*State Demonstrations to Integrate Care for Dual Eligibles*

*Demonstration Proposal*

*Colorado*

**Summary:** In 2011, Colorado was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Colorado Department of Health Care Policy and Financing has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

**Invitation for public comment:** We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, June 30, 2012. You may submit comments on this proposal to [CO-MedicareMedicaidCoordination@cms.hhs.gov](mailto:CO-MedicareMedicaidCoordination@cms.hhs.gov).

**STATE OF COLORADO
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**


**PROPOSAL TO THE
CENTER FOR MEDICARE AND MEDICAID INNOVATION**


**STATE DEMONSTRATION TO INTEGRATE CARE
FOR DUAL ELIGIBLE INDIVIDUALS**



**May 2012**

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# A. Executive Summary

Currently, almost 70,000 individuals in Colorado are fully eligible for both Medicare and Medicaid. For most clients who are served through Medicaid and Medicare, there is little coordination of care and no effective mechanism for a client's multiple providers to communicate regularly. Because of this lack of integration and coordination, it is difficult to ensure that client needs are being met and that all care provided is appropriate and integrated. Clients face multiple challenges navigating the different systems, and providers face challenges coordinating care. This often results in lower health outcomes, less positive experiences of care from both client and provider perspectives, and increased costs. This State Demonstration to Integrate Care for Dual Eligible Individuals (the Demonstration) outlines the Colorado Department of Health Care Policy and Financing's (the Department's) vision and commitment to improving care for this population, improving health outcomes and client experience of care, and reducing unnecessary expenditures.

The Department envisions the Demonstration as one part of a continuum of care options in which clients can participate. The Department's Demonstration utilizes its established Accountable Care Collaborative Program (ACC Program)[1], a managed fee-for-service (FFS) program already providing care for Medicaid clients throughout the state. The ACC Program, which was established in 2009, began enrolling clients in 2011. It will allow the Department to provide fully dual eligible clients with care coordination, a focal point of care, and data analytics through an existing program. Described in more detail in Appendix B, the ACC Program has three core elements: Regional Care Collaborative Organizations (RCCOs), Primary Care Medical Providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC).

The Demonstration builds upon the Department's ACC Program to improve coordination of care across Medicaid and Medicare. Coordinating services across the Medicare and Medicaid programs is intended to better align services, alleviate fragmentation, enhance quality of care, and reduce costs. The managed FFS model provides clients with access to all of the same services they currently receive, including primary and acute medical care as well as Long-Term Services and Supports (LTSS), which are made available through Medicaid Home and Community-Based Services (HCBS) waiver programs and coverage for institutional care. In the realm of behavioral health, RCCOs are being required to implement written protocols with Colorado's Behavioral Health Organizations (BHOs) in their corresponding regions. The Department aims to strengthen integration through contractual arrangements that put a special focus on fully dual eligible clients with behavioral health needs.

From the beginning, the Department has been actively engaging clients, stakeholders, and partners to develop the Demonstration. Throughout the coming months, the Department will continue to use its collaborative alliances with community organizations, task forces, and coalitions to share information about the project as the Demonstration is implemented. The Department also will continue to gather and incorporate stakeholder feedback as it works collaboratively with other state agencies and local partners serving dual eligible individuals. Additionally, the Department will monitor client and provider experiences through surveys,

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[1] A complete glossary of terms and acronyms used throughout the proposal is provided in Appendix A.

focus groups, and data analyses. Finally, the Department will develop input processes and systems to monitor and measure the level of care provided to fully dual eligible individuals. Table 1 below highlights the main features of the Demonstration.

**Table 1. Demonstration Proposal Features**

| | |
|---|---|
| **Target Population** | All full-benefit Medicare-Medicaid enrollees |
| **Total Number of Full-Benefit Medicare-Medicaid Enrollees Statewide** | 69,787[2] |
| **Total Number of Beneficiaries Eligible for Demonstration (Estimated)** | 62,982[3] |
| **Geographic Service Area** | The model is statewide. |
| **Summary of Covered Benefits** | <ul><li>Medicare Parts A, B, and D</li><li>Medicaid State Plan</li><li>Behavioral Health Services available under an existing 1915(b) Medicaid waiver</li><li>Home and Community-Based Services available under 1915(c) Medicaid waivers</li></ul> |
| **Financing Model** | Managed Fee-for-Service |
| **Summary of Stakeholder Engagement/Input** (Additional details are contained in Section D.) | <ul><li>6 stakeholder meetings hosted in Denver with toll-free call-in options (June 2011 – May 2012)</li><li>5 ongoing workgroups regularly meeting in Denver with toll-free call-in options (December 2011 – May 2012)</li><li>9 area meetings across the state (February 2012 – May 2012)</li><li>58 presentations to and conversations with individual stakeholders and specific organizations (June 2011 – May 2012)</li><li>Dual Eligible Demonstration Contract page on the Department's Web site</li><li>Toll-free question/comment hot line</li></ul> |
| **Proposed Implementation Date** | 2013 |

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[2] The number is based on fiscal year 2011. Colorado's fiscal year refers to each twelve-month period beginning on July 1 and ending on June 30.

[3] The difference between 69,787 and 62,982 is attributable to the approximate number of dual eligible clients who have already chosen to be part of another program, such as the Colorado Alliance for Health and Independence (CAHI), the Denver Health Medicaid Choice Plan, an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID), the Program of All-inclusive Care for the Elderly (PACE), or Rocky Mountain Health Plan.

## B. Background

The Department, along with its clients, stakeholders, and partners, has recognized that the Medicare and Medicaid status quo is no longer viable for dual eligible clients. Similarly, all recognize that real progress cannot be made by starting from scratch or by creating yet one more silo of care and services. As a result, the Department envisions developing an integrated model of care for those dually eligible for Medicare and Medicaid by using its existing managed FFS program, the ACC Program, as the foundation. Realizing that it takes time to unify systems of care and effect substantial, sustainable change, the Department is taking a deliberate and thoughtful approach in implementing and expanding the ACC Program. Step by step, in conjunction with its clients, stakeholders, and partners, the Department is making significant strides toward realizing a shared vision. As it proceeds in making incremental but continual progress, the Department views the Demonstration as another opportunity to take additional steps. In the following subsections, the proposal summarizes the Department's vision and rationale for integrating care for dual eligible clients and describes the population to be served.

### i. Vision and rationale

Colorado, like other states, has struggled to manage the potentially complex needs of dual eligible clients in a disjointed Medicare and Medicaid delivery system that lacks integration of benefits and services from client and provider perspectives. The fragmented system also lacks integration of data and payment from provider and payer perspectives. Incentives between Medicare and Medicaid are misaligned, and emphasis is placed on volume-driven sick care rather than on outcomes-driven preventive care and effective management of chronic conditions.

Providing dual eligible individuals with integrated, coordinated care and effective, innovative payment models will improve client experience and access to quality care. Coordinated care will also decrease Medicare and Medicaid expenditures for these clients over time. The ACC Program is one way to provide dual eligible individuals with the advantage of a focal point of care that proactively coordinates the health needs of each member and is designed to meet the needs of dual eligible clients. As previously mentioned, the history, development, and core elements of the ACC Program are summarized in Appendix B and further supplemented by information contained in Appendices C and D.

The ACC Program has two central goals. First, it aims to improve health outcomes of Medicaid clients through a coordinated, client/family-centered system by proactively addressing clients' health needs, whether simple or complex. Second, it seeks to control costs through reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The Department recognizes that changes to the delivery of health care services to Medicaid clients are essential to maximize their health, functioning, and independence. The ACC Program's goals and changes to the delivery system are compatible with the aims of the Demonstration.

Representing an innovative way to accomplish the Department's goals for Medicaid reform, the ACC Program provides a foundation for the Demonstration. Its design supports a shift from a volume-driven, fee-for-service (FFS) model to a coordinated, outcomes-based system that controls costs in a responsible manner. Not designed to take the place of the Department's

managed care programs, the ACC Program is a model for coordinating care that works within the existing FFS system.

One of the core tenets of the ACC Program is collaboration. This includes collaboration between the Department and the RCCOs, collaboration among the RCCOs, and collaboration among the different delivery systems that serve Medicaid clients, such as long-term services and supports and behavioral health. These efforts are supported by the Department, and the RCCOs and PCMPs are held accountable for collaboration in their contracts. RCCOs are also responsible for creating a virtual network of specialists and ancillary providers to meet their clients' needs. All of these relationships, both formal and informal in nature, comprise the actual and virtual networks of primary, specialist, and ancillary providers needed to successfully serve the ACC Program's clients. Moreover, the Department will be able to leverage these existing resources to undergird the Demonstration as it includes dual eligible individuals in the ACC Program.

## ii. Description of the population

Nationally, dual eligible individuals account for 16 percent of Medicare enrollment but 27 percent of its spending and 15 percent of Medicaid enrollment but 39 percent of its spending. Currently, 632,460 Coloradans are enrolled in Medicaid. Approximately 11 percent of the currently enrolled Medicaid clients are individuals who are eligible for Medicare and the full range of Medicaid benefits and services ("fully dual eligible" individuals). Total Medicaid expenditures for fully dual eligible individuals in Colorado exceeded $1.1 billion in 2011.

In Colorado, 85 percent of Medicaid clients are served through a fee-for-service (FFS) model. Little coordination of care exists with no effective mechanisms for a client's multiple providers to communicate regularly. It is difficult to ensure that client needs are met and that all provided care is appropriate and integrated. Given the lack of coordination and integration, the cost of care for dual eligible individuals is high and continues to increase.

The Department's Demonstration focuses on integrating care for fully dual eligible individuals. In fiscal year 2011[4], fully dual eligible individuals in Colorado numbered 69,787, which included those receiving services through Home and Community-Based Services (HCBS) waivers. Below are basic demographic data for this population:

- There were 43,769 female clients (63%) and 26,018 male clients (37%).

- 42,033 individuals (60%) were 65 years old and older; 27,615 individuals (almost 40%) were between the ages of 21 and 64; and 139 individuals (less than 1%) were under the age of 21.

- Individuals self-reported their race/ethnicity: 25,035 individuals as "Caucasian" (36%); 22,650 individuals as "Unknown" (32%); 10,974 individuals as "Hispanic or Latino"

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[4] Colorado's fiscal year refers to each twelve-month period beginning on July 1 and ending on June 30.

(15%); 2,819 individuals as "African American" (4%); and the remaining 8,489 individuals in other categories (12%).

- 56,611 individuals lived in urban counties (81%) while 13,176 individuals (19%) lived in rural and frontier counties.

In addition to the information provided in Table 2 below, Appendix E provides Medicare and Medicaid utilization and cost information for dual eligible clients for nursing facility, home health, hospice, and other acute care services.

**Table 2. Demonstration Population's Use of Long-term Services and Supports (LTSS)**

|  | Overall Total | Individuals Receiving LTSS in Institutional Settings | Individuals Receiving LTSS in HCBS Settings | Individuals with no LTSS Utilization |
|---|---|---|---|---|
| Overall Total (100%) | 69,787 (100%) | 10,533 (15%) | 23,081 (33%) | 36,174 (52%) |
| Individuals Age 65 and older (60% of Overall Total) | 42,033 (100%) | 9,161 (22%) | 11,941 (28%) | 20,931 (50%) |
| Individuals under Age 65 (40% of Overall Total) | 27,754 (100%) | 1,375 (5%) | 11,138 (40%) | 15,242 (55%) |
| Individuals with Serious Mental Illness (7.5% of Overall Total) | 5,256 (100%) | 545 (10%) | 2,212 (42%) | 2,500 (48%) |

## C. Care Model Overview

In this section of the proposal, the Department illustrates how the Demonstration's care model will serve dual eligible individuals. In the following subsections, the Department describes how it is making the most of existing delivery system elements, unifying them through stronger linkages, and supporting them with evidence-based practices within the context of Medicaid services and other CMS initiatives.

### i. Delivery system elements

The Demonstration will be implemented statewide and organized around the existing seven geographic regions of the ACC Program. All fully dual eligible individuals not already enrolled in another recognized program that provides care coordination will be enrolled in the ACC Program with the designated RCCO in the enrollee's county of residence. Appendix F reflects Colorado's population, Medicaid enrollment, and dual eligible clients by RCCO.

Enrollment Method
The Department envisions the Demonstration as part of a continuum of care options for dual eligible clients who, like other clients, can benefit from care coordination. The Department will use the ACC Program as a primary delivery system for dual eligible individuals who are not already participating in another recognized program that provides care coordination. Extending the ACC Program model to dual eligible individuals is a key component of the Demonstration.

The Department will use a voluntary enrollment process called "passive enrollment" to enroll any dual eligible clients into the ACC Program who are not already part of another program, such as the Colorado Alliance for Health and Independence (CAHI), the Denver Health Medicaid Choice Plan, an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID), the Program of All-inclusive Care for the Elderly (PACE), or Rocky Mountain Health Plan. It is anticipated that nursing facility clients will be eligible for the Demonstration. However, the Department is still exploring whether clients enrolled in a Special Needs Plan (SNP) will be eligible for or excluded from the Demonstration. Fully dual eligible clients in the Demonstration will be automatically enrolled into the ACC Program but can choose another program or delivery system if they wish as required by Title 42 Code of Federal Regulations (CFR) Section 438.52.

Enrollment will be closely related to attributing a client to a primary care medical provider (PCMP). The PCMP is a fundamental component of the ACC Program and the Demonstration, and the Department's objective is to maintain existing client-provider relationships to avoid disruption in care and services. The Statewide Data and Analytics Contractor (SDAC) will look at a dual eligible client's past 36 months of Medicare and Medicaid claims history to understand which medical provider the client has seen most frequently.

The Department has developed enrollment processes that minimize disruption to existing client-provider relationships. These processes will be used to enroll dual eligible clients as well, but with slight modifications to accommodate the possibility that a client's strongest relationship may be with a Medicare provider.

If the dual eligible client has a clear pattern of using a certain Medicare or Medicaid provider, who is a participating provider in the ACC Program, the client will be enrolled into the ACC Program and the Demonstration with the identified provider as the client's designated PCMP. If the dual eligible client has a clear pattern of using a certain Medicare or Medicaid provider who is not participating in the ACC Program, the RCCOs will conduct outreach with that provider to enroll the provider in the ACC Program. The Department and the RCCOs have a strong commitment to helping enroll providers in the ACC Program so that providers and clients have access to the support and benefits the ACC Program provides. In cases where a dual eligible client's Medicare or Medicaid provider is not participating in the ACC Program, the designated RCCO will contact the provider and make every attempt to enroll the provider in the ACC Program.

