supports easier to access and navigate	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Community Living Advisory Group recommendations fully or partially implemented <sup>1</sup>	N/A	15	17	21	31
% Persons receiving HCBS services expressing social inclusion or connectedness to the community <sup>2</sup>	N/A	58%	45%	46%	48%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services <sup>2</sup>	N/A	74%	67%	68%	70%

<sup>1</sup>The Department began implementing Community Living Advisory Group recommendations in FY 2015–16.

<sup>2</sup>The Department utilizes the NCI-AD (Aging and Disabled) and NCI-IDD (Individuals with Developmental Disabilities) Consumer Surveys to assess this measure and began tracking results in FY 2015–16. Data reported is up to 18 months in arrears.

The following programs assist in supporting our strategy to make Long-Term Services and Supports easier to access and navigate.

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## NO WRONG DOOR

The goal of our No Wrong Door (NWD) project is to make it easier for older adults and people with disabilities to learn about – and access – the long-term services and supports they need.<sup>11</sup>

Stemming from our 2014 NWD planning grant, we developed a regional model for deploying NWD in Colorado. In FY 2016–17, we identified regional pilot sites around the state to test and evaluate the model. The pilot sites will launch this summer and remain operational through 2019.

During FY 2017–18, we will work with the pilot sites and our evaluation vendors from the Center on Network Science at the University of Colorado-Denver to collect data and evaluate our NWD model. Nonprofit Impact, our technical assistance vendor, will create a NWD “toolkit” of operating protocols and job descriptions to support the business operations of the pilot sites. While an initial toolkit has already been drafted, it will be continuously refined over the course of the project with pilot site input.

We will also continue studying financing strategies for implementing our NWD model statewide, including maximizing Medicaid funding. We are currently partnering with the State Unit on Aging<sup>12</sup> to implement Medicaid federal financial participation (FFP) for NWD activities through Aging and Disability Resources for Colorado (ADRC) sites. This effort will inform how we finance statewide NWD implementation while the pilots are running. Implementation of FFP for the ADRCs is anticipated for January 2018. We also plan to study statutes and regulations impacting agencies involved in the NWD model, and how to address them as we work toward statewide implementation.

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## HOME AND COMMUNITY BASED SERVICES WAIVER REDESIGN

Our strategy for waiver redesign is to simplify access to services, and improve satisfaction, health, and quality of life for Coloradans requiring long-term services and supports. The Department operates 11 Home and Community-Based Services (HCBS) waivers through which we furnish an array of services that promote community living for Medicaid beneficiaries.

We set out to redesign our HCBS waivers in response to the Community Living Advisory Group recommendations<sup>13</sup> for simplifying our waivers and streamlining and simplifying access to long-term services and supports. Redesign efforts in FY 2016–17 focused on developing a consolidated HCBS waiver for adults with intellectual and developmental disabilities (I/DD). We began by establishing the Waiver Implementation Council to advise on the design and implementation of the new, redesigned waiver. We developed drafts of the new waiver’s 12 service definitions, all of which have been reviewed by the Council. We also developed quality measures, provider qualifications, service utilization forecasts, norm-referenced service limits, and new data for determining rates based on an impact analysis of the 12 services in the new waiver. Our development of the adult I/DD waiver is evolving into a broader effort from which we can inform and streamline redesign of the Department's other HCBS waivers.

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<sup>11</sup> No Wrong Door (NWD) is a grant program administered by the Federal Administration for Community Living. Grants are designed to help states develop NWD systems that streamline processes for accessing long-term services and supports.

<sup>12</sup> A division of the Colorado Department of Human Services.

<sup>13</sup> See Community Living Advisory Group, page 56.

Going into FY 2017–18, we anticipate using outcomes of impact analyses to ensure resources are appropriately allocated to sustain providers and their provision of quality, flexible, person-centered services. The effort will then move into developing the application to the Centers for Medicaid & Medicare Services for the new waiver, including gathering and incorporating stakeholder feedback.

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## CONFLICT-FREE CASE MANAGEMENT – NEW CHOICE INFRASTRUCTURE

In addition to separating case management from provision of services to remove conflicts of interest, implementing conflict-free case management will put individuals and families in control of choosing both their direct service provider agency and their case management agency.

One role of the HCBS case manager is to recommend and authorize service and support options. In some instances, the case manager works in an agency that provides both case management and direct services, presenting a potential conflict of interest in recommending and authorizing services. Eliminating this possibility is important to both access and quality of care. Otherwise, service plans can include expensive, complex, or unnecessary services that benefit the agency making the recommendation and authorizing the services.

We developed a conflict-free case management implementation plan and submitted it to the General Assembly in FY 2016–17.<sup>14</sup> In response, a 2017 conflict-free case management bill was passed relating specifically to individuals with intellectual and developmental disabilities enrolled HCBS. The statute requires a complete separation of case management from services provision by 2022.

During FY 2017–18, we will work with case management agencies regarding their options to become compliant with conflict-free case management. We will also work with all stakeholders as we develop regulations for case management agencies and case managers. Given the unique challenges in our rural communities, we will work to ensure people across the state will maintain access to services while we implement conflict-free case management.

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## FUNCTIONAL ASSESSMENT TOOL FOR LTSS

We are developing and implementing a new functional assessment tool, a systematic method used to determine the unmet needs, goals, and interests of a person applying for LTSS through the Medicaid program.<sup>15</sup> The tool is designed to help us determine the individual's eligibility for programs and the level and type of LTSS they require. Once it is finalized, the tool will improve efficiency of business processes critical to making it easier for members to navigate and access LTSS:

- increased reliability of eligibility decisions,
- a more comprehensive data set to better inform support planning, and
- new resource allocation processes to assign individuals eligible for Medicaid LTSS to different funding levels based on their needs.

During FY 2016–17, we initiated 14 public forums in seven locations to review the tool with stakeholders who would be impacted by its implementation. Information about this process is available on the

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<sup>14</sup> Pursuant to Colorado House bill HB 15-1318 to develop a plan to eliminate conflicts of interest in case management. The legislation was passed in 2015.

<sup>15</sup> The Colorado Health Foundation provided funding for development of the tool. Funding for the pilot comes from a Testing Experience and Functional Tools (TEFT) grant and Colorado Senate Bill SB 16-192.

[Colorado Assessment Tool Development Blog](#). Stakeholder meetings to adapt the tool for children were completed in June 2017.

We plan to finalize and release the new assessment tool and associated training manuals in November 2017.<sup>16</sup> During FY 2017–18, we will automate and pilot the tool. We will also develop a person-centered support plan to utilize information gathered with the tool. (See LTSS Assessment Tool for Support Planning on page 53.)

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## SUPPORTS INTENSITY SCALE ASSESSMENT PROCESS EVALUATION

We use the Supports Intensity Scale (SIS), a norm-referenced, reliable, and valid assessment tool, to determine the level of supports needed for all adults with intellectual and development disabilities (I/DD) and develop comprehensive service plans based on assessed needs. Last year, we contracted with the Human Services Research Institute to review policies and procedures regarding the use of the SIS in Colorado. We are currently implementing changes to ensure that SIS is administered accurately and used for the development of service plans.

We are also working to develop and implement a new assessment tool for all individuals needing long-term services and supports.<sup>17</sup> The new assessment tool will help streamline the process for members gaining access to long-term services and supports and reduce the number of assessments case managers conduct. (See Functional Assessment Tool for LTSS on page 31.) Upon completion of this work, we will determine if the SIS remains a viable assessment tool for individuals with I/DD.

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## SUPPORTED LIVING SERVICES ALLOCATION REDESIGN

We are increasing the administrative efficiency of the state-funded Supported Living Services (SLS) program to help our Community Centered Boards (CCBs) utilize available funds in serving adults receiving SLS program assistance.

The SLS program provides assistance and support to meet daily living and safety needs of adults who are responsible for their own living arrangements. This means they are living independently with limited supports, or if they need extensive support, are receiving it from other sources such as family. We distribute funds to CCBs, which allocate it to members. CCBs have been expending only 85–90% of the direct services funds – in FY 2015–16 only 85% were expended – because methodology for determining the amount of funding each CCB receives was outdated.

To solve this problem, we coordinated with volunteers from CCBs to improve program administration, completing a new funding allocation model in FY 2016–17. The new model will go into effect during FY 2017–18. Changes in funding due to the new model will be implemented over the next five years to minimize potential negative effects on individuals receiving services.

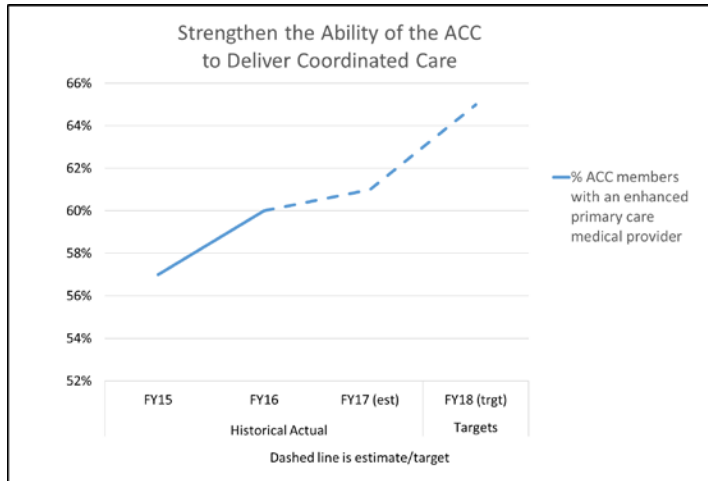
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<sup>16</sup> Our review of the new tool had been delayed pending Centers for Medicare & Medicaid Services release in January 2017 of a draft version of the Functional Assessment Standardized Items (FASI) for assessing the status of individuals receiving community-based LTSS.

<sup>17</sup> Pursuant to Colorado Senate bill SB 16-192, requiring development of a needs assessment tool for persons eligible for long-term services and supports including persons with I/DD. The legislation was passed in 2016.

## STRATEGY #1F STRENGTHEN THE ABILITY OF THE ACC TO DELIVER COORDINATED CARE

Care coordination has been shown to reduce costs and improve quality of care by ensuring that members receive the right services at the right place and at the right time. This is a central reform mechanism of the ACC. Programs supporting this strategy focus on coordinating member care through an enhanced primary care medical provider,<sup>18</sup> identifying members with complex medical needs and managing their care across providers, and adopting technology that facilitates shared access to member information among providers.



We are measuring success of the ACC's ability to deliver coordinated care by reporting the percent of ACC members with an enhanced primary care medical provider. Efforts to enhance primary care services include incentivizing providers to offer evening and weekend hours and consultations via telephone and secure e-mail.

Strengthen the ability of the ACC to deliver coordinated care	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% ACC members with an enhanced primary care medical provider	57%	60%	61%	65%	N/A

The enhanced primary care program will transition into a broader payment reform initiative in FY 2018–19; therefore, FY 2017–18 will be the final year for reporting this measure.

The following programs assist in supporting our strategy to strengthen the ability of the ACC to deliver coordinated care.

### PRIMARY AND PREVENTIVE CARE

The Accountable Care Collaborative (ACC) recognizes the importance of primary and preventive care to ensure the health and well-being of individuals. Upon enrollment into the ACC, members are attributed to a Regional Care Collaborative Organization (RCCO). The RCCOs coordinate care of members through outreach, referrals, and follow up, making sure they are connected to a primary care provider. That provider is central to their health, assessing health needs and providing preventive care such as information on nutrition, vaccinations, depression screenings and more. Preventive strategies help providers identify problems before they turn into serious complications.

<sup>18</sup> See description of enhanced PCMPs under Primary Care Medical Provider Outreach & Enrollment for the ACC on page 21.

The ACC uses a value-based payment system that rewards RCCOs if they reach predetermined targets on three key performance indicators (KPIs) – well-child visits, emergency department visits, and post-partum care. These KPIs incentivize health care providers to focus on primary and preventive care. Future KPIs will focus on chronic conditions, behavioral health, value, and member and provider experience with the goal of achieving improved health and well-being among the Medicaid population.

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## ACCOUNTABLE CARE COLLABORATIVE

The Accountable Care Collaborative (ACC) is the cornerstone of our efforts to improve member health while containing costs, and is the primary vehicle for Medicaid reform innovations that incentivize care coordination and the wise use of health services. The ACC focuses on the needs of its members and leverages local resources to best meet those needs, while fostering integration and collaboration across the spectrum of member health care.

Since the ACC's inception in 2011, member enrollment in the ACC has increased from fewer than 10,000 to more than one million. During that time, we have focused on expanding the ACC statewide, enrolling primary care medical providers (PCMPs),<sup>19</sup> and solidifying a strong stakeholder engagement process. As of July 2017, this work has largely met its goals, and our focus is shifting to include increased attention to RCCO activities, specifically, regular discussions of initiatives underway, reviews of contract deliverables and processes, and more frequent on-site visits. Moving forward, we will develop and implement new initiatives supporting member health outcomes, provider performance, and greater data and performance transparency. Internally, ACC processes and program activities will be optimized through process improvement efforts.