If a client's primary provider does not want to enroll in the ACC Program, even after outreach and education efforts by the Department and the RCCOs, and if the client wants to receive the benefits of the ACC Program, the Department and the RCCOs will work to assist the client in

finding a provider who does participate in the ACC Program. Clients may opt out of the ACC Program if efforts fail to link a client with a participating ACC Program provider.

If a client has no clear pattern of using a certain primary care provider, the RCCO is responsible for ensuring that outreach to the client is conducted to determine that care and services are being coordinated and delivered. If a client has a clear pattern of using two or more Medicare and/or Medicaid providers equally, the client will be associated with the provider most recently visited.

The Department has a strong commitment to maintaining existing client-provider relationships. Additionally, the Department has a strong commitment to ensuring that all clients have access to the enhanced care coordination services and supports provided by the ACC Program. Over time, it is expected that the ACC Program will be a primary system for ensuring that clients receive these services, and the Department will continue to work toward full participation of providers in the ACC Program so that these services are available to all clients.

Critical to the passive enrollment process is that individuals receive advance notice and have sufficient time and opportunity to make an informed choice. Currently, clients receive a letter thirty days prior to enrollment that tells them they will be enrolled into the ACC Program, including details about benefits and services, and instructions for opting out of the program if they choose to do so. The Department will work with CMS to ensure that enrollment processes for dual eligible clients meet all requirements, including a 60-day notification period if required.

The letter informs clients that they will also be able to opt out of the program during the first 90 days of their enrollment and again during an open enrollment period every year. Additionally, a client may disenroll from the ACC Program for cause. Reasons for disenrollment for cause are contained in Appendix G.

This approach presents a new opportunity to establish care coordination for individuals eligible for both Medicare and Medicaid who are not already participating in another recognized program that provides care coordination. Coordinating services across the Medicare and Medicaid programs is intended to better align services, alleviate fragmentation, enhance quality of care, and reduce costs for the state and the federal government. Through improved coordination across the two programs, the Demonstration will facilitate more seamless integration and access to all necessary services based on the individual's needs.

Available Networks
The Department's approach requires designing and implementing ACC Program modifications to further support the potentially complex needs of dual eligible individuals and the particular financing of their care. The Department continues to work with RCCOs, PCMPS, and other providers and systems of care to ensure that appropriate, high-quality care coordination is available for all clients who are served by the ACC Program. Service delivery is coordinated among RCCO staff, physician offices, hospitals, and specialists. RCCOs are continually identifying areas of improvement and ways to strengthen and improve the coordination of service delivery among providers of acute care, long-term services and support (LTSS), and behavioral health. Utilizing existing service delivery coordination provided by the Single Entry Points (SEPs) and the Community Centered Boards (CCBs), RCCOs are developing additional

linkages between LTSS systems and the physical and behavioral health systems, which include mental health and substance use disorder services.

A care coordination approach that is sensitive to clients and includes respect for and input from the client is currently being utilized within the ACC Program and will continue to be used to design appropriate care coordination activities to reflect the client's needs. Although each RCCO ensures the provision of care coordination differently at the individual level, each RCCO will continue to build upon its current care coordination practices to ensure that such coordination meets the needs of clients who may have complex needs. The Department does not intend to add another care coordinator or case manager to the existing systems of care for dual eligible clients. Instead, the Department will utilize the Demonstration to work collaboratively with current systems of care to achieve a more effective and streamlined approach to care and services for dual eligible clients.

Care coordination models for dual eligible individuals must have the ability to address chronic physical and behavioral health issues and acute care as needed. Additionally, coordination models must address both medical and non-medical needs (e.g., housing, transportation, and respite). Flexibility in financing is important to achieve care coordination success on an individual level. Therefore, care coordination for dual eligible clients, in particular, will be flexible enough to respond when an individual's needs increase or decrease.

The Department recognizes there may be a need for different kinds of care coordination for different groups of dual eligible individuals, such as children, persons whose primary language is not English, and persons with physical and developmental disabilities. Persons with physical and developmental disabilities not only have acute care medical needs but also have essential needs for LTSS, such as assistive technology, habilitation and day training, supported employment and supported living, and transportation. As the Department works collaboratively to develop enhanced requirements, RCCOs are continuing to increase awareness of and develop relationships with community providers relevant to persons with physical and developmental disabilities and determine how their services can be better accessed.

Primary Care Providers
RCCOs establish agreements with Primary Care Medical Providers (PCMPs) and relationships with all other necessary service providers. RCCOs and PCMPs serve as conduits to care by helping clients gain access to needed services. PCMPs are required to provide whole-person-oriented, coordinated, client/family-centered care in a culturally and linguistically sensitive manner. PCMPs in the ACC Program contract with both the Department and the RCCOs and are accountable to both. PCMPs must be committed to achieving operational and fiscal efficiencies, tracking performance and process improvement activities, tracking follow-up on diagnostic tests, and improving care transitions and coordination with specialists.

The Department and the RCCOs will work together to ensure that primary care providers who participate in the Medicare program are recruited to participate in the ACC Program and the Demonstration. To accommodate the enrollment of dual eligible individuals into the ACC Program, Medicare providers will be recruited to serve as PCMPs. The Department does not wish to disrupt established care relationships between dual eligible clients and their current

providers. Under the Demonstration, RCCOs will establish written agreements with PCMPs in their regions who provide Medicare-covered benefits to serve as medical homes for dual eligible members.

Long-Term Services and Supports (LTSS)
Compared to the population comprising current ACC Program enrollment, a higher percentage of dual eligible individuals will be significant users of LTSS. Particularly at transition points between Medicaid and Medicare coverage and during transitions in care settings, many opportunities exist to improve coordination of LTSS and other care, client outcomes, and client experience of care.

Complicating matters, many dual eligible individuals who need LTSS also have multiple chronic conditions. In Colorado, more than 40 percent of fully dual eligible individuals have one or more chronic conditions. These conditions have a progressively negative impact on health outcomes, the overall care experience, and costs. The Chronic Disease Prevention Branch (CDPB) of the Prevention Services Division in the Colorado Department of Public Health and Environment recognizes that health care is improved by a proactive focus on health. CDPB is continuing its work with partner agencies and organizations statewide to develop programs to address chronic diseases and associated risk factors. To that end, CDPB's collaborative efforts will provide added value to the Demonstration by sharing responsibility for improving health and health outcomes with its attention to the prevention and postponement of chronic conditions and resulting complications. This is an example of how the Department continues to maximize existing relationships in its model to better integrate care for dual eligible individuals.

For many dual eligible clients who utilize LTSS, depression also can be a significant problem, which can contribute to a reduction in overall functioning. As part of the Demonstration, RCCOs can encourage participating PCMPs to provide depression screening. In addition, RCCOs can work with the BHOs and other community providers to be responsive to dual eligible clients who are receiving LTSS and experiencing mild to moderate depression. Early detection and intervention can support the maintenance of health status and overall functioning.

The planning and provision of LTSS at transition points between acute Medicare and post-acute Medicaid care provide additional opportunities to achieve the goals of improved care coordination, outcomes, and client experience of care while reducing unnecessary costs. As part of this Demonstration, the Department will work with RCCOs to strengthen existing activities and implement new initiatives to help achieve these goals.

Clients accessing Medicare post-acute services in Skilled Nursing Facilities (SNFs) are another point for providing solid care coordination with a goal toward providing LTSS in the most appropriate, least restrictive setting. For clients who are in nursing facilities, enhanced care coordination can prevent hospital admissions and readmissions. For some nursing facility residents, enhanced care coordination can assist with discharging residents to community-based services. This requires early intervention; the longer Medicaid eligibility determination and transition take, the lower the odds of successful community reintegration. The Demonstration will build on the infrastructure for the Department's Money Follows the Person (MFP) Rebalancing Demonstration Program, known as Colorado Choice Transitions (CCT), to facilitate

transitions from nursing facilities to community settings. As the Department prepares to start its MFP enrollment in September 2012, it is beginning to incorporate processes into CCT workflows that reduce the potential for dual eligible clients to convert from Medicare post-acute coverage to long-term SNF coverage financed by Medicaid.

For all clients, improved communication among providers is critical to improving care coordination because, in many cases, multiple entities provide services to dual eligible clients, including Single Entry Points (SEPs), Community Centered Boards (CCBs), Area Agencies on Aging, and home health providers. All of these entities have experience supporting ongoing monitoring activities for clients that can be useful in preventing emergency department visits as well as hospital admissions or readmissions. By increasing communication between these entities, client care can be greatly enhanced.

A goal of the Demonstration will be to facilitate enhanced communication among these providers, potentially by amending contracts to require closer communication, development and sharing of treatment plans as appropriate, and enhanced collaboration. As an example, for a client who has been admitted to the hospital, RCCOs, SEPs, and hospitals might have a role in providing coordinated care by working together to facilitate the development of a transition plan. At the time of the client's hospital admission, the hospital would be able to notify the RCCO. The RCCO would then communicate with the client's SEP case manager. The case manager, in conjunction with the client, family members, and other caregivers, would work with the rest of the care team to develop a set of appropriate care options to be considered by the client and family. This approach would provide a more seamless experience for the client prior to and after discharge from the hospital, which is likely to improve health outcomes.

For clients receiving ongoing LTSS in the community, this enhanced communication is especially critical. By sharing care plans and health risk assessments, providers are able to more effectively support clients and to ensure care is coordinated and health information is acted upon to improve client health and experience of care. The possibility of utilizing different intake, assessment, and case management tools is being explored as part of a larger interagency effort to redesign long-term services and supports.

The SDAC also will be incorporating functional assessment data, which will contribute to a more comprehensive picture of dual eligible clients in the Demonstration. These data will assist in more timely identification of an individual's decline in functional status or quality of life, thereby allowing earlier detection of underlying causes and use of evidence-based interventions. As data become more available, opportunities increase for the Department, other state agencies such as Colorado's Department of Human Services and Department of Public Health and Environment, RCCOs, and LTSS providers to collaborate on activities that proactively support health.

Because LTSS providers often see clients on a more regular basis in the community and in the home than primary care practices, they are poised to assist RCCOs in the coordination of care and the implementation of interventions. Throughout the upcoming months, the Department will work with these organizations to more clearly define potential roles and responsibilities and to

determine which contract amendments, interagency agreements, and/or memoranda of understanding are needed to more appropriately reflect these roles.

Already, RCCOs are working to assist providers in communicating effectively. For example, they are establishing technology linkages among physician offices, hospitals, BHOs, and other providers as necessary to coordinate care. The Department will continue to facilitate and encourage these increased technology linkages among the RCCOs and among providers. Additionally, the Department will develop new analytics to measure cross-system care improvement opportunities as well as measuring joint successes and identifying areas for further improvement.

Behavioral Health
The Department currently administers a managed care program that provides comprehensive behavioral health services to all Coloradans with Medicaid. Medicaid members are assigned to a behavioral health organization (BHO) based on where they live. This carve-out system tends to separate behavioral health benefits from physical health care within Medicaid. Similarly, no strong care coordination effort exists as part of Medicare. Medicare Part A (Hospital Insurance) covers inpatient behavioral health care, Medicare Part B (Medical Insurance) covers outpatient behavioral health services, and Medicare Part D (Prescription Drug Coverage) helps to cover prescription drugs needed to treat a behavioral health condition.

Before implementation of this Demonstration, RCCOs will be required to implement written protocols with the BHOs in their ACC Program region. While the RCCOs are currently responsible for coordinating care with BHOs, the Demonstration will move further to provide "virtual integration" between physical and behavioral health care systems for dual eligible individuals. Because BHOs have core competencies, networks, and experience in this realm, prior to implementation of the Demonstration, the Department will strengthen integration through contractual arrangements that put a special focus on those dual eligible clients with behavioral health needs.

Formalizing the relationships between separate organizations of primary health and behavioral health providers will strengthen partnerships between them. These strengthened partnerships will ensure that clients with mental health conditions or substance abuse disorders receive appropriate health care that is comprehensive, coordinated, and person-centered. Contractual arrangements between RCCOs and BHOs will also address the inclusion of behavioral health providers as part of a broader health care team along with the Primary Care Medical Provider (PCMP).

In addition, the Division of Behavioral Health (DBH), which exists within the Colorado Department of Human Services' Office of Behavioral Health, is continuing to work collaboratively with the Department, the RCCOs, the Community Mental Health Centers, and other stakeholders and partners involved in the Demonstration. For example, DBH is assisting the RCCOs and substance abuse providers in understanding the existing substance use disorder FFS Medicare and Medicaid benefits to find practical solutions for substance use and abuse disorders among dual eligible clients. The Department is also attentive to initiatives that are examining ways to facilitate the enrollment of clients into other programs for which they are eligible, such as Medicare. Through the Demonstration, the Department will continue to be

aware of and coordinate with projects occurring within and outside of the Department that intend to improve accessibility of services for substance use disorders.

Other protocols are being explored and may be required, including those that can enhance the medical home model by including behavioral health providers as part of interdisciplinary care teams. For example, such protocols could include providing primary care physicians with real-time access to behavioral and psychiatric consultations, regular screening of basic metabolic indicators for those on psychotropic medications (e.g., blood pressure, glucose, lipid, and weight levels), co-locating personnel, and recruiting PCMPs willing to spend part of their time at behavioral health clinics or in other similar arrangements. RCCO and BHO contracts will be amended before implementation of this Demonstration to include requirements about these types of protocols.

One significant area to address in the model is facilitating data sharing to give providers the most complete picture of a client as possible. Currently, RCCOs can access data from the SDAC, but these data do not provide specific, detailed client-level behavioral health information. The Department is developing ways to allow RCCOs and BHOs to exchange data and to work together with existing network providers and/or care coordinators to access physical health information, substance abuse claims, and BHO encounter data for members. BHOs will make efforts to identify and include in their contracted networks providers who are capable of billing Medicare and will ensure that providers bill appropriately.