The ACC was formally evaluated by the Colorado School of Public Health and the TriWest HealthCare Alliance, with findings compiled in an October 2016 report.<sup>20</sup> The purpose of the evaluation<sup>21</sup> was to analyze member experience, and to quantitatively and qualitatively assess the impact of the ACC on health care utilization, costs, and quality. Findings resulted in important lessons learned and best practices that will be leveraged in the final year of the RCCO contracts, and built upon for the new contracts commencing on July 1, 2018.

Looking to the future, ACC Phase II will be implemented in FY 2018–19. There will be many changes to the ACC program at that time, including the administrative integration of physical and behavioral health care by contracting with one regional entity (the Regional Accountable Entity or RAE).

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## ACC PHASE II

The next phase of the Accountable Care Collaborative (ACC) will further advance the ACC's proven success as a vehicle for Medicaid reform innovations that incentivize care coordination and the wise use of health services.

Combining administration of physical health and behavioral health under one regional entity (the Regional Accountable Entity or RAE) will establish a cohesive network of physical health and behavioral health providers that can more effectively coordinate health care services for members across disparate

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<sup>19</sup> See description of enhanced PCMPs under Primary Care Medical Provider Outreach & Enrollment for the ACC on page 21.

<sup>20</sup> Tung, G., Santos, T., Hardy, R., O'Leary, S., & Lindrooth, R. (2016). *Evaluation of the Accountable Care Collaborative, final report*. Denver, CO. Colorado Department of Health Care Policy and Financing.

<sup>21</sup> The Colorado Health Foundation and Rose Community Foundation provided financial support for the evaluation.

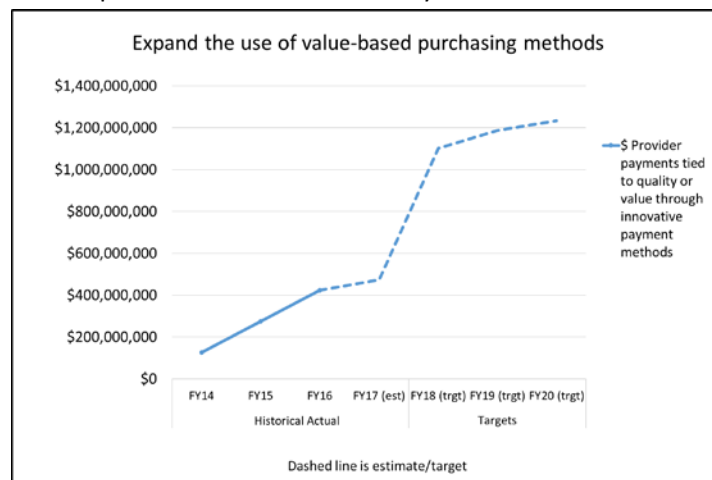
providers including Long Term Services and Supports (LTSS), specialty care, oral health, and social agencies.

We issued our formal request for proposals (RFP) for RAE contractors in May 2017, following a draft RFP public comment period in Fall 2016-Winter 2017. Contract awards for the seven regional RAEs will be announced during Fall, 2017, with contracts scheduled to be executed in Winter 2018. There will be overlapping contracts for current and new ACC vendors during Spring 2018 as the new RAEs prepare to begin operations on July 1, 2018. During the start-up period, the RAEs will establish their provider networks, policies and procedures, and technology systems to ensure the seamless delivery of services to members. The Department will also perform a readiness review of each RAE in compliance with federal regulations to ensure the new vendors are fully ready to begin operations.

## SPI #2 TOOLS OF TRANSFORMATION

### STRATEGY #2A EXPAND THE USE OF VALUE-BASED PURCHASING METHODS

This strategy focuses on purchasing value: effective services resulting in better health outcomes for the lowest practicable cost. Data analytics tools are used to correlate high quality with low cost to inform



selection of services and providers. Incentive programs reward providers for improving member health and limiting unnecessary use of services.

To measure performance of this strategy, we are reporting the dollar amount of provider payments tied to quality or value through innovative payment methods. Since FY 2014-15, the dollar amount of these payments has nearly doubled, and is on track to double again by the end of FY 2017-18.

Expand the use of value-based purchasing methods	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Provider payments tied to quality or value through innovative payment methods	\$275,265,225	\$424,606,261	\$474,552,208	\$1,102,223,409	\$1,233,374,433

Historical data is restated to align with the Centers for Medicare & Medicaid Services standard definition for measuring value-based purchasing efforts.

The following programs assist in supporting our strategy to expand the use of value-based purchasing methods.

### PAY FOR PERFORMANCE ACROSS THE ACCOUNTABLE CARE COLLABORATIVE

As part of our value-based purchasing strategy, we are employing alternative payment methodologies that measure, report, and reward excellence in the Accountable Care Collaborative. These take the form of payment agreements that hold a portion of compensation due to providers and contractors 'at risk,'



requiring measured performance prior to payment.

One dollar per member per month (PMPM) is withheld from payments made to the Regional Care Collaborative Organizations (RCCOs) and primary care medical providers (PCMPs). This money is then paid out based on performance in areas such as reduced emergency room visits, and increased postpartum and well-child visits. RCCOs also are at risk for reduced payment if members are not attributed to a PCMP for more than six months. PCMPs can earn incentive payments for participating in national practice transformation initiatives such as Comprehensive Primary Care Plus<sup>22</sup> and the State Innovation Model (SIM) program. Finally, the Department reimburses an additional \$0.50 per member per month for PCMPs who offer services beyond the traditional fee-for-service primary care model of care.

Several payment reform programs and initiatives are currently operating within the ACC. The Rocky Mountain Health Plans-Payment Reform Initiative for Medicaid Expansion (RMHP Prime), which launched in September 2014, is an initiative in which RMHP is at risk for all medical services needed by its members. The initiative also incorporates a medical loss ratio (MLR),<sup>23</sup> which is lowered based on performance on four different quality metrics. During FY 2016–17, RMHP’s MLR was reduced from 89% to 85% because it met all four quality targets. For FY 2017–18, we are looking to revise the metrics to include a clinical quality measure and increase targets to ensure ongoing improvement. A second initiative, Access KP, was implemented in September 2016 in ACC Region 3.<sup>24</sup> In this program, all covered services are at risk, and a little more than 5% of the PMPM is withheld for performance on well-child visits for ages 3–9, post-partum visits, emergency room visits, and inpatient admissions.

Through the SIM program, the RCCOs are making payments to selected PCMPs to help them integrate physical and behavioral health care. We supported nearly all of the 100 SIM Cohort 1 practices and in FY 2017–18 will support all PCMPs who are selected for SIM Cohort 2. (See page 27 to read more about SIM.)

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## PHARMACY PAYMENT REFORM

In addition to value-based purchasing efforts in the ACC, we are leading efforts for pharmacy payment reform. The reimbursement methodology for pharmaceuticals ties payment to the actual value or cost of the drugs rather than a pre-determined market price. Colorado was one of the first states to implement a pricing methodology like this. In 2013, we switched to using average acquisition cost, which involves obtaining invoices from Colorado pharmacies and using their acquisition costs to set reimbursement. This ensures reimbursement rates are updated regularly so pharmacies are reimbursed fairly on a continual basis, and so we receive maximum value for pharmaceutical expenditure.

Other states are now moving to an average acquisition cost methodology as required in the Covered Outpatient Drug rule by the Centers for Medicare & Medicaid Services.

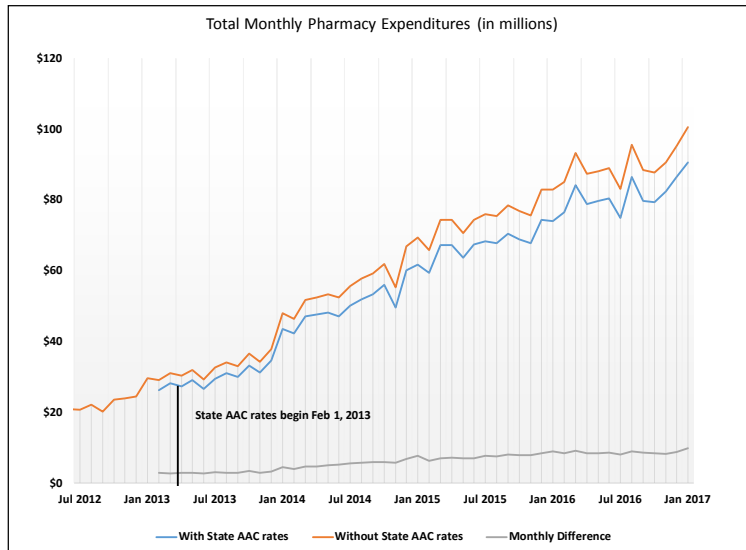
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<sup>22</sup> For a description of this program and its work with the ACC, see p. 39.

<sup>23</sup> MLR refers to the share of premium revenues a health care provider is required by law to spend on patient care and quality improvement activities.

<sup>24</sup> Access KP is a partnership between the Department, Colorado Access, and Kaiser Permanente.

We are continuing to investigate value-based purchasing options in the pharmacy arena, for example, our participation in the State Medicaid Alternative Reimbursement and Purchasing Test for High-Cost Drugs program (SMART-D). Led by the Center for Evidence-based Policy at Oregon Health & Science University, SMART-D is exploring alternative payment models focused on improving member health outcomes, increasing value, and managing prescription drug costs within state Medicaid programs.



For the Department, SMART-D offers new options for managing high cost specialty drugs within the existing regulatory and public policy framework by maintaining access for Medicaid members to effective drug therapy while finding the most cost-effective ways to pay for those drugs.

## MANAGED CARE PAYMENT REFORM

Adding to our value-based purchasing efforts, we recently completed medical loss ratio reconciliations with Rocky Mountain Health Plans<sup>25</sup> for the HB 12-1281 pilot program<sup>26</sup>. Through an innovative application of what is typically a financial control mechanism for managed care contracts, we were able to directly connect performance on quality metrics to payments under a capitated program in a truly meaningful way.

Over the next 24 months we will be working to broaden the scope of Medicaid value-based purchasing beyond the areas mentioned above. Behavioral health contract rates will be tied to performance on quality metrics, and a program for value-based purchasing of primary care services will be put in place. In addition, a primary care capitation pilot with payment tied to performance on quality metrics will be implemented, Program of All-inclusive Care for the Elderly payment rates will be tied to quality, and the reimbursement methodology for federally qualified health centers will be updated to reward quality and efficiency.

## STRATEGY #2B IMPLEMENT COST CONTAINMENT INITIATIVES

This strategy focuses on reducing the growth rate of Medicaid expenditures by implementing programs that lower per-capita costs while improving health outcomes and the experience of people served by Medicaid.

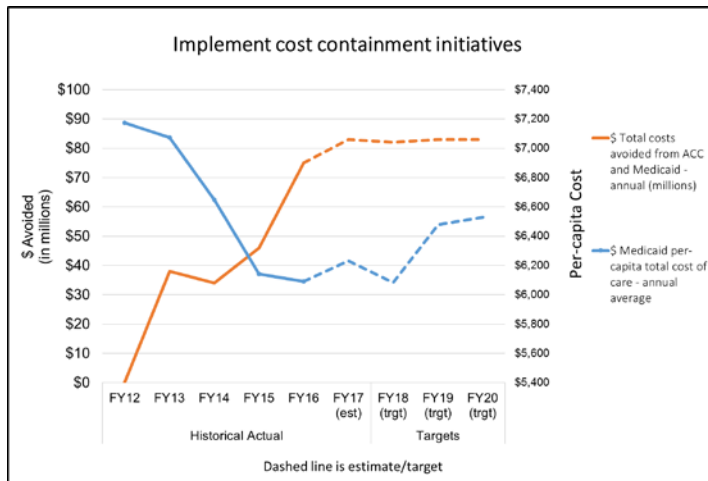
Two measures show progress toward this strategy: total costs avoided and Medicaid per-capita. Total costs avoided is a cumulative measure of prior year budget initiatives with savings, plus costs avoided from the Accountable Care Collaborative.

<sup>25</sup> For more about this methodology, see paragraph 3 of Pay for Performance Across the ACC, page 36.

<sup>26</sup> House Bill HB 12-1281 (HB12-1281), directing the Department to accept proposals for innovative payment reform pilots that demonstrate new ways of paying for improved member outcomes while reducing costs.

Since FY 2012–13, an estimated \$276 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 2017–18,

that figure is expected to be \$358 million. Medicaid per-capita is the annual average cost per member for total cost of care. Per-capita cost has decreased since FY 2012–13, and is expected to increase over the next few years with increased payments to hospitals and higher costs for community-based long term care and long term care provided through nursing facilities and the Program of All-inclusive Care for the Elderly.



Implement cost containment initiatives	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Medicaid per-capita total cost of care - annual average <sup>1</sup>	\$6,140	\$6,092	\$6,231	\$6,084	\$6,529
\$ Total costs avoided from ACC and Medicaid - annual (millions) <sup>2</sup>	\$46	\$75	\$83	\$82	\$83

<sup>1</sup> Measure uses a new methodology based on Exhibit Q from the Department’s annual budget request, reporting Title XIX (Medicaid) expenses only, where previously both Title XIX and Title XXI (CHP+) were included. In addition FY 2015–16 excludes additional hospital supplemental payments. All expenditures are restated.

<sup>2</sup> Measure restated to provide costs avoided per annum rather than life-to-date. ACC figures are based on FY 2016–17 Legislative Request for Information #3. Medicaid figures include annualized savings from prior year budget requests.

The following programs assist in supporting our strategy to implement cost containment initiatives.

### COLORADO INDIGENT CARE PROGRAM TRANSFORMATION

As part of our cost containment strategy, we are implementing a proposal to modernize the Colorado Indigent Care Program (CICP). This effort is improving the program’s ability to mitigate uncompensated health care costs that would otherwise drive up the cost of health care borne by payers such as private health insurance.

Historically, CICP has provided a partial solution to the health care needs of the state’s medically indigent citizens. It allows low-income Coloradans with incomes up to 250% of federal poverty level (FPL) who are not eligible for Medicaid or Child Health Plan *Plus* (CHP+) to obtain discounted health care services at participating hospitals and community health centers. CICP provides some reimbursement for uncompensated costs incurred by CICP providers serving low-income Coloradans. CICP is a cost-effective program because uncompensated costs in the health care system disproportionately impact overall health care costs and drive increases in insurance premiums for all payers.

The Affordable Care Act expansion of Medicaid coverage for adults in Colorado to 133% FPL reduced the number of uninsured Coloradans. Consequently, the number of persons served by CICIP decreased 76% in FY 2015–16 compared to FY 2012–13. However, while many former CICIP clients are now eligible for health coverage, individuals under 250% of the FPL who are not eligible for Medicaid or CHP+ and cannot meet their out-of-pocket expenses remain. We collaborated with stakeholders to understand the needs of lower-income Coloradans in the post-ACA environment.

In FY 2016–17, in close collaboration with stakeholders we developed program rule changes to modernize the CICIP in line with the needs of local communities today. Our goals are to improve administrative efficiency and preserve access to health care services for low-income Coloradans while encouraging enrollment in Medicaid or health insurance through the Connect for Health Colorado marketplace. We expect program changes will be implemented in FY 2018–19.

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### CLIENT OVER UTILIZATION PROGRAM

The statewide Client Over Utilization Program (COUP) identifies and addresses unnecessary or inappropriate utilization of pharmacy and emergency services. Members showing high utilization of these services are identified and the Department then works with the RCCOs to determine the best course of action with each member.

Strategies for addressing high utilization include individualized care coordination or case management for members, provider outreach and education, and potentially assigning members to a primary physician and primary pharmacy to better oversee care. In FY 2017–18 the program will continue to refine its processes in determining appropriate member interventions and improving appropriate utilization and health outcomes for members. Program modifications will be made in collaboration with stakeholders and include mechanisms to track the impact of interventions.

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### COMPREHENSIVE PRIMARY CARE PLUS

The Comprehensive Primary Care Plus (CPC+) program will enable us to build on our success improving quality and decreasing total cost of care. CPC+ complements progress made through our participation in the Comprehensive Primary Care Initiative (CPCi) from October 2012-December 2016.<sup>27</sup>

Through CPCi, we made additional investments in primary care to better manage physical and behavioral health with the goal of improving patient satisfaction, improving quality, and lowering costs. All Medicaid practices participating in CPCi were ACC primary care medical providers. Their performance was tracked on the same key performance indicators as other ACC providers. CPCi practices had access to Medicaid member data both through the statewide data and analytics contractor and the multi-payer funded data aggregator tool for Colorado's CPCi program.

CPC+ is a five-year initiative running from January 2017 through December 2021. Colorado has been accepted as a CPCi+ region, where 208 practices were accepted to participate. We will provide additional support to CPC+ practices that are primary care medical providers in the ACC during FY 2017–18.

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<sup>27</sup> A Center for Medicare & Medicaid Innovations project, CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. The four-year CPCi initiative served as its foundation effort.

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## MATERNAL AND CHILD HEALTH

We are advancing efforts in maternal and child health (MCH) services as part of our strategy for containing costs and improving health outcomes.

During FY 2016–17, we continued to utilize the Accountable Care Collaborative (ACC) key performance indicator (KPI) for postpartum care, which has been shown to reduce mortality and improve health in new mothers.<sup>28</sup> Increases in postpartum care utilization since addition of the new KPI have been encouraging.

During FY 2017–18, we plan to increase maternal and child health services for high-risk pregnant women and their children – particularly through the Nurse Home Visitor (NHVP) and Prenatal Plus (PN+) programs. NHVP, which provides home visits by a registered nurse from pregnancy through the child’s second birthday, is projected to reduce national Medicaid spending per child by 8.5%, saving \$1.4 billion.<sup>29</sup> PN+ provides extended services to pregnant women through 60 days postpartum, including provision of a care coordinator, dietitian, and mental health professional for women at risk for negative maternal and child health outcomes. This program reduces low birth weight, NICU admissions and premature birth rates. A program renewal initiated in FY 2015–16 will increase the number of PN+ providers offering the program, reaching more members and increasing cost savings.

Previously, NHVP could only bill Medicaid for targeted case management, which could not sustain the program and did not include the range of nursing services provided. A provision in the Physician Services rule prevented nurses from billing for services without a physician on site. The Colorado Medicaid Medical Services Board amended the rule in March 2017, allowing nurses to provide services within their scope of practice and creating sustainability for NHVP in the years to come.

Sister agency partnerships will further advance our MCH efforts. During FY 2016–17, we partnered with the Colorado Department of Public Health and Environment (CDPHE) in a data-sharing agreement focused on improving maternal depression screenings and referrals. Untreated postpartum depression is a strong predictor of unemployment, and early intervention and treatment can reduce the need for reliance on public assistance.<sup>30</sup> For FY 2017–18, CDPHE and HCPF are planning a referral program to increase dual enrollment in Medicaid and the WIC program (Special Supplemental Nutrition Program for Women, Infants, and Children). WIC provides nutrition education, breastfeeding support, health referrals and other services to Colorado families who qualify, and currently reduces the average Medicaid cost per member by 29%. In addition, Colorado has convened a cross-agency and cross-sector workgroup to improve infant and early childhood mental health services and access across the state. This treatment model can improve maternal mental health as well as child development.

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## COLORADO CHOICE TRANSITIONS

Another important component of our cost containment strategy is Colorado Choice Transitions (CCT). This program transitions Colorado Medicaid members out of long-term care facilities into home and

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<sup>28</sup>Cheng, C. Y., Fowles, E. R., & Walker, L. O. (2006). Postpartum maternal health care in the United States: A critical review. *The Journal of Perinatal Education*, 15(3), 34–42.

<sup>29</sup> Miller, T. R. (2015). Projected outcomes of nurse-family partnership home visitation during 1996–2013, USA. *Prevention Science*, 16(6), 765–777.

<sup>30</sup> Sontag-Padilla, L., Schultz, D., Reynolds, K., Lovejoy, S. L., & Firth, R. (2013). Maternal depression: Implications for systems serving mother and child. *Resource Document*. The RAND Corporation.

[http://www.rand.org/content/dam/rand/pubs/research\\_reports/RR400/RR404/RAND\\_RR404.pdf](http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf)

community-based settings, where they receive services designed to support their transition and promote their independence.

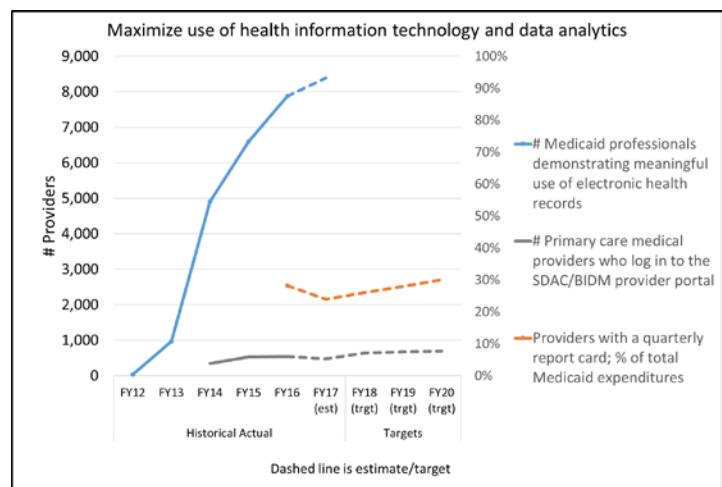
CCT was launched in April 2013, and is supported by a grant from the Centers for Medicare & Medicaid Services. As of April 2017, the program has completed 257 transitions.<sup>31</sup> As of December 2016, CCT had an estimated total cost savings of \$2,885,797.<sup>32</sup> We anticipate transitioning approximately 490 individuals by the end of 2018.

The program has encountered barriers to achieving the number of transitions initially targeted. These include scarcity of affordable and accessible housing in Colorado, and insufficient provider capacity in the areas of case management and transition coordination. To address the housing issue, we secured General Fund dollars to subsidize housing for up to 75 individuals per year. We recently selected a community-based housing navigation entity, and during FY 2017–18 we will execute a contract with them to be funded through the CCT rebalancing fund.

In addressing provider capacity, we secured a payment rate increase for our transition coordination agencies (TCAs) in FY 2015–16. During FY 2016–17, we recruited five additional TCAs and initiated a Denver-Boulder pilot extending community transition services. We plan to distribute a Request for Applications for transition expense grants funded through the CCT rebalancing fund in early FY 2017–18. We believe that housing navigation will improve TCA capacity by taking over housing-related responsibilities and providing expertise to the transition options process.

**STRATEGY #2C MAXIMIZE USE OF HEALTH INFORMATION TECHNOLOGY AND DATA ANALYTICS, ALIGNING THESE EFFORTS WITH THE BROADER HEALTH CARE SYSTEM**

This strategy emphasizes the importance of advancing information and data technologies as a means to improve health outcomes for members, reduce fraud, waste and abuse in the Medicaid program, and



reduce the cost of health care. Our work aligns with a statewide information technology strategy focused on radically transforming the state’s health care system.

Three measures show progress toward this strategy: number of Medicaid professionals demonstrating meaningful use of electronic health records, providers with a quarterly report card as a percentage of total Medicaid expenditures, and number of primary care medical providers who log in to the SDAC/BIDM Provider Portal.

<sup>31</sup> Transitions figure is based on claims paid through February 2017 for 205 CCT members who transitioned prior to December 2016.

<sup>32</sup> Savings amount does not include all 257 transitions due to prior authorization processing delays. Savings amount is based on actual member data, and differs from costs avoided figures in the Department’s February 2017 S-1 budget request, which are estimates based on average per diem costs and average number of members.

Maximize use of health information technology and data analytics	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Medicaid professionals demonstrating meaningful use of electronic health records <sup>1</sup>	6,597	7,878	8,393	N/A	N/A
Providers with a quarterly report card; % of total Medicaid expenditures	N/A	28%	24%	26%	30%
# Primary care medical providers who log in to the SDAC/BIDM provider portal	527	545	475	645	690

<sup>1</sup>The Electronic Health Records Demonstration Project completed the new provider enrollment phase in 2016. The project will cease in 2021. The Department is discontinuing reporting on this measure.

The following programs assist in supporting our strategy to maximize use of health information technology and data analytics, aligning these efforts with the broader health care system.

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## FINANCIAL REPORT TRANSFORMATION

This program analyzes variation among providers based on health care expenditure and utilization data, delivering reports through advanced dashboard technology. Sophisticated comparison and filtering options deliver maximum meaning to users — the public, providers, and Department staff. The goal of the program is to increase financial decision making transparency and provide a more complete view of financial performance.

The program began in FY 2015–16, when we released an interactive dashboard of county-level summaries of expenditure and utilization on our public web site. During FY 2016–17 we continued to develop this reporting technology, adding capability for viewing monthly premiums, expenditures, and caseload reports by program and county.

During FY 2017–18 our new health information systems<sup>33</sup> will allow us to launch a suite of financial reports helping primary care medical providers to increase quality and efficiency while containing costs. Ultimately, these reports will be shared publicly to highlight variation among providers and encourage sharing of information.

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## PROVIDER REPORT CARDS

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. Provider Report Cards use claims data and analytics to analyze and display variation in costs, processes, and health outcomes across our health care delivery systems. The goal of the program is to select the highest quality, most cost-effective care for members.

During FY 2015–16, we began developing report cards for three types of providers with the goal of assessing high and low value within each type: federally qualified health centers (FQHCs), Regional Care Collaborative Organizations/primary care medical providers (RCCOs/PCMPs), and hospitals.

The FQHC report card is expected to be released in FY 2017–18. In developing it, we consulted the Colorado Community Health Network and individual health centers to gather feedback, hear concerns, and refine how FQHCs are measured. The RCCO/PCMP report card is being designed in conjunction with

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<sup>33</sup> COMMIT project: The new Colorado interChange and connected systems, which went live during February-April 2017. See page 43.