In addition to considering and building on current efforts underway by the RCCOs and BHOs, the Demonstration will be informed by Department efforts to integrate physical and behavioral health care at both programmatic and policy levels. The Department will require BHOs and RCCOs to collaborate in submitting information on their current integration efforts and their future integration strategies. The Department will also require quarterly updates on the successes, failures, and challenges faced by the RCCOs and BHOs. Another change to reporting requirements is related to the RCCOs' practice support plans, which will soon include information on their behavioral health and substance abuse efforts.

Models of behavioral health service delivery will evolve over time to foster greater integration of care. The abilities and knowledge that already reside in Colorado's BHOs, Medicaid's capitated behavioral health care carve-out system, are an important resource whose value can be leveraged to best provide care to dual eligible individuals. In the near term, the Department will continue to operate a behavioral health carve-out system, and all BHOs will have written protocols with RCCOs. In the long term, the Department will explore models that promote greater integration. The Department, the RCCOs, and the BHOs have already begun to identify and document mutual expectations between the RCCOs and BHOs for the Demonstration. This collaborative work is an ongoing process that will continue during the summer of 2012 and throughout implementation.

Hospitals
Hospitals are a critical part of the continuum of care for Medicaid clients, including dual eligible clients. As part of the ACC Program, RCCOs have developed collaborative relationships with hospitals within their regions to help improve care coordination for clients. Transitions of care out of hospitals represent a particular area of vulnerability for clients and an area of opportunity

for improved health outcomes and achieving health care savings. RCCOs currently conduct activities to support care transitions following hospital discharge. Under the Demonstration, contracts between the RCCOs and the Department will be amended to facilitate and require even more utilization of proven and innovative programs and efforts to reduce re-hospitalizations, improve health outcomes, increase client satisfaction, and reduce costs associated with unnecessary re-hospitalizations. These activities will include increased efforts to ensure that discharge planning and client education is sufficient to support transitions that promote improved health outcomes and client experience of care. Programs and initiatives will focus on client centeredness and will provide comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults hospitalized for common medical and surgical conditions. Programs will also encourage a culture of personal responsibility for clients and stakeholders and will be grounded in evidence-based practices. Wherever possible and appropriate, the Department will engage community partners to assist in implementing these programs.

Additionally, the Demonstration will leverage current forces that create mutual incentives for hospitals serving Medicare beneficiaries to work with RCCOs and PCMPs to reduce potentially preventable readmissions. The Patient Protection and Affordable Care Act mandated that, starting October 2012, Medicare will penalize hospitals whose readmission rates for individuals with acute myocardial infarction, heart failure, or pneumonia exceed the average risk-adjusted, 30-day readmission rate for such individuals as calculated by CMS. By 2014, hospitals with higher than expected readmission rates stand to lose up to three percent of their regular Medicare reimbursements. Through the Demonstration, the Department will be able to use the resources of the ACC Program to provide incentives for greater collaboration, process improvements, and positive change in readmission patterns, which are expected to lead to improved health outcomes and care quality for dual eligible individuals.

In addition to enhanced care transition support, the Department will continue to work with RCCOs to develop and implement initiatives and activities designed to reduce unnecessary emergency department utilization. Best practices in this area suggest that conducting outreach and providing education, coaching, and telephone support, such as nurse advice lines for clients with frequent emergency department utilization, may be helpful in reducing unnecessary emergency department use and improving health outcomes. The Department will continue to work with RCCOs to further develop and implement these activities and, over the next several months, will amend RCCO contracts to require increased utilization of these activities as appropriate. Additionally, the Department will continue to evaluate the need for increased data linkages between emergency department providers and RCCOs to allow the data systems to support early identification of possible needs for emergency department diversion support.

### ii. Benefit design

The Department's Demonstration will include the full continuum of Medicare and Medicaid services that individuals eligible for both programs are entitled to receive: Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), and Medicare Part D (Prescription Drug Coverage), all Medicaid State Plan services, and the appropriate waiver services.

The Department will implement a managed fee-for-service (FFS) model delivering all Medicaid and Medicare services in a coordinated manner under the ACC Program. The managed FFS

financial alignment model allows clients access to primary and acute medical care, which is largely covered under Medicare. LTSS is also available through Medicaid HCBS waiver programs and coverage for institutional care.

The Department and stakeholders recognize that a key part of improving care for dual eligible clients is better coordination of pharmacy services. Comprehensive medication management has a positive effect on client care, health outcomes, and care transitions. It also improves medication reconciliation, which can prevent adverse drug interactions and can decrease duplicating medications and taking more medications than needed.

The Department is working with CMS to obtain Medicare Part D data for its dual eligible clients. Although the Department is not currently requesting to run a Medicare Part D plan for its dual eligible clients, the Department will continue to collaborate with CMS and other partners and stakeholders to explore proactive solutions for better medication management. All parties clearly understand that better management of pharmacy services is needed for the purposes of improving care coordination, health outcomes, and quality of care for dual eligible clients in the Demonstration.

Additional areas in existing care, services, and supports for dual eligible individuals may surface that warrant further collaboration between Medicare and Medicaid during the Demonstration. For example, the Department is aware that enhanced coordination is needed for the provision of durable medical equipment (DME). As a result, the Department will work closely with CMS and with other Departmental initiatives to explore improved DME solutions.

### iii. Ancillary and supportive services

In the Demonstration, RCCO infrastructure and systems will support the care teams needed to support the individual's person-centered care plan. Each team member will have a defined role appropriate to licensure and relationship to the client. Collectively, the team will share responsibility for coordinating care and services that meet the individual's needs. It is not the Department's goal to add another care coordinator or case manager to the current systems of care for dual eligible clients. Rather, through the Demonstration, the Department aims to work collaboratively with other state agencies and partners within existing systems of care to achieve a more effective and streamlined approach.

The Department does not anticipate changing current Medicare and Medicaid services for the Demonstration. Instead, it intends to ensure that all Medicare and Medicaid services offered to individuals eligible for both programs are coordinated and integrated. However, certain support services are available as an inherent part of the ACC Program. In addition to a designated Primary Care Medical Provider (PCMP), RCCOs will support Demonstration clients through medical management and care coordination. Another essential RCCO function is to manage, either directly or indirectly through program partners, client care throughout the care continuum and to ensure delivery of "the right care, in the right order, at the right time, and in the right setting."[5]

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[5] Colorado Department of Health Care Policy and Financing. (2010). Request for Proposals, RFP Number HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program.

The Statewide Data and Analytics Contractor (SDAC) is also critical to this effort. Analysis of a dual eligible client's Medicare and Medicaid claims is slowed by the time lags between service provision, service billing, transmission and receipt of claims files, and data linking. Although analysis cannot be instantaneous, the SDAC will minimize the negative impact of such delays as much as possible. The Department will continue to work collaboratively with the RCCOs, PCMPs, ancillary providers, and the SDAC to determine how time lags inherent in the current data process can be shortened to support more timely interventions.

Information provided by the SDAC will allow the RCCOs and PCMPs to ensure that clients receive the appropriate services from both programs. Linking a dual eligible client's Medicare and Medicaid data offers a complete picture of the care and services an individual is receiving. This increases a provider's knowledge of the client and helps to ensure that the most suitable care and services are delivered. As gaps in care and services are eliminated and duplication of services is reduced, more appropriate utilization of services is realized.

RCCO responsibilities also include care coordination to fill gaps in the current health care delivery system by identifying the range of a client's medical, behavioral, and social service needs and by removing barriers to meeting those needs in current systems of care. To accommodate the full range of client needs, RCCOs are continuing to expand their networks of ancillary providers. As an example, one RCCO is already utilizing interdisciplinary care teams that are linked to the client's local hospital as well as to behavioral health and ancillary providers to ensure coordinated care and services. By strengthening linkages with these ancillary providers, RCCOs can ensure that their clients' non-medical needs are supported. Appendix H illustrates current RCCO relationships that are strengthening their community capacity and preparing them to better serve dual eligible clients in the Demonstration.

The Department and stakeholders also recognize that problems can be created by the presence of multiple care coordinators and case managers, who may not be communicating or collaborating in a way that always best serves the client. A care coordination approach that is sensitive to clients and includes respect for and input from the client is currently being utilized within the ACC Program and will continue to be used to design appropriate care coordination activities to reflect the client's needs. Dual eligible individuals in the Demonstration will have access to a coordinated, team-based approach to care and services, and the individual's input is vital to informing that approach.

For example, a care team may consist of a lead primary care or behavioral health clinician, other supporting providers such as home health organizations, and community-based organizations such as Single Entry Points (SEPs), Community Centered Boards (CCBs), and other LTSS agencies as appropriate. SEPs determine functional eligibility for community-based long-term care programs, provide care planning and case management, and make referrals for additional resources. There is a designated SEP for each of Colorado's 64 counties. Colorado's 20 CCBs provide targeted case management services, including intake, eligibility determination, service plan development, arrangement for services, and delivery of services. CCBs are certified by the Colorado Department of Human Services. Appendix I illustrates the geographic service areas, functions, reporting requirements, and populations served by the CCBs and the SEPs and their relationship to the RCCOs. These mature community partners can provide additional expertise to

the RCCOs in ensuring the coordination of care and services for potentially complex clients who may be included in the Demonstration.

As the payer for services, the Department maintains contracts with the SEPs and the CCBs. As needed, the Department may consider modifying contract language to clarify the role and responsibilities of the SEPs and the CCBs in serving clients who are enrolled the ACC Program, including dual eligible clients. Also as needed, each RCCO may collaboratively develop and implement agreements with the SEPs and the CCBs in its region. Relationships among the Department, the RCCOs, the SEPs, and the CCBs illustrate another strength of the managed FFS model in the ACC Program's environment. The Demonstration will leverage these relationships among existing entities and providers to better integrate care for dual eligible individuals.

Consistent with the Department's Money Follows the Person (MFP) Rebalancing Demonstration Program, dual eligible clients transitioning from skilled nursing facilities to community-based programs will have the option to enroll in the Colorado Choice Transitions (CCT) program and to be assigned an intensive case manager and a transition coordinator. The transition coordinator will meaningfully engage the client in discharge and transition planning and collaboratively work with the interdisciplinary care team to arrange necessary community-based LTSS and other community services, such as housing and transportation.

### iv. Evidence-based practices

The Department established a Benefits Collaborative in 2008 to define those services covered by the Medicaid State Plan. The Benefits Collaborative serves as the Department's formal mechanism for developing coverage standards. It is a stakeholder-driven process that ensures benefit coverage standards are based on the best available clinical evidence to promote the health and functioning of Medicaid clients. The Department aligns its benefit coverage standards with national practice guidelines and promotes standards of care and appropriate utilization.

Through its numerous working relationships, the Benefits Collaborative continues to receive feedback and input from clients, advocates, individual providers, professional associations, policy makers, administrators, and corporations. Effective June 2012, the Department will make the benefit coverage standards enforceable as rules, and all Medicaid providers rendering services within a benefit coverage standard will do so in accordance with the standard.

The Benefits Collaborative and its coverage standards underpin the ACC Program. One of the ACC Program's key elements is providing care that is organized and evidence-based. RCCOs are responsible for maintaining a suite of clinical tools and resources readily available to support providers in offering evidence-based, comprehensive primary care in a manner that is accountable and outcomes-oriented.

Other initiatives in Colorado supplement the Department's evidence-based approach. For example, the Healthy Aging Unit in the Chronic Disease Prevention Branch (CDPB) of the Prevention Services Division in the Colorado Department of Public Health and Environment includes the utilization and promotion of evidence-based health services within community programs to prevent or minimize the impacts of acute illness and chronic conditions. The Healthy Aging Unit works to ensure quality health and wellness programs and services are

equitably provided on a statewide basis to manage chronic disease, conditions, and complications. These programs and services are designed to increase independence, reduce health care utilization, and improve quality of life for older adults. Through its interagency relationships, the Department will be able to strengthen linkages to related evidence-based practices to enhance the integration of care for dual eligible individuals.

Another thrust of this Demonstration is to effectively coordinate care at critical transition points across the existing Medicare and Medicaid fee-for-service (FFS) systems. One of those critical junctures is at the point of hospital discharge. Improving care transitions will involve RCCOs, associated PCMPs, and community partners, such as home health agencies, nursing homes, case managers, and LTSS providers. All will work collaboratively with hospitals and other providers to implement evidence-based practices focused on reducing avoidable readmissions and to offer provider incentives to support the goal of reducing readmissions. Again illustrating how current work is being utilized to support the Demonstration, the Department is leveraging coverage standards of the Benefits Collaborative to strengthen the ACC Program and to inform care transitions through evidence-based practices.

RCCOs are already beginning to implement care transition programs that incorporate evidence-based processes and programs that aim to reduce preventable readmissions. Additionally, the Department will continue to measure readmissions and changes in readmission rates. Over the coming months, the Department will also be exploring the relationship between readmissions and observation stays to determine the occurrence of any unintended negative consequences. The Department is incorporating an incentive payment into the ACC Program's payments that includes readmission rates as one measure.

As part of this Demonstration, the Department will continue to encourage increased use of these types of beneficial relationships, initiatives, and programs. Reinforcing the Department's framework for continuous improvement, additional examples of an evidence-based approach are contained in Appendix J.

### v. Context of Medicaid services and other CMS initiatives

The Demonstration will operate within the context of the Medicaid system and other CMS initiatives. To that end, the role of applicable Medicaid State Plan and waiver services, specialty behavioral health plans, other integrated programs, and additional CMS payment and delivery initiatives are summarized below.

Medicaid State Plan and Waiver Services Available to Dual Eligible Clients
Under the Demonstration, dual eligible clients will continue to have access to their Medicare benefits. They will also have access to all Medicaid State Plan services. The managed FFS model provides clients with access to all of the same services they currently receive, including primary and acute medical care as well as Long-Term Services and Supports (LTSS), which are made available through Medicaid Home and Community-Based Services (HCBS) waiver programs and coverage for institutional care. In the realm of behavioral health, RCCOs are being required to implement written protocols with Colorado's Behavioral Health Organizations (BHOs) in their corresponding regions.

Demonstration enrollees are eligible to apply for Home and Community-Based Services (HCBS) covered only through 1915(c) waiver programs. If the Department implements HCBS through some other authority, such as 1915(k), Demonstration enrollees will have the option to enroll if they meet the eligibility requirements. Those who are already enrolled in one of the HCBS waiver programs will continue to be enrolled in the waiver and receive those services.