ACC Phase II<sup>34</sup> and is expected to be released in FY 2018–19. The hospital report card which is still in development, will use advanced analytics to measure variation in procedures, surgeries, and aftercare.

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## HEALTH INFORMATION TECHNOLOGY

We have planned and developed our health information technology projects to align with the state of Colorado’s strategy for adoption and widespread use of health information technology (HIT) by enrolled medical providers.<sup>35</sup> The ultimate aim is to improve member outcomes and reduce health care costs.

We are leveraging federal funds to streamline our provider onboarding process and sustain our core HIT infrastructure development and implementation. In advancing use of health information technology and health information exchange across Colorado, we have supported design, development, testing, and implementation of the Medicaid Electronic Health Record Incentive program for providers.

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## COMMIT

Colorado Medicaid Management Innovation and Transformation (COMMIT) refers to our four-year project to design, develop, test, and implement systems to replace the 20-year-old Medicaid Management Information System (MMIS) and other information technology components. Health information technology and data analytics emerging from COMMIT will advance our ability to improve member health outcomes and reduce health care costs.

As an initiative that is aligned with the State of Colorado’s strategy for adoption and widespread use of Health Information Technology by enrolled medical providers, and with Colorado’s Health Information Exchange strategic plan that is integrated with broader statewide enterprise architecture development, COMMIT is contributing to expansion of health information technologies throughout the state.

The three systems comprising COMMIT became operational during Spring 2017, and are the culmination of work begun in 2013 to design, develop, test and implement a new state of the art Medicaid Management Information System.<sup>36</sup> The new system, Colorado interChange, together with new fiscal agent operations went live March 1, and will improve our ability to process and pay medical claims. The complementary Pharmacy Benefits Management System (PBMS) went live February 25, and will deliver functions including point of sale pharmacy claims processing, drug utilization review, and others. The complementary Business Intelligence and Data Management (BIDM) system went live April 17 and will enhance our analytic and business intelligence, program integrity, and provider reporting capabilities.

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## CROSS-AGENCY HEALTH STRATEGY ALIGNMENT

Among our efforts to advance use of health information technology and data analytics, we have partnered with our sister state health agencies in the Colorado Cross-Agency Collaborative (CCAC) to develop a data alignment strategy.<sup>37</sup>

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<sup>34</sup> See page 34 for more about ACC Phase II.

<sup>35</sup> Articulated in 2011 by the state’s Information Technology Advisory Committee.

<sup>36</sup> Medicaid Management Information System (MMIS) refers to the hardware, software, and business process workflows that process our medical claims and payments. Additional functions include provider enrollment and management, certain member management functions, and analytics and reporting.

<sup>37</sup> The Colorado Cross-Agency Collaborative is a partnership between the Colorado Departments of Human Services (CDHS), Public Health and Environment (CDPHE), and Health Care Policy and Financing (HCPF). It was established as a part of the Governor’s statewide health strategy.



The purpose of this strategy is to identify and align metrics relevant to the health outcomes of Coloradans through available data at each agency, enabling the three agencies to

- share a common list of population health metrics that help inform collaborative health improvement programs,
- collectively report on performance of health metrics relevant to assessing performance in areas of overlapping health impact,
- Identify gaps in measurement, and
- jointly determine where resources need to be focused so that health disparities in Colorado can be properly addressed.

As part of the data strategy, the CCAC has been tasked to complete four reports: Behavioral Health, Child Health, Older Adult Health, and Adult Health. All have been completed, and are in the process of being updated. Work to update and trend metrics in the Behavioral Health and Child Health reports has begun and will be completed in October of 2017. The Adult Health and Older Adult Health reports will be updated by October of 2018. Updated reports will be transformed into interactive dashboards shared through websites of the three agencies and trended on a yearly basis. Performance targets will be set on indicators the three agencies are utilizing to improve outcomes.

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## ELIGIBILITY REPROCUREMENT

The Eligibility Reprourement Project is advancing our strategy to maximize use of health information technology and data analytics by increasing the effectiveness and reliability of our eligibility and benefits-related systems. A central focus of the project is selecting a contractor to implement changes so Colorado's Medicaid eligibility system and application are more interoperable, configurable, and modular based on industry direction.

The project is a cooperative effort of the Department, the Office of Information Technology, the Colorado Department of Human Services, and the 64 Colorado counties. Systems involved are: The Colorado Benefits Management System (CBMS), which tracks member data, determines eligibility, and calculates benefits for medical, food, and financial assistance; the Program Eligibility and Application Kit (PEAK), an online service for Coloradans to screen and apply for medical, food, cash, and child care assistance programs; and related systems.

## SPI #3 PARTNERSHIPS TO IMPROVE POPULATION HEALTH

### STRATEGY #3A SUPPORT STATEWIDE EFFORTS TO IMPROVE POPULATION HEALTH

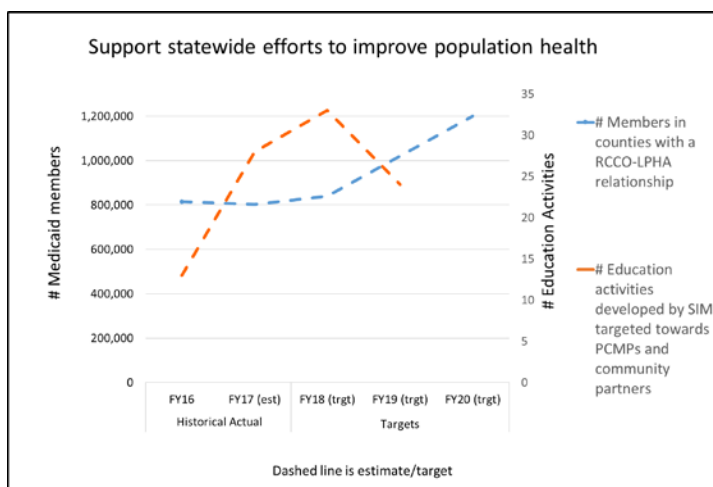
Impacting health goes beyond health care, and extends to socioeconomic circumstances and environmental influences, which disproportionately determine poor health in vulnerable populations across the U.S.<sup>38</sup> Cross-agency partnerships enable us to engage these critical factors and promote the health and well-being of all Coloradans.

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<sup>38</sup> Woolf, S. H., & Purnell, J. Q. (2016). The good life: working together to promote opportunity and improve population health and well-being. *Jama*, 315(16), 1706–1708.

Programs supporting this strategy include collaboration with Colorado Opportunity Project state partners to deliver high-quality, cost-effective, evidence-based programs to Coloradans with the goal of helping them move up the economic ladder and towards self-sufficiency.

Two measures show progress related to this strategy: members in counties with a Regional Care Collaborative Organization (RCCO) relationship with a local public health agency (LPHA), and education activities to help primary care medical providers and community partners work together to integrate physical and behavioral health care. Both are performance measures for newly launched programs with



only one year of historical data. There are an estimated 801,643 members in counties where RCCOs are working with LPHAs to provide community-based health supports; we expect this number to approach the total number of Medicaid members by FY 2019–20. The number of integration-targeted education activities increased to 28 last year, with 33 expected by the end of FY 2017–18. Examples of education activities include developing SBIRT<sup>39</sup> training to help ensure provider competency in substance use and depression screening and intervention.

Support statewide efforts to improve population health	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Members in counties with a RCCO-LPHA relationship <sup>1</sup>	N/A	814,606	801,643	840,000	1,200,000
# Education activities developed by SIM targeted towards PCMPs and community partners <sup>2</sup>	N/A	13	28	33	N/A

<sup>1</sup>RCCO – Regional Care Collaborative Organization; LPHA – local public health agency

<sup>2</sup>SIM (State Innovation Model) ends July 2019

The following programs assist in supporting our strategy to support statewide efforts to improve population health.

## COLORADO OPPORTUNITY PROJECT

The Colorado Opportunity Project represents the efforts of three Colorado state agencies aligning to deliver evidenced-based programs supporting low-income Coloradans with opportunities for moving up the economic ladder towards self-sufficiency, and away from reliance on safety net programs.

The impacts of poverty are significant. Those in poverty are more likely to have complex health conditions, and treating these conditions is expensive. The Project leverages high-quality, cost-effective, evidence-based programs already available in Colorado, helping them with improved coordination and well-defined goals and measures. The Project is a collaboration of the Colorado Departments of Health Care Policy and

<sup>39</sup> The Screening, Brief Intervention, and Referral to Treatment program is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment to persons with substance use disorders and those at risk of developing these disorders.

Financing, Public Health and Environment, and Human Services. Its alignment of government programs eliminates fragmentation among these agencies, reducing duplication of services and making more efficient use of taxpayer dollars.

Utilizing the Brookings Institution's Social Genome Model, the Opportunity Framework addresses different social determinants of health across nine life stages. Within each life stage a series of indicators serve as benchmarks for success.

During FY 2016–17, the Department and the RCCOs (Regional Care Collaborative Organizations) worked collaboratively to implement 17 community projects that addressed the indicators in the Family Formation life stage. In November 2016, the Department and Johns Hopkins University cohosted a conference focused on bridging the gap between policy and practice by addressing the social determinants of health and trauma-informed care in the pediatric setting. Additionally, the Project began measuring performance by developing a data-informed evaluation strategy, identifying evidence-based programs across all life stages, and finalizing a network evaluation tool.

In FY 2017–18 the RCCOs will develop a strategic work plan outlining how they will use the Colorado Opportunity Framework to address the needs of the population in their regions. The finalized evaluation strategy will collect indicator data across the life stages and increase data sharing between the Department and the RCCOs. The evaluation strategy, the list of evidence-based programs, and the network evaluation tool will be used to manage the RCCOs. The partnership with Johns Hopkins University will continue with two RCCO 1 pediatric practices participating in a year-long learning collaborative focused on pediatric trauma-informed care and social determinants of health. Also during FY 2017–18, the Department and the RCCOs will work together to address the social determinants of health and reduce health disparities across all life stages.

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## COUNTY INCENTIVES PROGRAM

The County Incentives Program advances our strategy to support statewide efforts to improve population health by incentivizing specific practices for county sites involved in Medicaid enrollment and eligibility determination. This work promotes access to timely and accurate benefits and a balance of health and social programs made possible through collaboration in the community. The program was developed in collaboration with county partners. Incentives are detailed in contracts with individual county departments.

The program includes several types of initiatives focused on member eligibility and population health. Eligibility incentives are both financial and education-focused. These strive to ensure county departments of human/social services meet federal requirements when determining eligibility of Coloradans for Medicaid (both in new applications and redeterminations). Based on Department audits of these entities, the program encourages county staff to engage in trainings.

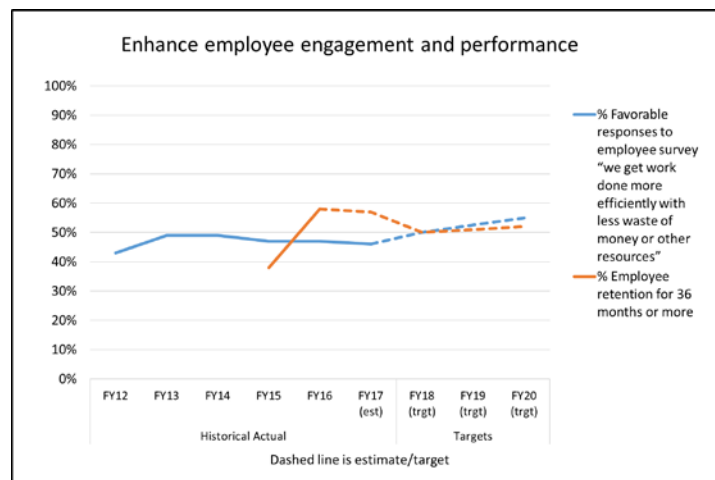
Beyond its focus on eligibility determinations, this program includes several initiatives supporting our efforts to improve population health. Incentives encourage counties to maintain and/or increase enrollment of child welfare youth in the Accountable Care Collaborative (ACC) so that care coordination for this vulnerable population is achieved. The program also encourages counties to expeditiously enroll foster care youth exiting the child welfare system so that gaps in their health care coverage are minimized. The Program brings together disparate entities to assist local population health efforts by encouraging collaboration between county agencies and entities such as Single Entry Points for member enrollment; community centered boards that are responsible for determining functional eligibility for LTSS programs;

and local law enforcement. Incentive outcomes are measured at the conclusion of each fiscal year, and provide performance benchmarks supporting efforts to continually improve the program.

## SPI #4 OPERATIONAL EXCELLENCE

### STRATEGY #4A ENHANCE EMPLOYEE ENGAGEMENT AND PERFORMANCE

Our strategy for enhancing employee engagement focuses on retention, recruitment, efficiency, and productivity. Work teams require a combination of relevant technical skills as well as the ability to collaborate productively, resolve conflicts, and integrate alternative thinking and working styles to solve



complex problems.

Two measures gauge progress related to this strategy: employee perception of efficiency, and retention for 36 months or more. The percentage of employees reporting increased efficiency within the Department dropped 1% in FY 2016–17. Employee retention reached 74% and 60% in the first and third quarters, respectively; and dropped to 44% in the second quarter of FY 2016–17. To improve in both areas of employee engagement and performance, we are focusing on the programs below.

Enhance employee engagement and performance	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% Favorable responses to employee survey "we get work done more efficiently with less waste of money or other resources" <sup>1</sup>	47%	47%	46%	50%	55%
% Employee retention for 36 months or more <sup>2</sup>	38%	58%	57%	50%	52%

<sup>1</sup>Result for FY 2016–17 is actual, not estimated.

<sup>2</sup>Retention rate of employees hired during the fiscal year three years prior

## HUMAN RESOURCES

Transforming the way we manage human resources is a key part of our strategy to enhance employee engagement and performance. The Human Resources (HR) Section provides a full range of personnel services pertaining to benefits, recruitment, selection, job classification, training, rules interpretation, and employee/manager counseling. It also oversees corrective and disciplinary actions, maintains personnel records, and oversees our delegation agreement with the Colorado Department of Personnel and Administration.

We aim to transform this work by improving HR efficiency and effectiveness while ensuring compliance with state and federal law. The HR Section is working to better define its role within the organization by proactively engaging managers and staff through a person-centered consulting role. It has created an operations dashboard that includes metrics on turnover, time to hire, position allocations, trust and confidence in leadership, and internal response times. The dashboard enables HR to measure improvements within these core service areas while working on goals identified in an operational plan to streamline HR business processes.

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## WORKFORCE DEVELOPMENT

The Workforce Development section provides three primary services to the Department: training, consultation and coaching. Although each has particular objectives, the overarching goals of the section are to enhance employees' ability to be efficient and effective in carrying out their job responsibilities and to improve employee experience.

Our training programs provide a spectrum of learning opportunities that increase technical knowledge and the ability to successfully navigate and negotiate with multiple internal and external stakeholders and perspectives. Coaching includes working with employees to determine goals and strategies to promote successful employment and full engagement. Consultation includes working with managers and teams to solve problems, build strong team relationships, and strategize for ultimate team performance.

We have utilized our evaluation process to gain insight into how our program enhances both ability to do the work and the employee experience. The evaluations reveal that over 90% of aggregate responses indicate that our programs add significant value.

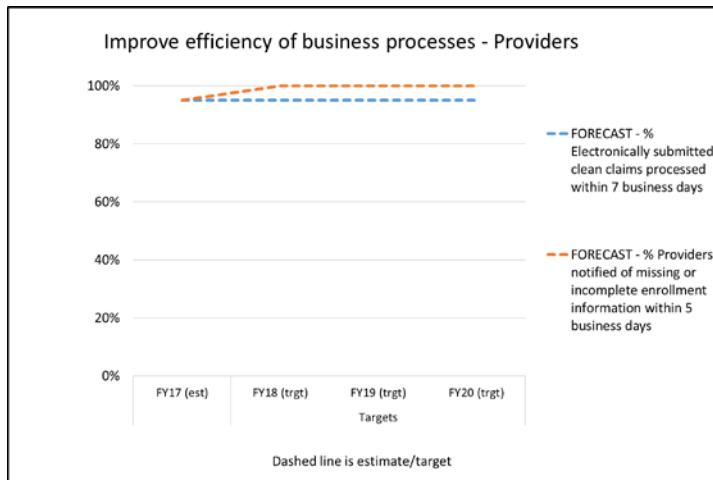
FY 2016–17 goals include increasing Medicaid literacy and employee engagement through the development of the Medicaid Learning Community, building upon and enhancing the success of the Onboarding and Ambassador programs, and continuing to build the capacity of staff and managers to work successfully together through continued and new training products.

## STRATEGY #4B IMPROVE EFFICIENCY OF BUSINESS PROCESSES

Programmatic areas supporting this strategy focus on efficient and effective administration of the Medicaid program. Mechanisms include improving information technology infrastructure, increasing efficiency of our employees and business processes, and promoting a culture of openness to change and continuous improvement.

We are using four measures to evaluate performance of this strategy (graphs/tables are presented throughout this section):

- Timely processing of provider claims
- Timely notification to providers about the status of their enrollment applications
- Lean efficiency gains
- First call resolution rates for the Member Contact Center



Timely processing of provider claims and timely notification about missing information in provider enrollment applications are new performance measures with no historical data. Data collection began with the launch of the new Colorado interChange in March, 2017.

Improve efficiency of business processes - Providers	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% Electronically submitted clean claims processed within 7 business days	N/A	N/A	95%	95%	95%
% Providers notified of missing or incomplete enrollment information within 5 business days	N/A	N/A	95%	100%	100%

The following programs assist in supporting our strategy to improve efficiency of business processes.

## LEAN COMMUNITY

In support of our business process efficiency strategy, the Lean Community program seeks to instill a continuous improvement mindset and customer focus throughout the Department. To advance this goal, the Lean Team works to integrate Lean methodologies, principles and tools into HCPF work processes by delivering facilitated sessions, large-scale Lean projects, Quick Hits,<sup>40</sup> and process improvement instruction.

During FY 2016–17, the Lean Community completed several large-scale Lean projects focused on streamlining administrative processes: Medical Services Board Rulemaking, Customer Journey-Mapping, Travel Reimbursement, and Provider Credentialing. In FY 2017–18, the program will focus on core Lean Six-Sigma principles, in particular, use of data to track process improvement efforts.<sup>41</sup> Other goals for the coming year include sustaining the Office of Community Living’s Provider Enrollment project and initiating new projects based on requests submitted by staff. The program will continue to focus on advancing the Department’s organizational maturity by expanding the number of employees participating in Lean projects, redesigning Lean training to reach more staff members, and recognizing staff who make Lean improvements.<sup>42</sup>

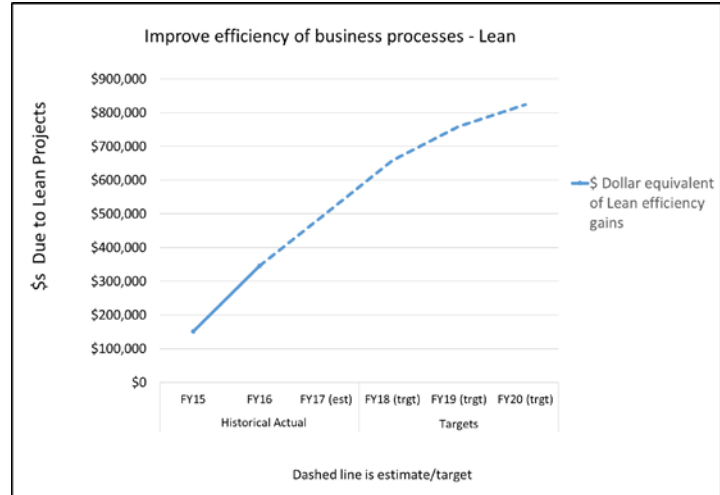
The Lean team is participating in the Department’s Strategic Management initiative by delivering Line of Sight training to staff and facilitating visioning sessions that help mid-level teams map their work products to strategic priorities connected to the Department Performance Plan.

<sup>40</sup> Small scale Lean projects requiring four hours or less to complete.

<sup>41</sup> Data is now higher quality and more readily available due to the launch of the interChange and related systems. See page 42.

<sup>42</sup> In alignment with the State’s Lean organizational model.

Lean efficiency gains illustrated in the graph and table are based on data collected as a result of streamlining processes such as travel approval and reimbursement. Dollar equivalent of staff time repurposed to higher priority work saved an estimated \$502 thousand in FY 2016–17.

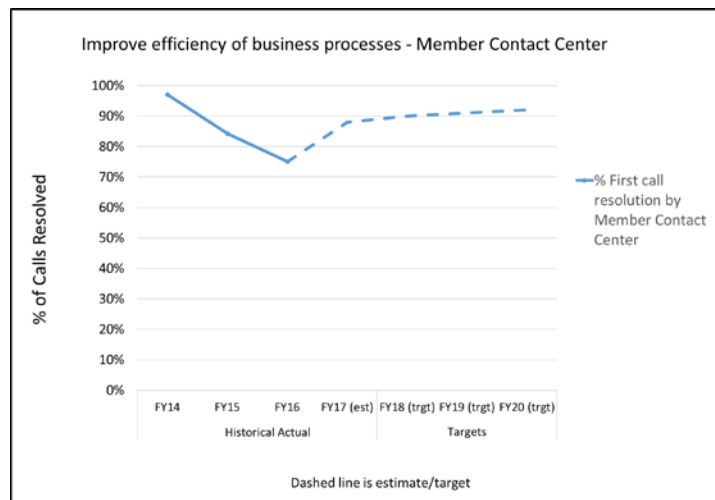


Improve efficiency of business processes - Lean	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Dollar equivalent of Lean efficiency gains	\$151,786	\$345,959	\$501,557	\$658,512	\$823,830

## MEMBER CONTACT CENTER TRANSFORMATION

The Member Contact Center (MCC), is improving customer service for members by integrating technology in its processes and using data to increase efficiency and measure performance.

The MCC is the Department’s main public-facing point of contact for members with inquiries about benefits and billing. To meet the challenges of high call volume, the MCC has incorporated new technological solutions and increased the number of agents in the center. Customer relationship management software has facilitated tracking of member interactions and, coupled with a new and improved interactive voice response (IVR) system, the MCC can maximize the use of data to drive greater efficiencies.



Improve efficiency of business processes - Member Contact Center	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
% First call resolution by Member Contact Center	84%	75%	88%	90%	92%

In addition to measuring its call answer rate, the MCC is collecting data on first call resolution (FCR), which tracks the effectiveness and efficiency with which representatives resolve customer issues. An important advantage of measuring FCR is its usefulness in assessing new process initiatives such as procedural changes, training, and coaching. Measuring FCR before and after introduction of a process improvement enables the MCC to track success and make adjustments.

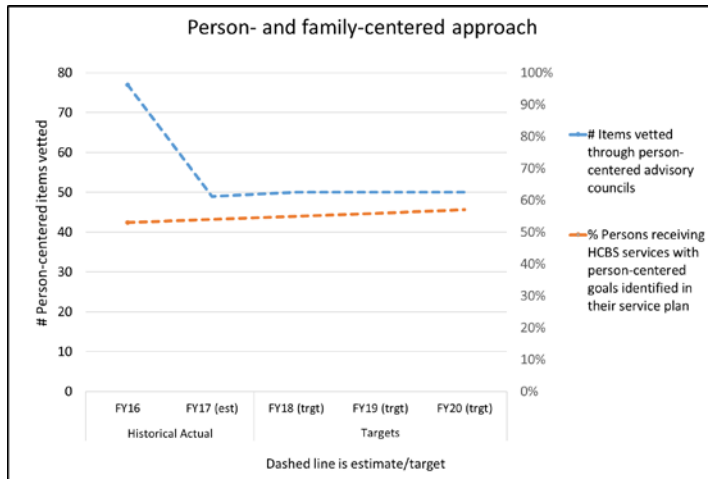
First call resolution rates increased from 75% to 88% in FY 2016–17. We have hired additional staff in the call center, and with enrollments stabilizing, we anticipate improvement to 90% by the end of FY 2017–18. Improvement in the FCR and advancement of the Department strategy can be attributed to the following factors:

- Increasing staffing levels
- Clearly defining the scope of responsibility of call agents including establishing second tier call resolution with higher skilled agents
- Transitioning to a more cost effective IVR vendor in April 2016 empowered agents to call out to partner agencies with members on the line to ensure problem resolution

In FY 2017–18, the MCC is focusing on improving the accuracy of information provided by agents through a refined training curriculum that incorporates quality assurance and reinforces best practices and performance expectations of agents.

**STRATEGY #4C INSTILL A PERSON- AND FAMILY-CENTERED APPROACH TO STRENGTHEN EMPLOYEE ENGAGEMENT, CLIENT EXPERIENCE, CLIENT ENGAGEMENT, AND CULTURE CHANGE**

Programs supporting this strategy focus on increasing awareness about member needs and perspectives in order to inform policy decisions, engage members in their health and health care, and infuse partnership into interactions with members and health care providers. A person- and family-centered approach ensures that our practices support the values, preferences, skills, and abilities of the individuals we serve.



Two measures show progress related to this strategy: items vetted through person-centered advisory councils, and existence of person-centered goals in service plans for individuals receiving home and community based services. The efforts described below are designed to maintain both of these measures at or above existing levels.

Person- and family-centered approach	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Items vetted through person-centered advisory councils	N/A	77	49	50	50
% Persons receiving HCBS services with person-centered goals identified in their service plan	N/A	53%	54%	55%	57%

The following programs assist in supporting our strategy to instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change.