Specialty Behavioral Health Plans
Under the ACC Program, the majority of behavioral health services will continue to be delivered through the Community Mental Health Services Program by BHOs. Members are assigned to a BHO based on where they live. Contracted BHOs were chosen through a competitive procurement process for each of the defined geographic service areas covering the state. Each of the five geographic service areas in the Community Mental Health Services Program contains one or more whole counties and is served by one or more Community Mental Health Centers (CMHCs). BHOs arrange or provide for medically necessary mental health services to members in their service areas and provide additional services (i.e., alternative services) to beneficiaries via savings from Medicaid managed care. BHOs provide or arrange for mandatory 1915(b)(3) waiver services in at least the scope, amount, and duration proposed by the BHO and specified in the BHO's contract with the Department as summarized in Appendix K.

Effective July 1, 2011, all 1915(b)(3) services provided to children and youth from ages 0 to 21, except for respite and vocational rehabilitation, were included in the Medicaid State Plan as expanded early and periodic screening, diagnosis and treatment (EPSDT) services. These services are not listed individually in the Medicaid State Plan but will continue to be provided to children and youth with covered diagnoses based on medical necessity.

A major benefit of this Demonstration will be greater integration of physical and behavioral health through enhanced linkages between RCCOs, PCMPs, and BHOs, as well as active care coordination that crosses over Medicaid and Medicare behavioral health services.

Other Integrated Programs
Individuals who are part of another program, such as the Colorado Alliance for Health and Independence (CAHI), the Denver Health Medicaid Choice Plan, an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID), the Program of All-inclusive Care for the Elderly (PACE), or Rocky Mountain Health Plan, will not be enrolled into the Demonstration. However, they may choose to disenroll from an existing program to join the Demonstration.

It is anticipated that nursing facility clients will be eligible to enroll in the Demonstration. The Department is still exploring if it is possible or appropriate to exclude all clients enrolled in a Special Needs Plan (SNP) from the Demonstration. The Department envisions the Demonstration to be part of a continuum of care and service options for dual eligible clients in addition to other integrated programs and not as a replacement. The ACC Program is one way to provide these individuals with the advantage of a medical home that proactively coordinates the health needs of each member and is designed to meet the needs of dual eligible clients.

<u>Other CMS Payment and Delivery Initiatives</u>
The Demonstration incorporates elements from other CMS initiatives, such as the Money Follows the Person (MFP) Rebalancing Demonstration Program. In 2011, the Department was awarded a five-year, $22 million federal grant to implement an MFP program to build and improve the infrastructure that supports Home and Community-Based Services (HCBS) for persons of all ages with long-term care needs. The vision of the project is to transform long-term care services and supports from facility-based and provider-driven care to person-centered and consumer-directed community-based care with the primary goal of transitioning individuals back into the community. The program being developed is called Colorado Choice Transitions (CCT).

CCT is expected to begin enrolling clients in the fall of 2012. The Department is currently putting in place the appropriate information technology systems changes, benefit design, policies, and procedure changes necessary for CCT. Once launched, CCT aims to transition nearly 500 individuals from institutional coverage to community settings. The vast majority of clients targeted for transition are from nursing facilities.

## D. Stakeholder Engagement and Beneficiary Protections

The Department realizes that the success of any project design or program implementation hinges on establishing and maintaining open and transparent communication and developing and sustaining viable relationships with all interested parties. The best work is accomplished when everyone is working together. To that end, the Department is committed to ongoing engagement with clients, stakeholders, and partners to inform the Demonstration. Currently, more than 550 individuals representing over 200 organizations comprise the active primary contact list. This section of the proposal describes the initial phases of stakeholder engagement, outlines the beneficiary protections that pertain to the Demonstration, and discusses plans for continuing the stakeholder process throughout subsequent planning and implementation phases.

### i.   Stakeholder engagement in the design phase

The Department has utilized a variety of mechanisms to engage a wide range of stakeholders and partners throughout the initial stages of proposal development. Different types of meetings have been convened. For example, the Department has hosted six large public meetings for all interested stakeholders. Although the meetings have been held in Denver, each has had a toll-free call-in option. The Department sent notices about these meetings to a distribution list of more than 700 persons and encouraged that the notices be forward to other interested parties. These meetings brought stakeholders together to hear the same information at the same time and to have an opportunity to be part of a larger group conversation about the project.

At the first full stakeholder meeting held in June 2011, the Department introduced the project and began to lay out a plan to work with stakeholders to develop a proposal to submit to CMS to integrate care for fully dual eligible individuals in Colorado. The Department used the opportunity to engage the public's interest, listen to ideas, and encourage participation. In October 2011, the Department hosted a second full stakeholder meeting. At that time, the Department updated stakeholders on preliminary research and progress to date and began to collect input from stakeholders. In December 2011, the third full stakeholder meeting was

primarily devoted to listening to and considering stakeholder input.

In January 2012, during the fourth full stakeholder meeting, stakeholders reviewed a summary of input and recommendations to date in addition to discussing a preliminary draft of the Demonstration proposal. Then, the Department collected all stakeholder comments, summarized the feedback, and distributed a document for stakeholder review. The Department also used the information in preparing the second draft of the Demonstration proposal. In early March during the fifth meeting, stakeholders discussed the feedback summary and the second draft of the proposal. Stakeholders continued to dialogue with the Department about the Demonstration.

By mid-April 2012, the Department posted the Demonstration proposal for a thirty-day public comment period on its Web site and distributed the proposal draft to all persons on its stakeholder list. A sixth full stakeholder meeting was subsequently held to listen to public comments and respond to stakeholder questions. Sensitive to the views expressed at the meeting and to feedback received during the public comment period, the Department reviewed all comments and incorporated them, as appropriate, into the final Demonstration proposal.

In addition to the six large meetings, the Department has placed significant emphasis on stakeholder involvement through developing and facilitating workgroups. The Department solicited voluntary stakeholder participation for five workgroups, whose tasks included sharing ideas, developing input, and making specific recommendations to inform the proposal for CMS. Workgroup participants have collaborated throughout the planning phase since December 2011. Thus far, each workgroup has met four to six times, for a total of 28 meetings. Participants' diverse backgrounds and experiences have contributed to thoughtful conversations and productive recommendations. Workgroups were organized into the following five categories:

- Communication (Outreach and Information)
- Coordination of Care
- Behavioral Health
- Developmental Disabilities
- Financing Strategies and Quality Medical Outcomes

Complementing other stakeholder outreach and engagement efforts, the Department has followed the Tribal Consultation process as described in its Tribal Consultation Agreement with the federally recognized American Indian Tribes in Colorado as well as the Urban Indian Health Organization (UIHO). As explained in the Medicaid State Plan, the Tribal consultation Agreement includes periodic submission of a Programmatic Action Log that describes various actions the Department intends to take that may have implications for the Tribes, their health programs, or their members. The Department maintains and submits the log to the chairpersons of the Ute Mountain Ute Tribe and the Southern Ute Indian Tribe or their designees as well as to the director of the Indian Health Service facility on the Ute Mountain Ute reservation, the director of the Tribally-operated health facility on the Southern Ute reservation, and the director of the UIHO, Denver Indian Health and Family Services. The Department also forwards the log to the executive secretary of the Colorado Commission of Indian Affairs and to the CMS Native American Contact for Region VIII. In its log submission, the Department included a description of the Demonstration along with clearly foreseeable implications and contact information.

Although the Department has not yet received any requests for further Tribal consultation on the Demonstration, communication and updates will continue throughout the development and implementation phases.

By the end of February 2012, the Department also had conducted nine regional meetings across the state in frontier, rural, and other urban areas. Additionally, the Department has made 58 presentations to individual stakeholders and specific organizations and has participated in several media interviews related to the Demonstration. Appendix L summarizes all stakeholder activities to date.

In addition to the meetings and presentations previously described, the Department has developed and is maintaining a page on its Web site dedicated exclusively to the Dual Eligible Demonstration Contract. Background information, reports, meeting schedules and agendas, and transcripts are housed on the page. The Department also hosts a toll-free number (1-855-739-7861) for individuals to express interest in the project, ask questions, request information, and/or provide comments and feedback.

Throughout the Demonstration's design phase, the Department continued to solicit comments, feedback, and additional recommendations from workgroups, regional meeting participants, individuals, and organizations. For example, stakeholders brought forth questions and recommendations related to such topics as enrollment, provider networks, care coordination, roles and relationships between RCCOs and existing community providers, refinement of Medicaid and Medicare administrative processes, and enhanced beneficiary protections and oversight mechanisms. Although all ideas could not be incorporated and all outstanding issues have not been resolved, the process has been transparent, collaborative, and respectful. To some extent, everyone's input shaped the proposal's development and influenced its content.

### ii. Beneficiary protections

All participants in the Accountable Care Collaborative (ACC) Program are guaranteed certain fundamental rights. These include but are not limited to the right to be treated with respect; to receive information on available treatment options in an appropriate manner; to participate in decisions regarding his or her health care, including the right to refuse treatment; to request and receive copies of his or her medical records; and to request that records be amended or corrected.

In addition to overarching rights, through contractual agreements with the RCCOs and through discussions with CMS, the Department will ensure that fully dual eligible participants enrolled into this Demonstration are provided with high quality health and supportive services that are appropriate for their individual needs. The Department will continue to work with CMS to articulate any additional beneficiary protections that may be needed in the Demonstration. Existing beneficiary protections within the ACC Program include the following:

Choice of Providers
Fully dual eligible individuals who participate in the Demonstration, like other ACC Program participants, will have the option to select a primary care medical provider from the network of providers participating in the ACC Program. If a client has a provider not currently participating in the ACC Program, the client's RCCO is responsible for contacting the provider and making

every effort to enroll the provider into the ACC Program. At the request of the client, RCCOs can facilitate the selection of and communication with providers. Further, contractual agreements between the Department and the RCCOs enable individuals to select providers outside their own RCCO region. In those cases, the RCCO in the client's region coordinates with the other RCCO to prevent disruptions in care.

To ensure that fully dual eligible individuals receive appropriate and timely care, RCCOs are required to develop a robust network of primary care medical providers in their respective regions of Colorado. With the addition of fully dual eligible individuals in the ACC Program, primary care medical providers who work with Medicare clients will be recruited for participation. Also, in anticipation of the Demonstration's implementation, the RCCOs are making the establishment of informal agreements with ancillary providers a high priority.

Complaints, Grievances, and Appeals Process
An important but challenging part of integrating care for dual eligible clients is integrating the administrative processes for Medicare and Medicaid. Medicare and Medicaid each has its own appeals process with its own regulations. Both processes can be difficult for clients to understand and navigate. The Department is committed to working with CMS to help dual eligible clients understand both processes and to integrate and simplify those processes to the fullest extent possible. Additionally, the Department is committed to conversations with stakeholders in the upcoming months about the adequacy of existing grievance and appeals processes and exploration of ways to help clients more easily navigate the separate Medicaid and Medicare grievance and appeals processes. The existing processes and resources are described below.

The Department and the ACC Program offer responsive and thorough complaints, grievances, and appeals processes. Contractual requirements mandate that each RCCO be responsive to and assist clients with problems they experience in receiving care and services. RCCOs are specifically required to document and maintain a record of the following:

(1) All problems and issues presented by clients with respect to access to and quality of their care; and

(2) All proposed solutions to the problems raised by clients.

The Department reserves the right to review all RCCO records and to direct RCCOs to provide alternative solutions should the original solution be determined insufficient or inappropriate.

Fully dual eligible individuals will also have access to the appeals process extended to all Medicaid recipients. All Medicaid clients are informed of their appeal rights when:

(1) An application for services is denied or is not acted upon with reasonable promptness.

(2) The recipient requesting the hearing believes the action is erroneous.

(3) The resident of a nursing facility believes the facility has erroneously determined that he/she must be discharged.

(4) An individual who believes the determination with regard to the preadmission and annual resident review requirements is erroneous.

The Department also realizes the importance of a comprehensive, easy to navigate ombudsman process for dual eligible clients. Currently, dual eligible clients in Colorado may have several avenues for addressing problems and complaints such as the Medicare Beneficiary Ombudsman, the Long-term Care Ombudsman, and/or the Ombudsman for Medicaid Managed Care. In addition, the ACC Program's RCCOs have defined grievance and appeals processes. During the upcoming months, the Department will be bringing clients, stakeholders, and partners together to assess the ombudsman needs for the Demonstration, to explore opportunities to make the process more seamless, and to determine any additional resources that may be required. This is another example of how the Department will utilize existing experience in current processes as the basis for establishing a more unified approach to serve dual eligible clients in the Demonstration.

### iii. Ongoing stakeholder input

The Department recognizes the value of ongoing stakeholder engagement. Participation by all interested parties is essential to improving communications, developing appropriate client materials, and promoting shared responsibility. As it continues to focus on client/family-centered care, the Department will gather and incorporate input from clients, stakeholders, and partners throughout the implementation and operational phases of this Demonstration. The Department believes that bringing many perspectives together in the planning, delivery, and evaluation of the Demonstration will improve its quality.

The Department will continue to work with stakeholders to find more ways to foster collaboration and mutual understanding. For example, the ACC Program Improvement Advisory Council has expanded its membership to include one representative from the dual eligible stakeholder community. Additionally, the Department will work with stakeholders to establish a separate Dual Eligibles Advisory Committee, whose application and selection process will be defined in June 2012. The Department and the Dual Eligibles Advisory Committee will work together to determine the most appropriate use of existing workgroups while taking advantage of opportunities to interact with other groups such as the Long-term Care Advisory Committee, the Nursing Facility Culture Change Accountability Board, and the standing ACC Program subcommittees.

To obtain additional first-hand information relevant to successful implementation of the Demonstration, the Department will ensure that focused interviews and focus groups are conducted with clients, family members, and caregivers during the summer of 2012. Additionally, the Department will continue to host periodic full stakeholder meetings and to conduct statewide and regional outreach.

The Department will also reinforce the Demonstration's relevance to other activities. For example, the Department has already planned to participate in state and regional conferences during the coming months that are related to case management and care coordination, persons with developmental disabilities, Medicare, and aging and disability. To benefit from the experience of other states partnering with CMS in Demonstration projects, the Department will

continue to participate in regularly scheduled calls, webinars, and national conferences. The Department will also avail itself of technical assistance and support from CMS, the Center for Health Care Strategies, and other national partners.

Also, the Department plans to convene several statewide and regional conferences that will bring together clients, stakeholders, RCCOs, providers, and other agencies and partners to focus on specific themes of the Demonstration. For example, conferences may be held to concentrate on topics such as long-term services and supports (LTSS), ancillary community services, or care transitions. The Department recognizes the importance of facilitating conference and training opportunities for clients and their advocates. The Department also understands the need for enabling existing systems of care to strengthen their connections with the ACC Program to better serve dual eligible clients in the Demonstration.

Before the Demonstration is implemented, the Department will work with CMS and stakeholders to determine readiness assessment content and process. In keeping with Demonstration requirements and with guidance from CMS, the Department will work collaboratively with the Dual Eligibles Advisory Committee to ensure that readiness criteria are satisfied. Other details will continue to be defined and operationalized during the coming months. For example, as the Demonstration moves toward implementation, the Department will work with stakeholders and CMS to develop relevant public outreach, education, and training materials in various media. The Department will ensure that all materials and communications are reflective of and sensitive to the diverse needs of the clients.

Finally, the Department will maintain the continuity of the Demonstration's existing infrastructure with such tools as the dedicated page on the Department's Web site and the toll-free number. Efforts will continue so that all interested parties can be readily informed about the Demonstration, its development, and progress.

## E. Financing and Payment

The Department is pursuing a managed fee-for-service (FFS) model for the Demonstration that builds upon the prevailing approach to financing and payment currently operating in Colorado. It provides a stable foundation as the Demonstration's starting point with sufficient flexibility to accommodate step-by-step evolution of policy and practice over time. The first subsection outlines the payment methodology for Medicare and Medicaid services, the payment and incentive structure of the ACC Program, and the Demonstration's costs, cost savings, and cost sharing logic. The second subsection discusses existing state-level payment reforms. Each has not only a positive individual impact but also a collective influence through interfacing with related elements of the Demonstration.

### i. Payment methodology

Medicare and Medicaid Services
In the managed fee-for-service (FFS) model currently in place for the ACC, Medicaid-covered acute care wraparound services, as well as long-term services and supports (LTSS), are provided in accordance with requirements in the approved Medicaid State Plan and applicable home and

community-based services (HCBS) waivers. For the Demonstration, the Department will continue to pay for Medicaid services as it does now. Additionally, for the Demonstration, all Medicare-covered benefits for acute physical care and post-acute care will be provided in accordance with existing Medicare FFS rules. Providers will continue to bill and receive payment for Medicare services as they do now. Rather than operating at a plan level, the managed FFS approach functions at the practitioner level and builds upon the existing FFS delivery system. In addition, the ACC Program contributes a substantial resource investment to better organize the delivery system and ensure a focal point of care and the provision of coordinated care for all clients.

The ACC Program's Payment and Incentive Structure
The two central goals of the ACC Program are to improve the health outcomes of Medicaid clients through a coordinated, client/family-centered system by proactively addressing clients' health needs, whether simple or complex, and by controlling costs through reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The effective operation and success of the ACC Program are reliant on several interdependent relationships and expectations as described below.

To fund the operations of the ACC Program, the Colorado General Assembly authorized a 20-dollar per member per month (PMPM) amount to cover the services of the Regional Care Collaborative Organizations (RCCOs), the Primary Care Medical Providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC). Of the 20 dollars, 17 are used to fund PMPM payments to the RCCOs and participating PCMPs.

During the ACC Program's initial phase, PMPM payments were limited to 13 dollars for RCCOs and four dollars for PCMPs. Beginning July 1, 2012, it is expected that PMPM payments will be up to 12 dollars for RCCOs and three dollars for PCMPs. RCCOs and PCMPs then have the opportunity for each to earn incentive payments up to an additional one dollar PMPM for meeting or exceeding performance targets for identified utilization and outcome measures.

Initially, three utilization measures and performance targets have been established for assessing performance against regional baselines and will be the basis of determining incentive payments. In addition to containing costs, RCCOs and PCMPs are responsible for attaining health improvement goals. The Department, in consultation with the RCCOs and the SDAC, will continue to establish both cost and health measures to determine incentive payments in future years and will identify additional performance measurement areas and targets to further improve program effectiveness. The ACC Program's existing measurement areas, performance targets, and incentive payment methodology are provided in Appendix M.

From its inception, the vision of the ACC program has been that, over time, RCCOs and PCMPs would be increasingly accountable for improving health outcomes and reducing avoidable costs, with future ACC payment reform efforts building on this increased accountability. To that end, the Department is continuing to work with stakeholders, the RCCOs, PCMPs, and other providers on future payment reform efforts, including the development of additional performance measures. These efforts are described in greater detail below in the subsection for state-level payment reforms.

Demonstration Costs, Cost Savings, and Cost Sharing
For purposes of the Demonstration, the SDAC will link Medicare and Medicaid claims data at the client level and use 3M's Clinical Risk Groups (CRGs) to determine risk score acuity for dual eligible individuals. The SDAC will use the acuity score to calculate an appropriate administrative PMPM for clients who will be participating in the Demonstration. For example, if an acuity score of "1" for the ACC Program's Medicaid-only enrollees is used to calculate a PMPM of 20 dollars, then an acuity score of "3" for the Demonstration's dual eligible clients would be used to calculate a PMPM of 60 dollars.

For the Demonstration's basic financing structure, the Department envisions a shared risk model in which both Medicare and Medicaid provide a share of the initial costs needed to operate the Demonstration. Medicare and Medicaid will pay the adjusted dual eligible PMPM on a prospective monthly basis to the same extent as their total service costs for dual eligible clients. For example, if claims analysis determines that dual eligible client costs are paid 40 percent by Medicare and 60 percent by Medicaid, then Medicare and Medicaid will split the PMPM by the same 40-60 percentages. The Department will continue to manage Medicaid funds and payments to providers, and Medicare intermediaries and carriers will maintain their traditional roles as payers for Medicare-covered services. The Department assumes no change in the way Medicare and Medicaid services are paid in the current state and federal funding partnership.

For Medicaid-only participants, the ACC Program is financed through anticipated savings to the Medicaid program. The Department proposes a similar financing strategy that relies on both Medicare and Medicaid savings to finance the cost of the ACC Program model for dual eligible enrollees. The Demonstration will achieve cost savings by adopting principles of the ACC Program. The RCCOs, serving as Accountable Care Organizations (ACOs), are responsible for network development, provider support, and medical management. By implementing structured care coordination approaches, the Department has established a system that leads to better quality and lower cost. The same philosophy will be applied to the Demonstration.

Cost savings will be defined by calculating the actual expense of the Demonstration under traditional FFS payment methods versus payments under the managed FFS model structure. This requires determining what the payments would be for Medicare and Medicaid under the traditional FFS program. This expense amount will be compared to actual payments made under the Demonstration. The Department assumes savings will exceed the limited cost of operations, will be pooled between the Medicare and Medicaid programs, and will be returned to each commensurate with the investment each has made in those costs of operations. Savings resulting from the improvement in quality and cost for dual eligible clients are intended to be shared between the two payers. The Department also anticipates a degree of flexibility in the reinvestment of savings so that they could be used to pay for additional client benefits and/or to generate provider incentives to continually improve care, outcomes, and client satisfaction with care.

### ii. State-level payment reforms

A number of projects that directly and indirectly address payment reform are currently in process. For example, Colorado is one of the first states to have both a Medicaid Nursing Facility

(2009) and Medicaid Hospital (2012) pay-for-performance program. This subsection outlines the current state of health care payment reforms in Colorado.

As noted above, during the first year of the ACC Program, the full PMPM was paid to RCCOs and PCMPs. In the second year of the ACC Program, which begins July 1, 2012, RCCOs and PCMPs will be paid one dollar less than the full PMPM and will have the opportunity to earn this incentive by meeting performance goals, including reducing unnecessary use of emergency rooms and reducing avoidable hospital readmissions.

It is the Department's intention that, in future years, additional payment reform will occur to hold RCCOs and PCMPs accountable for improving outcomes and reducing avoidable and duplicative costs while continuing to improve client experience of care. Several efforts are currently under exploration and development, including shared savings with Federally Qualified Health Centers and Rural Health Clinics; this is intended to provide incentives to reduce avoidable costs and improve health outcomes. Also, the Department is exploring shared savings for Behavioral Health Organizations in reducing inappropriate use of psychotropic medications. Additionally, the Department is beginning to explore the possibility of implementing global payment in the future.

Last, several other payment reform efforts are currently underway or in development within the Department that are not directly related to the ACC Program. However, these efforts demonstrate Colorado's commitment to innovative payment reform to support improved health outcomes and reduced cost. For example, in fiscal year 2009, the Department made a transformational change in the way it pays nursing facility providers for performance. The Department adopted a pay-for-performance program, which offers financial incentives to providers that offer high levels of quality of life and care. Also, the Colorado Hospital Oversight and Advisory Board (OAB) voted to implement a Hospital Quality Incentive Payment (HQIP) program for participating Medicaid providers in the spring of 2011. The HQIP program promotes quality, reduces cost, and creates more efficient processes. Additionally, the Department is implementing a rate reform effort for Medicaid hospital services that utilizes all-patient refined (APR) diagnosis-related groups (DRGs), ambulatory payment classifications (APCs), and other reforms for inpatient and outpatient hospital rates. Inpatient hospital rates should be updated during fiscal year 2013 and outpatient hospital rates during fiscal year 2014. Each of these efforts works in alignment with the ACC Program and supports the Department's goal of deliberately and slowly implementing effective changes that will continue to improve health outcomes and reduce unnecessary costs.

The Department and its stakeholders and partners are well aware that significant and lasting reform in the health care system stems from changes in both delivery of care and payment for care. The Demonstration and other initiatives underway in Colorado are converging to produce higher quality of care, better health outcomes, and lower costs. In support of the Demonstration's goals, the Department, through its managed fee-for-service (FFS) model, seeks to improve the coordination of care and services, health outcomes, and client experience while generating cost savings to fuel a financially sustainable model for dual eligible individuals.

## F. Expected Outcomes

Building upon the incentives developed as part of the ACC Program, the Demonstration will utilize incentives to improve access and quality and reduce overall cost of care. Over time, the Department expects to see reduced hospital admissions and readmissions, reduced use of emergency rooms, greater use of medical homes, reductions in unnecessary or duplicative radiology testing, smarter use of specialists, reduced nursing home admissions, increased use of home and community-based services, and improved client experience. The Department will seek to expand access to comprehensive primary care through a focal point of medical/health homes and use statewide data and analytics to improve quality and achieve cost reductions.

As with the ACC Program, this model places an unprecedented focus on metric reporting. Through the work of the ACC Program, the Department is able to measure Potentially Preventable Events (PPEs) and group clients by Clinical Risk Groups (CRGs) by RCCO and provider. This enhanced data reporting has allowed the Department to develop dashboard reports that identify cost and utilization patterns by client acuity. The dashboard provides a drill-down capability that enables further research of patterns that deviate from an accepted standard. Risk-adjusted metrics define outlier utilization, readmissions, and emergency department usage. Performance measures have been developed for the current adult mix of ACC Program clients, and additional measures are being developed specifically for children. In anticipation of the Demonstration's implementation, performance measures specific to dual eligible clients will be developed.

These population-specific data adjustments will improve care and allow the Department to develop payment methods that create incentives for better health outcomes for clients. For example, the RCCOs began operations in 2011, and some are already able to identify high-cost users and better coordinate the care provided to these clients. As the SDAC seeks to add additional measures to the data repository, these may include appropriate quality or performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the National Quality Forum (NQF), Meaningful Use, the Children's Health Insurance Program Reauthorization Act (CHIPRA) Adult and Child Quality Measures, Physician Quality Reporting System (PQRS), or CMS. The Department will follow guiding principles for measurement in the dual eligible beneficiary population as outlined in the table on the following page.

**Table 3: Guiding Principles for Measurement in the Dual Eligible Beneficiary Population[6]**

| Categories | Principles |
|---|---|
| Desired Effects of Measurement | • Promoting Integrated Care<br>• Ensuring Cultural Competence<br>• Health Equity |
| Measurement Design | • Assessing Outcomes Relative to Goals<br>• Parsimony<br>• Inclusivity<br>• Avoiding Undesirable Consequences of Measurement |
| Data Platform Principles | • Data Sharing<br>• Using Data for Multiple Purposes<br>• Making the Best Use of Available Data |

The Department will collect and assess appropriate quality measures and client outcomes for dual eligible clients in the Demonstration. A draft set of measures that the Department plans to evaluate are included in Appendix N. The measures were chosen from those currently in existence from the Department, the Children's Health Insurance Program Reauthorization Act (CHIPRA) Child and Adult Core Measure Sets, Meaningful Use, the Agency for Healthcare Research and Quality, Healthcare Effectiveness Data and Information Set (HEDIS), and the National Committee for Quality Assurance. The Department intends to align as much as possible with the National Quality Strategy and other efforts to align measurements federally, across states, and with plans to be able to compare metrics across populations and simplify measurement burden on providers.

The Department will seek CMS input both on aligning benefits such as home health and behavioral health services and on developing appropriate quality management strategies and performance measures. This will allow CMS to collect national comparative data on all state Demonstrations. Success in improving integration between Medicare and Medicaid will be measured across different forums. For example, Medicare and Medicaid service delivery should be as seamless as possible; administrative efforts should be simple; and data should be transparent. The Department and CMS, as payers, will collaborate to integrate these domains to produce cost-effective, quality care.

The SDAC will play a critical role in the Demonstration. The SDAC minimizes the reporting burden of the RCCOs and provides them with national expertise. It will be necessary to risk adjust claims data, define appropriate quality metrics, and create a collaborative data-sharing environment. Based on agreements with CMS, the Department will receive historical Medicare data as well as Medicare data on an ongoing basis. Upon receipt, the SDAC will be able to match and link the Medicare and Medicaid data to provide a more complete picture of the conditions, service utilization, costs, and opportunities to provide additional support and care coordination

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[6] National Quality Forum. (2012). *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population.* Retrieved from
http://www.qualityforum.org/Setting_Priorities/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx.

for dual eligible clients in Colorado. The Department will continue to foster a robust quality measurement process that includes client experience, which is another expected outcome in an improved health care system. When all relevant Medicare data are received and analysis begins, the Department and CMS actuaries will discuss the Demonstration's cost savings potential in the ACC Program and its expected reduction of Medicare and Medicaid expenditures.