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## COMMUNITY LIVING ADVISORY GROUP RECOMMENDATIONS

The Community Living Advisory Group (CLAG) was created in 2012 by Governor’s Executive Order to recommend changes focused on providing efficient and person-centered community-based care through Colorado’s delivery system for long-term services and supports (LTSS). The resulting CLAG Recommendations Report, published in 2014, has contributed significantly to our work orienting staff and the LTSS system toward person-centeredness.

During FY 2016–17, the Department launched a pilot to develop a replicable model for connecting older adults and people with disabilities to long-term services and supports, regardless of pay source, using funding from a federal No Wrong Door implementation grant. (See No Wrong Door on page 30.) During the same year, the legislature passed a bill to implement conflict-free case management, which was based on our work with a task group and community input to develop a plan for conflict-free case management. Once implemented, the plan will increase person-centered service coordination in Colorado. (See Conflict-Free Case Management on page 31.) In spring of 2017, we delivered training in person-centered thinking to providers across the state, including case managers and state staff.

We will be implementing other CLAG recommendations going forward, for example the Consumer-Directed Attendant Support Services (CDASS) for members receiving services through the Supported Living Services waiver. CDASS enables members to manage their own supports and services. CDASS is already available to members who are older or have long-term disabilities and are receiving services under the four other home and community-based services waivers.

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## HCBS FINAL RULE

Our work to comply with the HCBS Final Rule is advancing implementation of a person- and family-centered approach for individuals receiving home and community-based services (HCBS). The Final Rule, issued by the Centers for Medicare & Medicaid Services (CMS) in 2014, requires states to add protections and defines person-centered planning requirements for persons receiving HCBS.

We have been working with stakeholders, the public, and CMS to develop a Statewide Transition Plan (STP) to meet Colorado’s March 2022 deadline for ensuring HCBS settings (the nature and quality of where people receive services) are complying with the rule. As part of the STP, we developed a systemic assessment crosswalk — a roadmap for amending related Colorado statutes, regulations, and waivers. We expect to implement changes to statutes, regulations, and waivers identified by the crosswalk in FYs 2017–18 and 2018–19. The STP also includes a plan for verifying each affected HCBS setting’s compliance with the Final Rule. We have created an interagency agreement with the Colorado Department of Public Health and Environment (CDPHE) to implement the plan. CDPHE has completed randomly selected site visits, and is expected to finish reviewing and verifying Provider Transition Plans by the end of December 2017.

To promote the Department’s person- and family-centered strategy, we invite individuals and their families to participate in site visit interviews and to provide feedback about their settings via a survey. The Department is educating providers and stakeholders about complying with the Final Rule through webinars, technical assistance, and collected frequently asked questions (FAQs) to which answers will be issued on a rolling basis.

Further, we are working on implementing conflict-free case management (see page 31) and person-centered support planning (see page 53) as part of the Final Rule and to strengthen our person-and family-centered approach to providing HCBS to members.

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## MEMBER AND FAMILY ENGAGEMENT – PHASE II

We began planning for a person-centered approach to Department operations in 2012 with the goal of ensuring that all members and their families, as well as employees, providers, stakeholders and advocates experience person-centered policies, practices, and partnerships that respect and value individual preferences, strengths, and contributions. Work conducted since that time has included development of in-person and virtual advisory councils to work on person- and family-centered projects; creation of a Person- and Family-Centeredness Advisory Council, now renamed the Member Experience Advisory Council; and engaging an internal group of champions to lead, manage, and facilitate culture change by identifying specific processes and policies that can become more person-centered.

In March 2016, we were awarded funding from the Colorado Health Foundation to extend person-centered practices to selected contractors as a pilot project, with the ultimate goal that person- and family-centered principles permeate all Department business practices, policies and partnerships. The same month, the Division for Intellectual and Developmental Disabilities launched a statewide person-centered thinking training initiative for stakeholders of the Intellectual and Developmental Disabilities system.

During FY 2016–17, we continued to implement our strategic plan for person- and family-centeredness, with a focus on increasing employee engagement, connecting employees to the member, and improving member engagement and experience. During FY 2017–18, we plan to focus on externalizing our engagement work with counties and other partners to improve the experience of members as they apply and are determined eligible for Medicaid.

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## LTSS ASSESSMENT TOOL FOR SUPPORT PLANNING

Another component of our strategy to instill a person- and family-centered approach will be further modifying of our new long-term supports and services (LTSS) assessment tool to accommodate person-centered support planning.<sup>43</sup>

This modification involves collecting additional information from the member related to their life, goals, and interests in the community, which can in turn be used to develop their support plan. Ultimately, the modified tool will allow us to ensure that members can access a flexible package of benefits, create person-centered budgets, and be empowered in the planning process.

The new assessment tool is still in the development phase, but once it is finalized, we will develop and roll out a formal support plan template leveraging the robust information gathered through its use. For more about the LTSS assessment tool, see page 31.

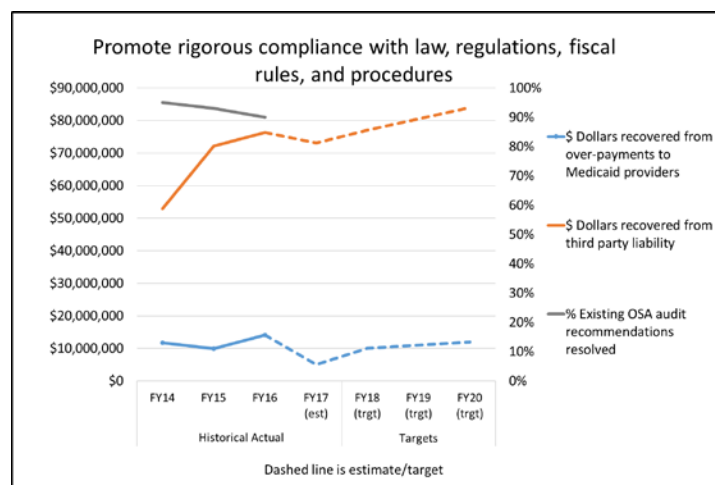
## STRATEGY #4D PROMOTE RIGOROUS COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS, FISCAL RULES, AND INTERNAL OPERATING PROCEDURES

Our work administering the federal Medicaid program in Colorado takes place in a heavily regulated environment. Ensuring rigorous compliance internally with our own processes, and externally by holding our business partners accountable, enables us to minimize waste of resources resulting from fraud, waste and abuse.

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<sup>43</sup> The assessment tool is a systematic method used to determine the unmet needs of a person applying for LTSS through the Medicaid program.

Three measures show progress related to this strategy: dollars recovered from overpayments to providers, dollars recovered from third party liability, and the number of Office of the State Auditor (OSA) audit recommendations resolved. Dollars recovered from overpayments to medical providers increased in FY 2015–16, and a reduction is anticipated this year while we complete preliminary implementation



work to launch the Recovery Audit Contract described below. Third party liability recoveries are projected to increase up to 10% per year over the next two to three years, eventually tapering downward as we reduce the amount of post-payment recoveries needed by ensuring more claims are initially submitted to the correct payer.

Measurement and forecasting of OSA audit recommendations resolved will resume once data validation and reconstruction of a database is completed.

Promote rigorous compliance with law, regulations, fiscal rules, and procedures	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
\$ Dollars recovered from over-payments to Medicaid providers <sup>1</sup>	\$9,873,560	\$14,125,130	\$4,993,230	\$10,000,000	\$12,000,000
\$ Dollars recovered from third party liability	\$72,091,076	\$76,333,409	\$73,151,614	\$77,000,000	\$84,000,000
% Existing OSA audit recommendations resolved <sup>2</sup>	93%	90%	N/A	N/A	N/A

<sup>1</sup>Staff turnover and change in COMMIT project implementation date delayed claims-driven recoveries.

<sup>2</sup>Audit recommendations data invalid during FY 2016–17. Database reconstruction and future targets pending.

There are many programs that support our strategy to promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures. Three are listed below.

## RECOVERY AUDIT CONTRACT

The Recovery Audit Contract (RAC) is a federally required program in an early stage of implementation at the Department. The RAC’s primary responsibility is to identify and recover overpayments from medical assistance providers. The RAC will analyze provider claims and review those most likely to contain improper payments for both fee-for-service and managed care populations. Improper payments can come in the form of payment for items or services that do not meet our coverage or medical necessity criteria, payment for items that are incorrectly coded, and payment for services where documentation submitted did not support the ordered service. RAC oversight promotes provider compliance with state and federal regulations and coding guidelines. The RAC contractor is also required to develop provider training so that the providers become aware of rules they may not have known about or understood. The RAC is expected to be operational with recoveries commencing in FY 2018–19.

## EXTERNAL AUDITS

Audits conducted on the Department by external agencies such as the Office of the State Auditor, help to identify areas of non-compliance within Department programs, processes or systems. Once issues are

identified through an audit, appropriate areas within the Department develop comprehensive corrective actions along with timelines for completion. Timelines for the strategies developed to correct problems are monitored internally and externally to ensure compliance is achieved as soon as possible.

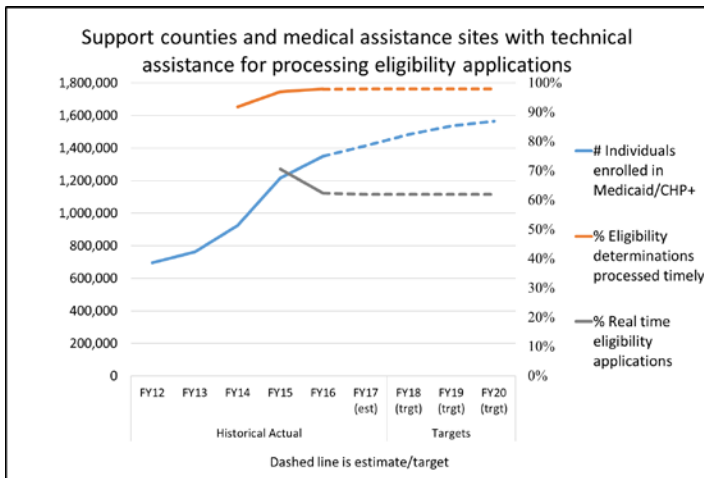
## BENEFITS COORDINATION

The Benefits Coordination Section is responsible for recovering monies from third parties and ensuring that Medicaid dollars are spent appropriately and in compliance with state and federal regulations. The Section's approaches include: 1) avoid costs where appropriate by identifying third party payers and directing claims to such payers, 2) recover medical payments from liable third parties, 3) fund premium assistance for commercial health coverage when doing so is cost-effective, 4) recover trust dollars where appropriate, 5) facilitate access to other available federally funded health coverage, and 6) identify areas of waste and eliminate funding of Medicaid to non-eligible individuals.

Approximately 70% of the Section's recoveries come from recovering payments from health care payers after the claims system has already paid the provider. With the development of a new claims system, we will improve processes to acquire and retain information pertinent to other health coverage held by a Medicaid member. The new claims system will modernize these processes to enhance our cost avoidance. Specifically, it is more efficient to facilitate submission of claims to the primary payer prior to adjudication of the claim than to recover the payment after paying the claim. The goal is to reduce the amount of post-payment recoveries over time by ensuring claims are initially submitted to the correct payer, rather than to the Department.

## STRATEGY #4E SUPPORT COUNTIES AND MEDICAL ASSISTANCE SITES WITH TECHNICAL ASSISTANCE FOR PROCESSING ELIGIBILITY APPLICATIONS ACCURATELY AND EFFICIENTLY

Work supporting this strategy is critical to bringing Medicaid-eligible individuals into the health care system so their health and quality of life can be improved. Three measures show progress related to this strategy: number of individuals enrolled in Medicaid/CHP+, percent of timely eligibility determinations, and percent of real-time eligibility (RTE) applications.



We anticipate Medicaid and CHP+ caseload to increase approximately 6% per year through FY 2018–19. This is a result of processing applications from eligible individuals who apply through counties, medical assistance sites, PEAK,<sup>44</sup> and the Connect for Health Colorado exchange website. We expect the efforts described below to help us maintain our timely processing rate of 98% indefinitely, and for RTE applications to plateau at approximately 62%, as not all applications qualify.

<sup>44</sup> The Program Eligibility and Application Kit (PEAK) is an online service for Coloradans to screen and apply for medical, food, cash, and early childhood assistance programs.

Support counties and medical assistance sites with technical assistance for processing eligibility applications	Historical Actual		FY 2016-17 YE Estimate	1 and 3 Yr Target	
	FY 2014-15	FY 2015-16		FY 2017-18	FY 2019-20
# Individuals enrolled in Medicaid/CHP+ <sup>1</sup>	1,215,592	1,348,695	1,415,022	1,483,524	1,564,573
% Eligibility determinations processed timely	97%	98%	98%	98%	98%
% Real time eligibility applications <sup>2</sup>	71%	62%	62%	62%	62%

<sup>1</sup>Annual average of monthly enrollment (excludes dual-eligible members). Three year target is not official budget forecast.

<sup>2</sup>Real-time eligibility data is for medical-assistance-only applications. Percentages represent the percent of applications submitted receiving real time eligibility determination. Not all applications qualify for real time eligibility determination.