## G. Infrastructure and Implementation

In anticipation of implementation, the Department has assigned resources to execute and to oversee the Demonstration. As seen in the following subsections, the Department is analyzing capacity, exploring the potential need for waiver of rules, assessing expansion plans, and developing an implementation strategy and timeline.

### i. Capacity to implement and oversee

With staff assembled to focus directly on the Demonstration, staff dedicated to the ACC Program, and ancillary staff supporting related functions, the Department is well positioned to implement and oversee the Demonstration.

The Department is the single state agency to administer Colorado's Medicaid program. Executive Director Susan E. Birch, MBA, BSN, RN, has ultimate responsibility for the Department, including the ACC Program and the Demonstration.

The Department has assembled a competent team to manage and oversee the development and implementation of the Demonstration. The team includes:

- Laurel Karabatsos, MA, Deputy Medicaid Director
- Judy Zerzan, MD, MPH, Chief Medical Officer
- Jed Ziegenhagen, MPA, Rates and Analysis Division Director
- Marci Eads, PhD, Medicaid Reform Unit Manager, Dual Eligibles Project Director
- Teri Bolinger, MA, MPA, Dual Eligibles Project Manager
- Kirstin Michel, MPA, Dual Eligibles Policy and Stakeholder Specialist
- Vickie Sims, MPA, Dual Eligibles Outreach Coordinator
- Laura Pionke, Dual Eligibles Program Assistant

In addition to this core team, other Department staff will play an important role in the Demonstration, including staff dedicated to managing the ACC Program and RCCO contracts, staff in the Long-Term Care Benefits Section, staff managing the behavioral health contracts, and staff focusing on behavioral health integration. Suzanne Brennan, the Department's Medicaid Director, provides additional support to the Demonstration.

The ACC Program has been in operation since early 2011. Multiple divisions and offices within the Department provide support to the ACC Program, including:

- Chief Medical Officer's Office
- Medicaid and CHP+ Program Administration Office

- Medicaid and CHP+ Benefits and Policy Division
- Long-Term Benefits Operations Division
- Rates and Analysis Division
- Budget Division
- Claims Systems and Operations Division

Additionally, the Department has supplemented its own staff through contracting with the Public Consulting Group to assist in various aspects of Demonstration development and stakeholder engagement. Also, Treo Solutions, the Statewide Data Analytics Contractor, is working with the Department and CMS to receive Medicare data. With its own data analysis capabilities and those of its contractor, the Department will optimize the use of data in the Demonstration.

### ii. Need for waivers

The Department does not anticipate any necessary rule waivers to implement the Demonstration. The existing ACC Program's RCCOs meet the CMS definition of Primary Care Case Managers and fulfill the pertinent requirements set forth in 42 CFR Section 438.

However, stakeholders have repeatedly reported that navigating between federal Medicare and state Medicaid regulations is daunting. The system is too complex from the standpoint of the persons needing services, their families and other caregivers, and providers. Significant administrative burden for providers can take away time and resources better spent on clients. Additionally, stakeholders have reported that the differences between Medicare and Medicaid remain confusing and problematic for dual eligible individuals. Two frequently cited examples are differences between Medicaid and Medicare related to home health services and behavioral health services, including mental health and substance abuse services. Although the Demonstration will include changes to improve the delivery of care to dual eligible individuals, the Department also recognizes the need for administrative simplification, for clients as well as providers, across the Medicare and Medicaid programs.

Making measured progress toward simplification is an explicit goal of the Demonstration. Programs need to be coordinated with linkages established among agencies to ensure compatible eligibility requirements, policies, and procedures. Programs need to work together in simple and understandable ways. The Department, along with CMS and contracted entities, will work to simplify and reduce the number of applications, forms, interviews, and calls that persons must make to obtain services. The Department and CMS recognize that this area requires exploration and additional work. Both parties are committed to continue identifying issues and articulating solutions over time with additional stakeholder input. The possibility of achieving some administrative simplification via waivers of Medicare rules will be explored in upcoming months.

### iii. Expansion plans

The Department's Demonstration is a statewide model with the enrollment of fully dual eligible clients into the ACC Program to occur in a deliberate, phased-in manner. A phased-in manner means that the Department will use a voluntary passive enrollment process to enroll a percentage

of fully dual eligible clients into each RCCO each month over approximately six months. All fully dual eligible clients will not be enrolled into the Demonstration in the first month. This deliberate, phased-in approach will allow the Department to work with specific populations in certain areas of the state to optimize solid infrastructure that already exists and to build upon that foundation as more clients are enrolled.

### iv. Overall implementation strategy and anticipated timeline

Since May 2011, the Department has enrolled more than 125,000 persons in its ACC Program. After CMS approves the Demonstration's implementation, the Department will begin to gradually enroll dual eligible individuals in 2013 according to the plan outlined throughout this proposal. The Department anticipates no additional infrastructure to be required in 2012. However, the Department will submit a request to CMS for funding to support implementation, which is contingent upon approval of its Demonstration proposal by CMS. Activities related to the Demonstration, including those illustrating the development of the ACC Program, are reflected in the timeline in Appendix O. Illustrating the ACC Program's foundation and its continued development, these activities demonstrate the Department's unique position to be successful in integrating care for dual eligible clients in this Demonstration.

## H. Feasibility and Sustainability

In support of the Demonstration's successful implementation, the Department has openly considered its feasibility and sustainability. The Department's thorough and ongoing stakeholder process has revealed concerns and potential challenges, which have been and continue to be addressed. In addition, the Department has examined the potential need for statutory or regulatory changes, funding commitments, and the Demonstration's ability to be sustained and replicated. The following subsections address these elements. Also, a broad spectrum of supporters have provided letters encouraging the Department's efforts to move forward with the Demonstration and voicing their willingness to continue to participate in the process.

### i. Potential barriers, challenges, and future actions

The Department has an understanding of the work and ongoing processes involved with the Demonstration's proposed implementation. The Department will continue to seek assistance from CMS, communicate with other states selected for the Demonstration to Integrate Care for Dual Eligible Individuals, and work collaboratively with stakeholders to make progress.

Thus far, the Department and stakeholders have identified the following areas of concern, possible challenges, and key areas for continued efforts and discussion:

- *Communications* – Stakeholders have expressed a concern that dual eligible clients have anxieties related to how clients are enrolled into the Accountable Care Collaborative (ACC) Program. They want to make sure that extra care and caution are used to ensure that clients are able to make an informed selection with regard to enrollment and that clients are able to disenroll if they would like to do so. The Department has heard and understands this concern. To help ensure that these processes feel appropriate and

reasonable to stakeholders, the Department will continue to work with stakeholders to provide information about how enrollment happens and the ways that clients can disenroll. Also, the Department will continue to communicate with dual eligible clients to reassure them that the Demonstration not only provides the same Medicare and Medicaid benefits they currently receive but also provides additional supports through the ACC Program.

- *Coordination with existing systems of care* - Service providers, such as providers of long-term services and supports, have expressed concern about their role in this Demonstration. The Department intends to continue to facilitate greater coordination within the ACC Program between the RCCOs and these providers. Leveraging existing expertise and high-quality providers will help ensure that those providing valuable services to clients are able to continue to do so. The proposed managed FFS model builds upon the existing FFS delivery system, but it will provide greater integration through the RCCOs. By using the ACC Program, providers will be able to serve dual eligible clients in a more coordinated fashion in ways that are more useful and helpful to those clients. The goals are to improve the client's health outcomes and experience of care and to reduce unnecessary costs by providing a mechanism for quality services to be integrated. The Department will rely heavily on the ACC Program model and relationships between the RCCOs and the PCMPs, relationships with behavioral health providers and providers of long-term services and supports (LTSS), and relationships with and ongoing feedback from all stakeholders.

- *Existing relationships between clients and providers* – Stakeholders have expressed concerns about whether dual eligible clients who are part of the Demonstration and enrolled into the ACC Program will be required to have a new primary care provider. They have also expressed concerns about whether being part of the Demonstration would disrupt the continuity of their care. Clients who are enrolled in the ACC Program currently are linked with providers with whom they already have an established relationship, to the degree that this is possible based on claims history. The Department intends to continue this practice for dual eligible clients.

- *Number and adequacy of participating providers* – Stakeholders have expressed concern about whether there is an adequate number of different types of providers in different geographical areas of Colorado who provide services to dual eligible clients. The Department understands this concern for all Medicaid clients, including dual eligible clients, and continually works to increase the number of Medicaid providers. The federal government also recognizes the need to continue to increase provider accessibility and has implemented initiatives to help with this issue. The Department will continue to work on this issue and solicit ongoing input from stakeholders about specific concerns in this area and possible ways to improve.

- *Nursing facility clients* – It is the Department's intention to allow nursing facility clients to be eligible to enroll in this Demonstration. The Department has begun meetings with nursing facility administrators and physicians to discuss the potential care coordination benefits to nursing facility clients if included in the Demonstration. Also, the Department

is interested in building upon the strengths and lessons learned by nursing facility providers as a result of the unique type of care coordination they provide clients. Additionally, the Department and providers are in discussions about the supports the Demonstration and the ACC Program could provide to gerontologists and nursing facilities relative to additional care coordination efforts. Moving forward on an ongoing basis, the Department and stakeholders will continue to dialogue and explore collaborative solutions around this issue.

- *Provider concerns* - Existing organizations and providers have expressed concern about their funding and enrollment levels and concern about potentially losing clients to the new program. However, because the Department will not be enrolling into the Demonstration those clients already enrolled in previously mentioned programs that provide coordinated care, this concern has been alleviated.

The Department and its stakeholders recognize that no single, simple solution exists for these concerns. However, as the process moves forward, the Department will continue to engage all stakeholders, listen to concerns, and publicly participate in candid dialogue.

### ii. Statutory or regulatory changes

No statutes or regulations currently bar the Department from implementing the Demonstration. However, expansion of the ACC Program to optimally serve dual eligible clients may require changes to the model. Any proposed changes would need to be considered within the context of assuring the continued financial viability and success of the overall ACC Program. Additionally, the Department recognizes the need for CMS approval to implement the Demonstration as well as Department approval of the Demonstration terms offered by CMS. These factors have potential to drive a need for future statutory or regulatory changes.

### iii. Funding commitments or contracting processes

The Department has contracted with Treo Solutions as the SDAC to assist with coordinating data analysis and storage and to provide feedback to and facilitate communications with the RCCOs and PCMPs. The Department has also contracted with the Public Consulting Group for assistance in the Demonstration's proposal development, data analysis, and stakeholder engagement.

### iv. Scalability and replicability

With more than 125,000 individuals already enrolled in the ACC Program, the system is proving itself sustainable and capable of serving large numbers of individuals. The ACC Program is transforming care delivery at the point of care, one provider at a time. It is a "come as you are" model, which offers a replicable example to other states. The model is designed to meet the varying needs of different communities as it has been doing across Colorado, a very diverse state. The model holds providers accountable to outcome-based performance standards, with uniformity in accountability but flexibility in approach. The planned flexibility of the Department's model should be easy to replicate in other states, and the Department is willing and

interested in sharing experiences gained through the design and implementation of this Demonstration.

### v. Letters of support

Letters of support for the Demonstration are provided in Appendix P.

## I. CMS Implementation Support – Budget Request

If the Demonstration is approved for implementation, the Department and its stakeholders have identified major areas of funding that will be needed to ensure its success. In addition to maintaining existing positions and support funded by the current contract with CMS through November 2012, additional Departmental support, contracted services, and resources have been outlined in Appendix Q. Any other areas of support determined necessary by the Department and CMS after submission of the proposal will be addressed during development of the Memorandum of Understanding.

## J. Additional Documentation

The Department will provide additional documentation at CMS's request.

## K. Interaction with Other HHS/CMS Initiatives

The Department recognizes the importance of integrating and building upon existing initiatives designed to improve care for those receiving Medicare and Medicaid benefits and services. The Department's goal is to continue to align and synthesize various initiatives over time, directing these resources toward a single focus: providing high-quality, coordinated, whole-person care. The lessons learned and relationships developed through other initiatives are intangible but essential resources for this Demonstration. Appendix R contains a description of the existing initiatives that the Department will build upon for this Demonstration.

## L. Conclusion

The Center for Medicare and Medicaid Innovation is exploring changes in health care delivery and payment to enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of these individuals, and lower costs through improvement. The Department is in alignment with these goals. By using the ACC Program, its existing managed fee-for-service model, as the basis for the State Demonstration to Integrate Care for Dual Eligible Individuals, the Department is charting a purposeful and deliberate course to effect change. The Department values a balanced and interactive approach that continues to unite clients, stakeholders, and partners around a common vision. To that end, the Department sees the Demonstration as another opportunity to fulfill its mission to improve access to cost-effective, quality health care services for Coloradans.

# Appendix A:  Glossary of Terms and Acronyms

**1915(c) Waiver or Home and Community-Based Services (HCBS) Waiver** is a waiver authorized pursuant to Section 1915(c) of the Social Security Act. It permits the Secretary of Health and Human Services to exempt a state's Medicaid program from compliance with certain Title XIX requirements so that it can provide home and community-based long-term care services to specified populations. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health, habilitation (both day and residential), and respite care.

**Accountable Care Collaborative (ACC) Program** is a Colorado Medicaid program designed to improve clients' health and reduce costs. Medicaid clients enrolled in the program receive the regular Medicaid benefits package on a fee-for-service (FFS) payment basis, are assigned to a Regional Care Collaborative Organization, and choose a Primary Care Medical Provider.

**Behavioral Health** refers to mental health issues and substance use and abuse.

**Behavioral Health Organization (BHO)** is an entity contracting with Colorado's Department of Health Care Policy and Financing to provide only behavioral health services.

**Beneficiary** is an individual entitled to receive benefits.

**Care Coordination** is a process used by a person or a team to assist clients or beneficiaries in gaining access to Medicare, Medicaid, and waiver services regardless of the funding source of these services. It is the deliberate organization of client care activities between two or more participants (including the client) involved in the client's care to facilitate the appropriate delivery of health care services. It involves bringing together personnel and other needed resources to carry out all required client care activities, and it is often managed by the exchange of information among participants responsible for different aspects of care.

**Case Management** includes services to determine eligibility for supports and services and service and support coordination. It includes the monitoring of all services and supports pursuant to the individualized plan and evaluation of results identified in the individualized plan.

**Centers for Medicare and Medicaid Services (CMS)** is a branch of the U.S. Department of Health and Human Services. It is the federal agency responsible for administering the Medicare and Medicaid programs as well as the Children's Health Insurance Program.

**Client/Family-Centered** is used to refer to bringing the perspectives of clients and their families directly into the planning, delivery, and evaluation processes of health care.

**Clinical Risk Group (CRG)** is a claims-based classification system for risk adjustment. It assigns each individual to a single mutually exclusive risk group based on historical, clinical, and demographic characteristics to predict future use of health care resources.

# Appendix A: Glossary of Terms and Acronyms (cont'd.)

**Code of Federal Regulations (CFR)** is the official annual compilation of all regulations and rules published during the previous year by the agencies of the United States government, combined with all previously issued regulations and rules of those agencies that are still in effect.

**Colorado Alliance for Health and Independence (CAHI)** is a nonprofit organization authorized in 2006 by Colorado Senate Bill 06-128 to address the unique needs of adults with disabilities through an integrated, consumer-centered health plan. Its primary purpose is to improve health care by coordinating a high-quality, cost effective network of integrated care services that spans the continuum of care and support.

**Colorado Choice Transitions (CCT)** is Colorado's Money Follows the Person (MFP) Rebalancing Demonstration. It seeks to reform the long-term care system for persons of all ages and to rebalance funding and policy toward home and community-based services.

**Colorado Health Care Affordability Act of 2009 (House Bill 09-1293)** is legislation that authorizes the Department of Health Care Policy and Financing to collect a hospital provider fee to expand health care coverage to more than 100,000 Coloradans.

**Colorado Hospital Association (CHA)** represents the Colorado hospital community. It is an organization of 95 hospitals and health systems throughout the state.

**Community-Based Care Transitions Program (CCTP)** is a Medicare Demonstration program authorized by Section 3026 of the Patient Protection and Affordable Care Act of 2010. It is designed to reduce hospital readmissions; test sustainable funding streams for care transition services; maintain or improve quality of care; and document measurable savings to the Medicare program.

**Community Centered Board (CCB)** is a private non-profit organization designated in Colorado statute as the single entry point into the long-term services and supports system for persons with developmental disabilities. A CCB is responsible for case management services including intake, eligibility determination, service plan development, arrangement for services, delivery of services (either directly and/or through purchase), and monitoring. A CCB is also responsible for assessing service needs and developing plans to meet those needs in its local service area.

**Developmental Disabilities** include disabilities that manifest before a person reaches twenty-two years of age, that constitute a substantial disability to the affected individual, and that are attributable to conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior.

**Dual Eligible Individual** is a person who qualifies, either partially or fully, for both Medicare and Medicaid coverage.

# Appendix A:  Glossary of Terms and Acronyms (cont'd.)

**Durable Medical Equipment (DME)** is medically necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.

**Federally Qualified Health Center (FQHC)** is a health service facility for low-income persons living in a medically underserved area.

**Fee-For-Service (FFS)** is a payment system that pays for health care services as each unit or procedure is provided.

**Fully Dual Eligible Individual** is a person entitled to receive all Medicare benefits (Medicare Part A, Hospital Insurance; Medicare Part B, Medical Insurance; and Medicare Part D, Prescription Drug Coverage) as well as the full range of state Medicaid benefits and services.

**Healthcare Effectiveness Data and Information Set (HEDIS)** is a tool used by many health plans to measure performance on important dimensions of care and service. The measures are specifically defined to make comparison of performance possible and illustration of improvement areas easy.

**Hospital Provider Fee Oversight and Advisory Board (OAB),** authorized by the Colorado Health Care Affordability Act, is comprised of 13 members responsible for working with the Department of Health Care Policy and Financing and the Medical Services Board to develop the hospital provider fee model, monitor the implementation of the Colorado Health Care Affordability Act, and assist in the preparation of all necessary annual reports.

**Hospital Quality Incentive Payment (HQIP) Committee**, authorized by the Colorado Health Care Affordability Act, makes recommendations to the Hospital Provider Fee Oversight and Advisory Board (OAB) regarding quality and performance measures and incentive payment models.

**Integrated Care** is intended to provide one seamless set of Medicare and Medicaid benefits and providers, higher quality of care, and less confusion in services, including medical and long-term services and supports. It is designed to ensure that beneficiaries receive the right care at the right time in the right setting instead of receiving care driven by conflicting state and federal rules and misaligned payment systems. It can potentially reduce fragmentation, increase flexibility in the types of services that can be provided to beneficiaries, enhance budget predictability, and control the costs of care.

**Long-Term Services and Supports (LTSS)** provide persons with disabilities and chronic conditions choice, control, and access to a full continuum of services that assure optimal outcomes such as independence, health, and quality of life. Services are intended to be person-driven, inclusive, effective and accountable, sustainable and efficient, coordinated and transparent, and culturally competent.

# Appendix A: Glossary of Terms and Acronyms (cont'd.)

**Managed Fee-For-Service (FFS)** is an arrangement in which quality and utilization are improved through greater payer-provider collaboration than in traditional fee-for-service programs. Most or all payments for services remain fee-for-service with little or no insurance risk to providers. Payments may be based on such arrangements as bundling of certain services and/or incentives for high quality and efficient performance.

**Meaningful Use** requires providers to show they are using certified electronic health record technology in ways that can be measured significantly in quality and in quantity. The American Recovery and Reinvestment Act of 2009 specified three main components of Meaningful Use: use of a certified electronic health record in a meaningful manner (e.g., e-prescribing); electronic exchange of health information to improve quality of health care; and use of certified electronic health record technology to submit clinical quality and other measures.

**Medicaid** is a joint federal and state program that helps with medical costs for persons with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if the individual qualifies for both Medicare and Medicaid.

**Medical Home** is an approach to providing comprehensive primary care that facilitates partnerships between individuals, their providers, and where appropriate, their families. The ACC Program includes medical home model principles in its contractual language.

**Medicare** is a federal health insurance program for persons who are age 65 or older, for certain younger persons with disabilities, and for persons with end-stage renal disease.

**Money Follows the Person (MFP)** is a Rebalancing Demonstration Program authorized by Congress in Section 6071 of the Deficit Reduction Act of 2005. It is designed to assist states in balancing their long-term care systems and to help Medicaid participants transition from institutions to the community.

**National Quality Forum (NQF)** is a nonprofit organization that operates to improve the quality of American health care by building consensus on national priorities and performance improvement goals; working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting performance; and promoting education and outreach programs to achieve national goals.

**Passive Enrollment** is a process by which Medicaid clients are enrolled into a program but can choose another program or delivery system if they wish as required by 42 CFR Section 438.52. Thirty days before they are enrolled into the ACC Program, clients will receive a letter that tells them they will be enrolled into the program, describes the benefits of the program, identifies the services covered in the program, provides the contact information if they have questions, and gives instructions for opting out of the program if they choose not to participate. The letter informs clients that they will also be able to opt out of the program during the first 90 days of their enrollment and again during an open enrollment time every year.

# Appendix A:  Glossary of Terms and Acronyms (cont'd.)

**Patient Protection and Affordable Care Act (ACA)** of 2010 is often referred to as the Affordable Care Act. The federal statute aims to reform health care. It contains provisions to provide quality health insurance coverage; to prohibit a health plan from withdrawing coverage from an enrollee except in case of fraud; to establish health insurance exchange plans; to establish one or more reinsurance entities for reinsurance programs to assist in health care coverage; to provide for individual health care; and to impose penalty for any failure to maintain minimum health care coverage.

**Person-Centered** is often used to refer to a process in which the individual and his or her strengths, capacities, preferences, needs, and desired outcomes are actively solicited, considered, and incorporated when planning the delivery of appropriate care and services.

**Physician Quality Reporting System (PQRS)**, formerly the Physician Quality Reporting Initiative, provides an incentive payment to practices with eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B fee-for-service beneficiaries. Providers are identified on claims by their individual National Provider Identifier and Tax Identification Number.  .)

**Potentially Preventable Events (PPEs)** include five types of health care encounters or events that lead to unnecessary services that could possibly be prevented. They are hospital admissions, readmissions, emergency department visits that lead to inpatient admissions, complications such as infections, and outpatient procedures such as unnecessary imaging tests.

**Program of All-inclusive Care for the Elderly (PACE)** is a Medicare/Medicaid managed care program that provides health care and support services to persons 55 years of age and older. The program's goal is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services based upon their needs.

**Primary Care Medical Provider (PCMP)** is a Medicaid client's main health care provider who serves as a medical home where clients receive the majority of their primary care services. The primary care medical provider helps to identify the most appropriate service provider for clients who need specialist care.

**Regional Care Collaborative Organization (RCCO)** is one of the Accountable Care Collaborative Program's three main components. Each RCCO is responsible for connecting Medicaid clients to Medicaid providers and for assisting Medicaid clients in finding community and social services in their area. The RCCO helps providers communicate with Medicaid clients and with each other to ensure that clients receive coordinated care.

**Rural Health Clinic (RHC)** is a health care provider or center designed to provide access to primary care services in rural areas. Established by the Rural Health Clinic Services Act of 1977, RHCs were intended to address the inadequate supply of physicians in rural areas and to increase the utilization of non-physician practitioners.

## Appendix A:  Glossary of Terms and Acronyms (cont'd.)

**Serious Mental Illness (SMI)** includes schizophrenia, severe affective disorders, and emotional or mental health problems that significantly impair an individual's ability to function and create risk for out-of-home placement.

**Single Entry Points (SEPs)** are state agencies that determine functional eligibility for community-based long-term care programs, provide care planning and case management for clients in these programs, and make referrals to other resources.

**Skilled Nursing Facility (SNF)** primarily provides inpatient skilled nursing care and related services to clients who require medical, nursing, or rehabilitative services, meets specific regulatory certification requirements, but does not provide the level of care or treatment available in a hospital.

**Special Needs Plans (SNP)** is defined by the Medicare Modernization Act of 2003 as a Medicare Advantage coordinated care plan specifically designed to provide targeted care to institutionalized beneficiaries, dual eligible individuals, and/or individuals with severe or disabling chronic conditions.

**Stakeholder** is an inclusive term that refers to any individual, member, group, organization, or system with a significant interest in a decision to be made or an action to be taken.

**Statewide Data and Analytics Contractor (SDAC)** is the component in the Accountable Care Collaborative Program that provides the Department, Regional Care Collaborative Organizations, and Primary Care Medical Providers with client utilization and program performance data. It provides a continuous feedback loop of critical information to foster accountability and ongoing improvement.

## Appendix B:  The Accountable Care Collaborative Program

The Accountable Care Collaborative Program (ACC Program) was conceived several years ago when Colorado embarked on a journey to improve Coloradans' access to cost-effective, quality health care services. The Blue Ribbon Commission for Health Care Reform (the Commission) assessed a variety of health care reform models in Colorado. After months of careful deliberation and discussion with stakeholders, constituents, legislators, and executive officials, the Commission presented a comprehensive report in 2007 that provided a blueprint for health care reform in Colorado. Drawing upon the Commission's recommendations, the Administration at that time proposed a series of legislative initiatives referred to as the Building Blocks to Health Care Reform. During the 2008 legislative session, the Colorado legislature passed all of the initiatives.

The Department began to implement the legislative initiatives contained in the Building Blocks to Health Care Reform and to make plans for the additional reform strategies that had been identified. The Department was particularly interested in how to better contain health care costs while improving or maintaining the overall health and functioning of the clients served.

At that time, the majority of Medicaid clients in the state accessed their health care services in a service delivery model that did not always support coordinated care and the appropriate utilization of services. Clients often sought care in emergency rooms or other sites that offered episodic services. As a result, providers would not know the clients' history or ongoing health care needs. Since clients interacted with a host of Medicaid and non-Medicaid provider organizations, ranging from schools and county government services to independent living centers and transportation vendors, access to and interaction between these providers and support organizations varied, and little or no data were available to facilitate coordination and continuity of care.

One of the identified reform strategies was the Medicaid Value-Based Care Coordination Initiative, which became known as the ACC Program. The Department began the planning process for the ACC Program in 2008 and worked with a broad and diverse group of clients, stakeholders, and partners. The extensive, multi-year planning process allowed thoughtful input in shaping the program at every step of development.

In 2008, consultants facilitated two workgroups to help the Department identify the challenges, opportunities, and concerns about care delivery and care management. One of the workgroups was made up of clients and advocates; the other was comprised of providers and health plans. This essential first step afforded the Department recommendations that became the foundation of the ACC Program.

The Department submitted a formal budget action for the ACC Program on November 3, 2008. Passage of Colorado House Bill 09-1293 (the Colorado Health Care Affordability Act) in April 2009, coupled with unprecedented growth in the Medicaid caseload because of the economic recession, reinforced the need for the Department to implement the ACC Program.

# Appendix B:  The Accountable Care Collaborative Program (cont'd.)

The Department continued to bring its program plan to stakeholders from March through June 2009, with well attended public forums that were broadcast by webinar and conference call.  The Department also set up mechanisms for ongoing communication and updates, such as a listserv. More than 500 individuals and organizations, ranging from providers to community stakeholders, participated in this ongoing communication.

In July 2009, the Department began to create the scope of work for what would become the Regional Care Collaborative Organizations (RCCOs) and issued a Request for Information (RFI). Stakeholders helped to create the RFI and assisted the Department in asking the right questions. The RFI asked interested stakeholders to give specific feedback on more than 200 questions to better understand what providers and other stakeholders thought about the program details. The RFI received 81 responses, which affected many program decisions. As one of the three core components of the ACC Program, RCCOs were designed to ensure the provision of medical management, particularly for medically and behaviorally complex clients, care coordination among all service providers, and provider assistance in care coordination activities, clinical performance, and practice improvement and redesign. Provider feedback also guided the Department to create a program structure that was not prescriptive or rigid but allowed providers and health plans the flexibility to focus on improving health outcomes in their regions.