The following programs assist in supporting our strategy to support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.

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### STAFF DEVELOPMENT CENTER

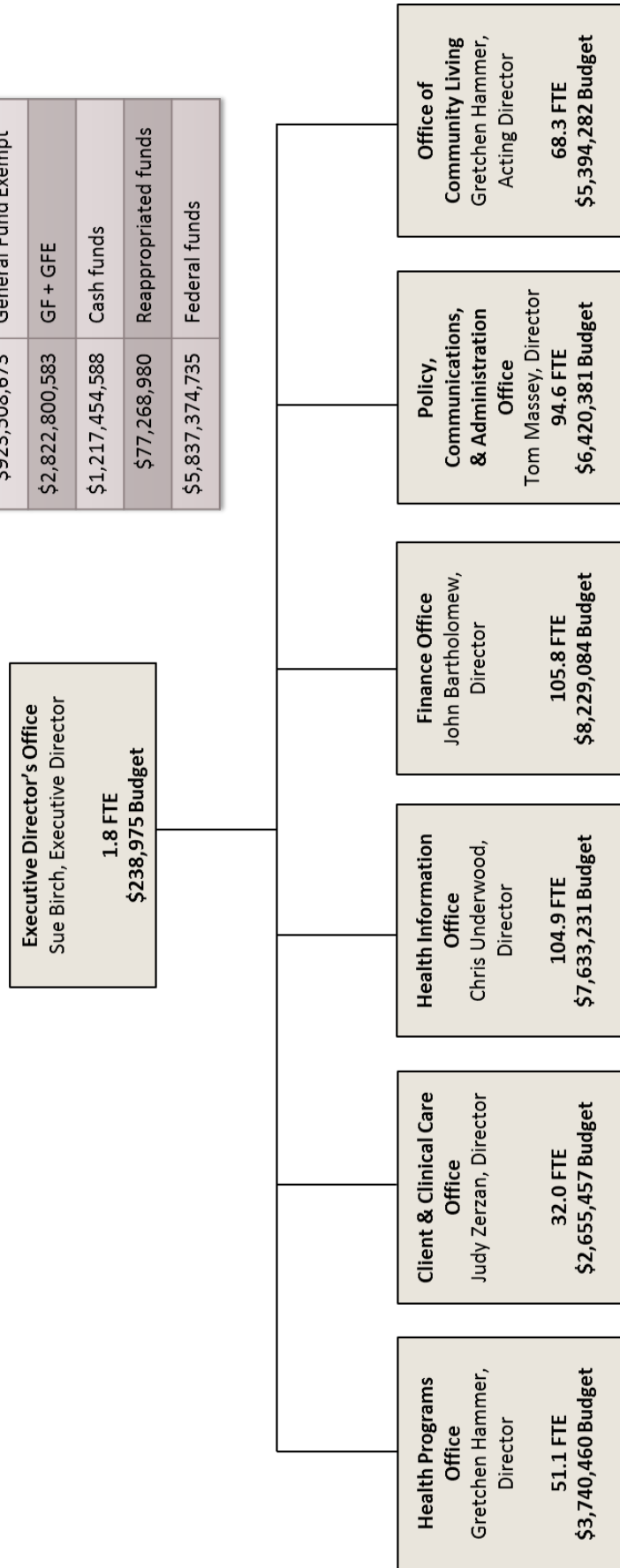
The Staff Development Center (SDC) contributes to our strategy to support counties and medical assistance sites by serving as their training connection to the Department.

The SDC works to identify essential training needs and to establish, facilitate, and maintain competency-based training curricula while continually evaluating results. Its training represents a collaboration of the Colorado Departments of Human Services and Health Care Policy and Financing and the Governor’s Office of Information Technology. Its training supports county-based departments of social/human services and medical assistance sites throughout Colorado as they assist Coloradans in accessing medical and other public assistance.

In FY 2016–17 the SDC began development of a new process-based training model and delivery system focused on the day-to-day activities of a generalist. The trainings will be based on three guiding principles: customer-centric, process-based, and outcomes-focused work. The customer-centric approach is designed to meet diverse learner needs and utilizes a variety of mediums including instructor-led, and self-paced on-demand modules. Process-based training focuses on specific eligibility tasks completed by specialists, with the goal of allowing them to focus on member needs rather than memorizing rules or regulations. Benefits of the new model include decreased error rates, increased efficiency through remote delivery, and improved learner retention of training material and concepts. In FY 2017–18 the SDC will continue work on the new training model, which will be reviewed by a panel of experts. After review is complete, the training model will be piloted with several eligibility sites.

# Organizational Chart & Total Budget

Total Department FTE & budget breakdown (based on FY 2017-18 appropriations)	
458.5	Total FTEs
\$9,954,898,886	Total funds*
\$1,899,291,910	General Fund
\$923,508,673	General Fund Exempt
\$2,822,800,583	GF + GFE
\$1,217,454,588	Cash funds
\$77,268,980	Reappropriated funds
\$5,837,374,735	Federal funds



\*\$9.9 billion in total funds is not distributed across the organizational chart, as the majority of the Department's budget is for expenditures across multiple offices and programs, e.g. medical services premiums.

# Department Description

## Executive Director's Office

Susan E. Birch was appointed Executive Director of the Department effective January 18, 2011. The Executive Director is responsible for setting the strategic direction of the Department, defining its vision and mission, and ensuring we are operating 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 for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

## Health Programs Office

The Health Programs Office develops, implements, administers, monitors, and improves Medicaid acute care and the Child Health Plan *Plus* (CHP+) programs. The Office is made up of three divisions: Delivery System and Payment Innovation, Provider Relations and Dental Program, and Health Programs Benefits and Operations.

### **DELIVERY SYSTEM AND PAYMENT INNOVATION DIVISION**

The Delivery System and Payment Innovation Division is responsible for administering Colorado Medicaid and CHP+ acute care physical and behavioral health programs, including the Accountable Care Collaborative. Its responsibilities also include program monitoring, performance, innovation/delivery system reform, and payment reform.

### **PROVIDER RELATIONS AND DENTAL PROGRAM DIVISION**

The Provider Relations and Dental Division is responsible for provider outreach, enrollment support, retention, and ongoing relations. The Division manages the dental program for children and adults including stakeholder relations, policy development and implementation, contract management and performance, and program administration.

### **HEALTH PROGRAMS BENEFITS AND OPERATIONS DIVISION**

The Health Programs Benefits and Operations Division is responsible for Medicaid acute care benefits management and operations activities. The Benefit Management Section defines, updates, implements, and manages Colorado Medicaid fee-for-service benefits, including defining coverage, and implementing, monitoring, and evaluating benefits. The Operations Section develops, oversees, and executes numerous processes that support the acute care fee-for-service benefits and managed care programs. These processes include medical coding, utilization management, contract management and performance, program development and management, member appeals, the Benefits Collaborative process, stakeholder engagement, project management, federal and state compliance activities, as well as collaborative benefit development and implementation.

## Client and Clinical Care Office

The Client and Clinical Care Office provides clinical expertise and advice regarding Department services, programs, policy, client and provider relations, and performance. The Office is comprised of the Chief Nursing Officer, the Pharmacy Section, the Data Analysis Section, and the Quality and Health Improvement Section. It focuses on preventing the onset of disease and helping our clients manage chronic diseases in such a way that their health improves.

### PHARMACY SECTION

The Pharmacy Section oversees access to medication for Medicaid clients dispensed from a pharmacy. The Section ensures clinically appropriate and cost-effective use of medications through the Colorado Preferred Drug List program, drug-utilization analysis, and input from the Drug Utilization Review contractor. Additional responsibilities include collecting federal and supplemental drug rebates from pharmaceutical manufacturers, ensuring pharmacy benefit compliance with federal and state statutes and regulations, providing pharmacy benefits information and assistance to clients, pharmacies, and prescribers, and managing the Durable Medical Equipment benefit.

### DATA ANALYSIS SECTION

The Data Analysis Section establishes standards for analysis of data utilized in Department decision making. It also provides data and analytical services inside the Department and externally to stakeholders, partners, and others who request it. Specific functions include extracting data for research, policy formation, report writing, forecasting, and rate-setting related to Department programs; and contributing quality-related analysis to the Department's value-focused analytics tools.

### QUALITY AND HEALTH IMPROVEMENT UNIT

The Quality and Health Improvement Unit conducts and coordinates performance improvement activities supporting care and services delivered by Colorado Medicaid and Child Health Plan *Plus* (CHP+). Specific functions of the unit include

- managing external quality review,
- monitoring managed care plan contract compliance,
- overseeing client satisfaction surveys for Medicaid and Child Health Plan *Plus* (CHP+),
- developing long-term care quality tools and interagency quality collaborations,
- developing and implementing quality strategies, and
- consulting with program managers regarding performance measurement and improvement.

## Health Information Office

The Health Information Office (HIO) 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 (Medicaid Management Information System or MMIS) and member eligibility system (Colorado Benefits Management System or CBMS) by developing requirements documentation, reviewing detailed system design approaches, proposing



systems solutions to program staff and implementing systems solutions to support Department initiatives. The Office supports the Department's operations related to claims processing and member eligibility. In addition to aligning the Department's infrastructure and related operations, this office creates a foundation for emerging HIT solutions that will be necessary to implementing the Department's transformational vision for the future of Medicaid.

HIO project management teams provide coordination and management assistance for projects and serve as a bridge between the Department, OIT, providers, and contractors to streamline project approval processes and timeframes for completion of project work. The HIO contract management team provides coordination and management assistance for contracts and serves as a bridge between our Department and contractors. The contract management team helps to establish a clear scope of authority, and clear lines of communication and reporting when interacting with contractors. These teams play a vital role, as our Department contracts out IT and HIT solutions rather than building and maintaining infrastructure in-house.

HIO serves as the primary point of contact regarding data integration and interoperability for multiple external stakeholders, including OIT; the Governor's Office of eHealth Innovation; the Center for Improving Value in Health Care, which administers the All-Payers Claims Database; Colorado Regional Health Information Organization; and Quality Health Network.

HIO is comprised of the HIO Systems Division, HIO Operations Division, Eligibility Determination Division, Health Data Strategy Section, and the Purchasing and Contracting Services Section.

### **HEALTH INFORMATION OFFICE SYSTEMS DIVISION**

The HIO Systems Division is made up of the Colorado interChange Systems Section, the Case and Care Management Section, Testing Support Section, and Eligibility Systems Section. The Division is responsible for enhancing and maintaining our claims payment and member eligibility systems by developing requirements documentation, reviewing system design approaches, proposing systems solutions to program staff, and implementing systems solutions to support Department policies. The Division manages maintenance of and updates to Department systems by working closely with its contractor and gathering requirements in consultation with policy staff. The Division also proposes and implements solutions for program staff, and uses feedback from project stakeholders to verify and ensure accuracy of the claims payment and member eligibility systems.

### **HEALTH INFORMATION OFFICE OPERATIONS DIVISION**

The HIO Operations Division is comprised of the Fiscal Agent Operations Section and the Eligibility Monitoring and Quality Section. The Fiscal Agent Operations Section supports health care claims processing, provider reimbursement, provider enrollment, and state and federal audits of the Medicaid Management Information System<sup>45</sup> related to health care claims processing and provider enrollment. The Eligibility Monitoring and Quality Section oversees the work and performance of eligibility sites statewide where Coloradans can sign up for Medicaid and receive eligibility services (point of entry sites). Section staff interpret state and federal regulations concerning Medicaid eligibility, ensure compliance with state and federal regulations and laws, and enroll members in Medicaid.

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<sup>45</sup> The Medicaid Management Information System is comprised of the Colorado interChange claims management system, Business Intelligence and Data Management Services/BIDM, and Pharmacy Benefit Management System.

## **ELIGIBILITY DETERMINATION DIVISION**

The Eligibility Determination Division is comprised of the Eligibility Contracts and Site Relations Section, the Eligibility Policy Section, and the Eligibility Project Management Unit. The Division is responsible for policy and operations related to Medicaid and CHP+ eligibility. The Division is responsible for ensuring policy and contracts implementation required by changes in eligibility due to changes in law. The Division interprets new and existing Medicaid/CHP+ law to define eligibility requirements for Coloradans, and oversees the site agreements, contracts, rules, processes, and systems involved in granting membership, as well as determining and redetermining eligibility. The Eligibility Project Management Unit provides coordination and management assistance for projects throughout our Department that impact the MMIS, CBMS, and PEAK. The Unit works with Department staff, state agencies, federal partners, and vendors to guide project costs, time, scope, quality, and approval processes.

## **HEALTH DATA STRATEGY SECTION**

The Health Data Strategy Section is responsible for managing our Business Intelligence and Data Management Services/BIDM and implementing a Medicaid data infrastructure that supports strategic uses of health data. In addition, the Section provides data-related expertise to Colorado health reform efforts such as the Accountable Care Collaborative.

## **PURCHASING AND CONTRACTING SERVICES SECTION**

The Purchasing and Contracting Services Section provides all aspects of procurement and contracting for our Department. The Section drafts and runs competitive solicitations, drafts and executes contracts, interagency agreements, and purchase orders for the Department and ensures all work is completed in compliance with federal and state laws, rules, and regulations, and in accordance with contracting standards and processes.

# **Finance Office**

The Finance Office consists of the Chief Financial Officer, Budget Division, Controller Division, Payment Reform Section, Special Financing Division, Audits and Compliance Division, and Strategy Section.

The Chief Financial Officer (CFO) is accountable for the financial and risk management operations of the Department, and oversees control systems that report financial results and maintain Department compliance. The CFO is responsible 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.

## **BUDGET DIVISION**

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. Additional Division functions include preparing fiscal impact statements for proposed legislation and ballot initiatives, performing our federal reporting, and coordinating with other state agencies on budgetary issues presenting mutual impact.

The Budget Division is also tasked with working closely with the Centers for Medicare & Medicaid Services to ensure that we are maximizing available federal funds for Medicaid and Child Health Plan *Plus*. In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

## **CONTROLLER DIVISION**

The Controller Division oversees the Department's accounting functions. The Division ensures proper recording and reporting of revenues and expenditures in compliance with generally accepted accounting principles and state and federal rules and regulations. The Division is comprised of

- the Operations Unit, which is responsible for recording cash receipts, accounts receivable, accounts payable, and payroll;
- the Federal and State Grants Section which is responsible for cash management, cost allocation, grant management, and federal, state and private grant reporting;
- the Medicaid and Provider Fee Unit, which is responsible for all accounting related functions for medical service premiums, mental health capitations, upper payment limit and disproportionate share hospital payments, and hospital and nursing facility provider fees; and
- the DHS/DIDD Unit, which is responsible for the recording and reporting of transactions between the Department of Human Services and the Department of Health Care Policy and Financing related to the budgetary lines shared between the two agencies and the processing of transactions to Counties for administrative payments and Community Centered Boards for Developmentally Disabled members.

## **PAYMENT REFORM SECTION**

The Payment Reform Section develops rate-setting methodology and implements managed care rates for contracted health maintenance organizations, behavioral health organizations, and the Program of All-inclusive Care for the Elderly providers. The Section monitors and updates rates paid for home and community-based services. The Section is also responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics.

## **SPECIAL FINANCING DIVISION**

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 Division administers the Colorado Indigent Care Program, the School Health Services Program, the hospital and nursing facility provider fee programs, the Primary Care Fund, the Old Age Pension Health and Medical Care Program, the Colorado Dental Health Care Program for Low Income Seniors, and other financing mechanisms.

## **AUDITS AND COMPLIANCE DIVISION**

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. It actively monitors implementation of all audit findings. The Department is responsive to all information requests from auditors, and is committed to implementing all agreed audit findings and continually improving processes and policies. The Division consists of the Program Integrity Section, the Audit Information Management Section, and the Eligibility and Claims Review Section.

The Program Integrity Section holds primary responsibility for detection and deterrence of provider fraud, waste, and abuse. The Section's Claims Investigation Unit monitors provider compliance with rules and statute in billing Medicaid. Functions include identifying possible fraud, conducting preliminary investigations of fraud and referring providers to law enforcement when appropriate, identifying and recovering overpayments, and terminating provider participation when appropriate.

The Audit Information Management Section monitors Department compliance with federal and state laws, rules, regulations, policies, and procedures. The Section also performs county-related compliance review functions and supports county investigations of member fraud. The Section specializes in the use of data analysis to identify and recover inappropriate payments, and supplies data to the Audits and Compliance Division and law enforcement.

The Eligibility and Claims Review Section manages federally required programs such as Medicaid Eligibility Quality Control, Payment Error Rate Measurement, and the Recovery Audit Contract. These programs review the accuracy of eligibility determinations and/or conduct claims review to recover improper payments made to providers. The Section also includes the Predicative Analytics Program Manager who is responsible for determining the most effective approach for implementing a prepayment claims review model.

## **STRATEGY SECTION**

The Strategy Section is responsible for developing and articulating our strategy, mission, and goals. The Section provides strategy-related guidance throughout the Department; develops, edits, and produces public-facing reports including our Department Performance Plan; and collects, manages, and publishes performance data. The Strategy Section leads our Lean Community, which is responsible for implementing a culture of continuous improvement throughout the Department. It facilitates Lean process improvement initiatives for groups and administrative units throughout the agency. In partnership with the Workforce Development Section, it presents the Culture of Improvement Academy training for Department employees on a semi-annual basis.

## **Policy, Communications, and Administration Office**

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

The Office is comprised of the External Relations Division, the Client Services Division, the Operations Section, the Grants Unit, the Federal Policy and Rules Officer, the Engagement and Development Division, and the Legal Division.

## **EXTERNAL RELATIONS DIVISION**

The External Relations Division is comprised of the Government Relations and Partner Outreach Section and the Communications Section.

The Government Relations and Partner Outreach Section is responsible for creating our legislative agenda, informing legislators and the Governor's Office about our legislative priorities, and advocating for passage of Department initiatives. It maintains relationships with members of the state General Assembly, their staff, the Governor's office, and other leaders and stakeholders across the state. The Section's Partner

Outreach staff conduct educational, and collaboration-oriented outreach to county leadership, local public health, community partners, and other stakeholders including Connect for Health assistance sites.

The Communications Section develops and coordinates communications plans, products, and activities for external audiences. It is responsible for representing the mission and accomplishments of the Department to a range of external audiences including policy makers, members, and stakeholders.

## **OPERATIONS SECTION**

The Operations Section is responsible for department-wide safety and security, office administration, facilities management, and real estate services. Its office administration functions include ensuring coordination of and compliance with standard operating procedures, event planning and coordination, office supplies oversight, and coordinating Department support staff and special projects. The Section houses the Governor's Citizen's Advocate, and is responsible for managing problems, disputes and issues pertaining to high needs Colorado Medicaid members that reach federal and governor levels.

The Section performs key security functions including managing physical security; oversight of our public reception function and first point of contact, including identification badge issuing and compliance; and creating and managing our Emergency Action Plan and Continuity of Operations Plan.

## **GRANTS UNIT**

The Grants Unit requests and secures grant funding to pursue pilot program initiatives and strategic projects not funded through the regular budget process. Funding secured by the Unit also assists legislative directives requiring gifts, grants, or donations for implementation. Functions include

- coordinating and overseeing use of funds from grants received,
- maintaining relationships with private foundations and federal project officers,
- working with Department staff to match funding needs with potential funders,
- responding to funding solicitations, and
- working with the Department's executive team and management to prioritize projects related to grant funding.

## **FEDERAL POLICY AND RULES OFFICER**

The Federal Policy and Rules Officer is our legal expert regarding compliance with federal rules and regulations. The Officer is responsible for managing our State Plan and drafting amendments. The Officer also oversees coordination of our rule-making body, the Medical Services Board, and provides assistance to staff in drafting proposed rules.

## **ENGAGEMENT AND DEVELOPMENT DIVISION**

The Engagement and Development Division is comprised of the Human Resources Section and the Workforce Development Section.

The Human Resources Section is responsible for filling Department staff positions in accordance with State rules and procedures. Functions include

- recruitment, testing and selection;
- position classification;
- salary administration;

- dispute resolution;
- performance management; and
- administration of annual compensation/benefits.

The section guides and assists Department managers and staff in their use of the state personnel system, and delivers workplace training on topics including sexual harassment, violence in the workplace, and maintaining a respectful workplace.

The Workforce Development Section is responsible for creating and delivering facilitated and e-learning employee engagement and professional development training to benefit the Department and its workforce. The Section also provides consultation and coaching for managers, employees, and teams.

## **CLIENT SERVICES DIVISION**

The Client Services Division provides a high level of communication and assistance to clients who contact the Department. The Division's Member Contact Center serves as the focal point for callers requiring assistance with questions about eligibility and program information and who need help navigating their Colorado Medicaid health care system. Serving a range of internal and external customers, the Division's Education and Design Unit evaluates and reports on instructional effectiveness, creates and improves materials presented or shared by the Department, and designs visual communications. The Division's Eligibility Training Section provides training to counties and contracted agencies where Coloradans sign up for Medicaid and receive eligibility services (point of entry sites).

## **LEGAL DIVISION**

The Legal Division is comprised of the Appeals Section, the Americans with Disabilities Act Coordinator, the Privacy Officer, and the Benefits Coordination Section. The Division is responsible for HIPAA and ADA training and compliance. The Division also acts as records custodian and coordinates Colorado Open Records Act requests. Additional functions include

- managing and coordinating external data requests through our data review board,
- managing our privacy database,
- coordinating our relationship with the Attorney General's office,
- providing analysis and guidance to Department personnel regarding regulatory and legal issues,
- monitoring the impacts of federal health care reform, and
- through its Benefits Coordination Section, preventing or recovering Medicaid payments made for medical care from responsible third parties, including private health plans, and trusts and estates. The Benefits Coordination Section also administers our Health Insurance Buy-In program.

## **Office of Community Living**

The Office of Community Living provides direction and strategic oversight of Colorado Medicaid's programs, services, and supports for older adults, and children and persons with disabilities. The Office implements our efforts to transform the long-term services and supports system into a person-centered system that ensures responsiveness, flexibility, accountability, and person-centered supports for all eligible persons.

The Office is comprised of the Division for Intellectual and Developmental Disabilities and the Long Term Services and Supports Division.

### **DIVISION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES**

The Division for Intellectual and Developmental Disabilities leads efforts for the direction, funding and operation of individualized and flexible supports enabling individuals with intellectual and developmental disabilities to live everyday lives in the community. The Division oversees three Home and Community Based Services waivers serving individuals with intellectual and developmental disabilities, as well as the state-funded Supported Living Services Program, the Family Services and Supports Program and Loan Fund, and Preventive Dental Hygiene services.

### **LONG TERM SERVICES AND SUPPORTS DIVISION**

The Long Term Services and Supports Division oversees eight Medicaid-funded Home and Community Based Services waivers, the Program of All-inclusive Care for the Elderly and the Nursing Facility and Hospital Back-Up State Plan benefits. The Division is responsible for managing two consumer-directed service delivery models which enable qualifying individuals to self-direct their care.

# Glossary

ACA — Affordable Care Act

ACC — Accountable Care Collaborative

ADA — The Americans with Disabilities Act of 1990 requires that state and local government entities do not discriminate against people with disabilities in their programs, services, and activities.

BHO — behavioral health organization

BIDM — The Business Intelligence and Data Management (BIDM) system, one of the three systems in COMMIT

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

CBMS — Colorado Benefits Management System

CDASS — consumer directed attendant support services

Centers for Medicare & Medicaid Services — See CMS.

CHP+ — Child Health Plan *Plus*

Claims run-out — the time period required for a claim to be billed, validated, paid, and entered into an electronic system

CMS — The Centers for Medicare & Medicaid Services, the federal agency overseeing the Medicaid program. CMS is part of the U.S. Department of Health and Human Services (HHS). CMS works in partnership with state governments to administer the Medicaid and the State Child Health Insurance programs.

COMMIT — Colorado Medicaid Management Innovation and Transformation, the Department's four-year project to design, develop, test and implement systems to replace the 20-year-old Medicaid Management Information System (MMIS) and other information technology components.

CORHIO — Colorado Regional Health Information Organization, a nonprofit partnering with the Department on technology projects related to health information exchange.

ED — emergency department

EHR — Electronic Health Record

EPSDT — Early and Periodic Screening, Diagnostic and Treatment benefit providing comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

FCR — first call resolution

FQHC — federally qualified health center

FY — fiscal year

HCBS — home and community based services

HCPF — Colorado Department of Health Care Policy & Financing

HIPAA — Health Insurance Portability & Accountability Act of 1996

HIT — health information technology

HMO — health maintenance organization

I/DD — intellectual and developmental disabilities

interChange — The Colorado interChange is one of the three computer systems included in COMMIT, and relates to payment of claims.



IT — information technology

KPI — key performance indicator. The KPIs form the basis for incentive payments designed to encourage ACC providers to use services and practices that improve health outcomes.

LTSS — long-term services and supports

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.

MLR — medical loss ratio, the proportion of premium revenues an insurance provider spends on clinical services and quality improvement

NAL — Nurse Advice Line

OSA / Office of the State Auditor — a nonpartisan agency in Colorado's Legislative Branch that conducts performance, financial, and information technology audits of the operation of state programs and the use of state and federal funds

Passive enrollment — being automatically enrolled in a benefit

PBMS — Pharmacy Benefit Management System, one of the three systems in COMMIT

PEAK — Program Eligibility Application Kit

PCMP — primary care medical provider

PMPM — per member per month

PACE — Program of All-inclusive Care for the Elderly

RCCO — Regional Care Collaborative Organization

SIM — State Innovation Model

SLS — Supported Living Services program

State Plan / Medicaid State Plan — A Medicaid and CHP+ state plan is 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 specified member population with needed services