The Department subsequently solicited competitive proposals for RCCOs in August 2010. Contractors were to be accountable for improving the health of Medicaid clients and for controlling costs in one or more of seven regions statewide. Appendix C contains a map of Colorado and illustrates the RCCOs and the counties they serve. By establishing connections between existing systems of care and services, RCCOs were designed as the mechanism of accountability for ensuring cohesive delivery of ACC Program services. RCCOs were selected in December 2010. In addition, the competitive procurement process for the SDAC began in September 2010 with a contract awarded in January 2011. Subsequently, client enrollment in the ACC Program successfully began in May 2011.

Central to the success of the ACC Program's core elements is the interaction among three key roles: RCCOs, PCMPs, and the SDAC.

First, Regional Care Collaborative Organizations (RCCOs) ensure comprehensive care coordination and a focal point of care for every participant by developing a robust network of providers, supporting their providers, providing medical management and care coordination, and being accountable to the Department for progress. RCCOs are responsible for creating a virtual network of specialists and ancillary providers to meet their clients' needs. The network is automatically comprised of all participating Medicaid providers in the state, including Single Entry Points (SEPs), Community Centered Boards (CCBs), and long-term services and supports (LTSS) providers. RCCOs administratively support the provider networks with clinical tools, client materials, data, and analytics. RCCO reporting requirements are specified in their contracts with the Department and are outlined in Appendix D. RCCOs are currently required to submit information about provider networks, stakeholder engagement, client experience, and

# Appendix B:  The Accountable Care Collaborative Program (cont'd.)

performance on a regular basis. The RCCOs continue to work with each other and with the Department to develop recurring and ad hoc reports as needed.

Second, Primary Care Medical Providers (PCMPs) provide comprehensive primary care for ACC Program clients and coordinate a client's health needs across specialties. PCMPs provide whole-person-oriented, coordinated, client/family-centered care in a culturally and linguistically sensitive manner. PCMPs include individual physicians; advance practice nurses and physician assistants; federally qualified health centers (FQHCs); rural health clinics (RHCs); and clinics or group practices with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, and obstetrics and gynecology. PCMPs in the ACC Program contract with both Medicaid and the RCCOs and are accountable to both the Department and the RCCOs. PCMPs are committed to achieving operational and fiscal efficiencies, tracking performance and process improvement activities, tracking follow-up on diagnostic tests, and improving care transitions and coordination with specialists.

Third, the Statewide Data and Analytics Contractor (SDAC) is responsible for building and implementing a data repository, hosting and maintaining a web portal, providing data to RCCOs and PCMPs, providing a continuous feedback loop of critical information, and creating reports using advanced health care analytics. The data are used to foster accountability among the RCCOs and PCMPs and to identify data-driven opportunities to improve care and outcomes, including peer learning between and within the RCCOs. The SDAC assists the Department in developing baseline performance measurements. The SDAC provides operational information and tools to promote change and leverage opportunities for improvement in a timely and meaningful way. Reliable, timely information furnished by the SDAC supports care of clients while identifying proactive interventions for the population of a community to trigger positive changes in the delivery of care.

In response to the changing health care environment, the ACC Program has been designed to address the two central goals and focus on the following objectives:

(1) Expand access to comprehensive primary care.

(2) Provide a focal point of care/medical home for all participants, including coordinated and integrated access to other services.

(3) Ensure a positive client and provider experience and promote client and provider engagement.

(4) Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent and secure data sharing, and enable the near real-time monitoring and measurement of health care costs and outcomes.

# Appendix B:  The Accountable Care Collaborative Program (cont'd.)

The ACC Program addresses supportive infrastructure needs with several core elements. When combined and executed properly, these elements drive accountability and success in achieving improved health outcomes and managing costs. These core elements include:
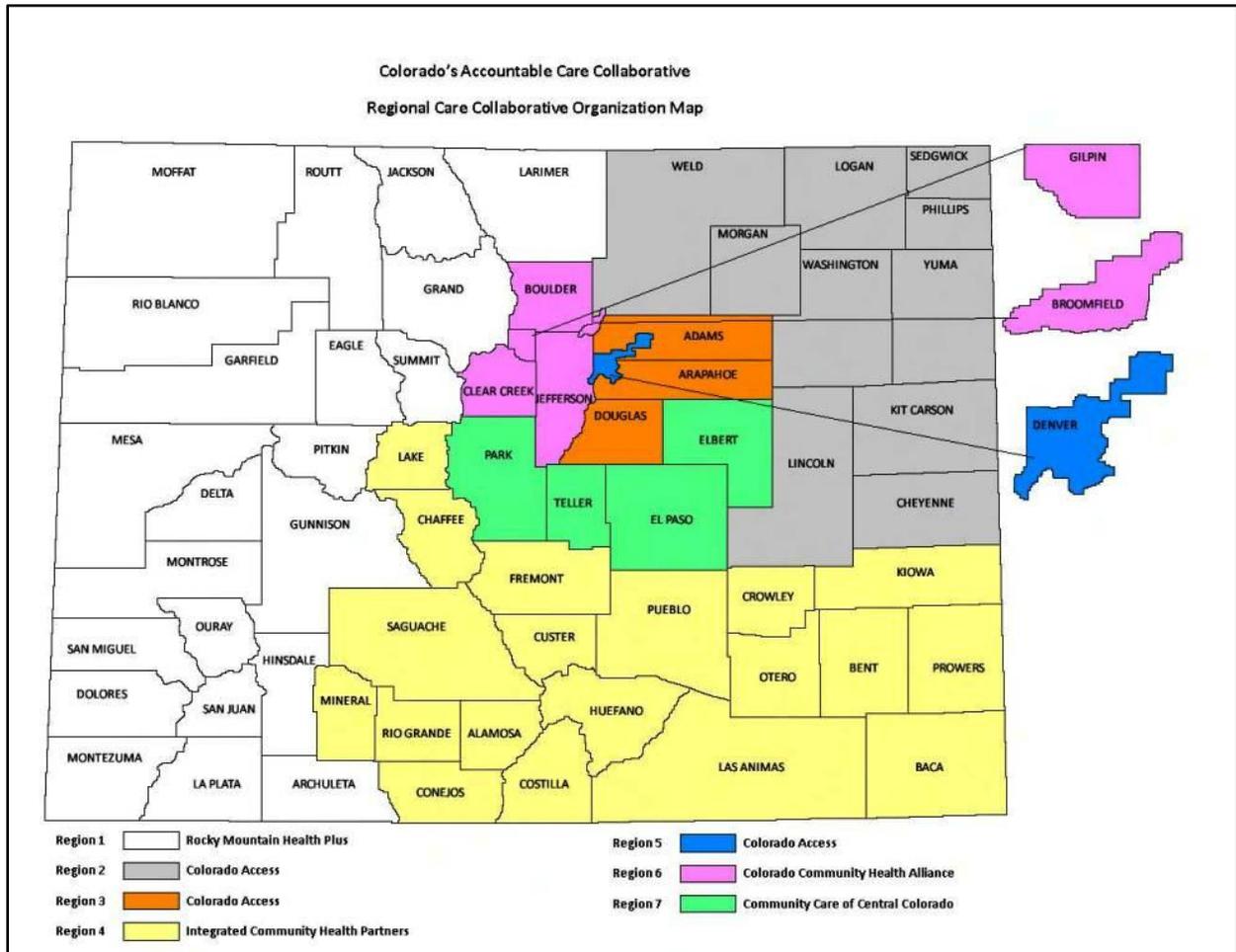
(1) A regional approach to managing, providing, and coordinating care

(2) The principles of a client-centered medical home model

(3) An integrated network of providers

(4) The provision of high-quality care coordination and medical management services

(5) An unrelenting focus on accountability to improve outcomes and control costs

(6) Analysis and application of informatics and benchmarking to review, measure, and compare utilization, outcomes, and costs

(7) A focus on continuous improvement and innovation, constant learning, and the sharing of best practices

The ACC Program is designed to directly invest in community infrastructure and utilize existing community resources to support care teams and care coordination. It also aligns incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program seeks to make the people and organizations that actually provide care accountable for the quality and cost of that care.

The ACC Program is based on the fundamental premise that communities are in the best position to make changes that address the cost and quality problems resulting from a system of fragmented care, variation in practice patterns, and volume-based payment systems. The Department recognizes that the commitment and participation of providers is essential to driving these changes and realizes that supportive infrastructure is necessary to make the paradigm shift possible.

The Department continues to engage stakeholders through the ACC Program Improvement Advisory Committee and its three subcommittees: Payment Reform, Provider and Community Relations, and Quality Health Improvement. Stakeholders include clients and families, other provider groups, PCMPs, RCCOs, Department staff, and representatives from the Colorado Department of Human Services (CDHS), the Colorado Department of Public Health and Environment (CDPHE), and Behavioral Health Organizations (BHOs). The Advisory Committee provides technical assistance and guidance and makes recommendations on all aspects of the ACC Program. The ACC Program also holds two monthly operations meetings to ensure adequate communication and coordination among RCCOs, the SDAC, and the Department. In addition to the forums sponsored by the Department, the RCCOs meet independently and work together on certain issues.

## Appendix C: Map of Colorado – RCCOs and Counties Served



Colorado's Accountable Care Collaborative

Regional Care Collaborative Organization Map

| Region 1 | | Rocky Mountain Health Plus | Region 5 | | Colorado Access |
| Region 2 | | Colorado Access | Region 6 | | Colorado Community Health Alliance |
| Region 3 | | Colorado Access | Region 7 | | Community Care of Central Colorado |
| Region 4 | | Integrated Community Health Partners | | | |

# Appendix D:  RCCO Reporting Requirements

| Administrative Reports | Required Information | Frequency |
|---|---|---|
| Key Staff Changes | • Vacancies of key staff, including the interim plan for covering vacant position's responsibilities and the plan for filling the vacancy | • Ongoing |
| | • Hiring of new key staff | • Within five business days after a candidate has been approved to fill a key staff vacancy or five business days prior to the candidate's start date, whichever occurs first |
| Program Integrity | • Possible instance of provider Medicaid fraud | • Immediately upon receipt of information |
| | • Background information, name of provider, and a description of how the RCCO became knowledgeable about the occurrence | • Within ten business days by means of a written referral containing more detailed information |
| Network | • Total number of providers by type of provider and county (including, but not limited to, PCMPs, specialists, and hospitals)<br><br>• Number of providers accepting new clients<br><br>• How the provider network meets the needs of the member population<br><br>• Summary of challenges and opportunities for improving the provider network, unmet needs in the network, and strategies for meeting unmet needs[7] | • Thirty days after the end of the quarter |

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[7] This information is included in the report submitted to the Department at the beginning of each fiscal year.

# Appendix D:  RCCO Reporting Requirements (cont'd.)

| Performance Reports | Required Information | Frequency |
|---|---|---|
| Management | • Performance on health outcomes and cost containment measures<br><br>• Emphasis on health outcomes, affordability, access, and members' and stakeholders' experience with the program | • Quarterly |
| Performance Measures and Activities | • Performance on the measures included in the performance improvement plan<br><br>• Performance during the current quarter, previous four quarters, cumulative performance during the previous 13 months to date<br><br>• Summary of performance improvement activities, completed and in process<br><br>• Performance improvement activities scheduled for the next quarter | • Quarterly |
| Stakeholder Feedback | • Summary of the feedback received from members and stakeholders<br><br>• Trends and themes in feedback | • Quarterly |

## Appendix E: Average Individual Utilization of Medicare and Medicaid Services by Dual Eligible Clients[8]

### Nursing Facility Services

| | Number of Medicare Beneficiaries | Average Medicare Utilization per Beneficiary | Number of Medicaid Clients | Average Medicaid Utilization per Client |
|---|---|---|---|---|
| Home and Community-Based Services Waiver | 2,038 | $1,377 | 1,982 | $955 |
| Persons with Developmental Disabilities (Waiver) | 73 | $1,134 | 118 | $5,655 |
| Persons with Developmental Disabilities (Non-Waiver) | 262 | $1,301 | 625 | $3,816 |
| Serious Mental Illness | 606 | $1,324 | 1,624 | $3,264 |
| Nursing Facility (Residential) | 2,533 | $1,155 | 7,634 | $2,994 |
| End-Stage Renal Disease | 0 | $0 | 0 | $0 |
| Substance Use Disorder | 0 | $0 | 0 | $0 |
| Chronic Physical Condition | 0 | $0 | 0 | $0 |
| Other | 0 | $0 | 0 | $0 |
| **Total** | **5,512** | **$1,262** | **11,983** | **$2,763** |

### Home Health Services

| | Number of Medicare Beneficiaries | Average Medicare Utilization per Beneficiary | Number of Medicaid Clients | Average Medicaid Utilization per Client |
|---|---|---|---|---|
| Home and Community-Based Services Waiver | 4,301 | $453 | 17,718 | $1,046 |
| Persons with Developmental Disabilities (Waiver) | 166 | $337 | 2,907 | $5,387 |
| Persons with Developmental Disabilities (Non-Waiver) | 128 | $354 | 30 | $1,059 |
| Serious Mental Illness | 205 | $385 | 21 | $309 |
| Nursing Facility (Residential) | 642 | $412 | 34 | $636 |
| End-Stage Renal Disease | 49 | $377 | 9 | $1,040 |
| Substance Use Disorder | 17 | $196 | 0 | $0 |
| Chronic Physical Condition | 364 | $343 | 71 | $864 |
| Other | 644 | $351 | 75 | $936 |
| **Total** | **6,516** | **$424** | **20,865** | **$1,648** |

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[8] The information in Appendix E has been provided by The Public Consulting Group.

## Appendix E: Individual Utilization of Medicare and Medicaid Services by Dual Eligible Clients (cont'd.)

**Hospice Services**

| | Number of Medicare Beneficiaries | Average Medicare Utilization per Beneficiary | Number of Medicaid Clients | Average Medicaid Utilization per Client |
|---|---|---|---|---|
| Home and Community-Based Services Waiver | 1,087 | $1,169 | 301 | $716 |
| Persons with Developmental Disabilities (Waiver) | 34 | $796 | 10 | $778 |
| Persons with Developmental Disabilities (Non-Waiver) | 83 | $791 | 65 | $1,121 |
| Serious Mental Illness | 275 | $1,253 | 246 | $1,307 |
| Nursing Facility (Residential) | 1,512 | $959 | 1,156 | $993 |
| End-Stage Renal Disease | 7 | $587 | 2 | $365 |
| Substance Use Disorder | 7 | $729 | 3 | $973 |
| Chronic Physical Condition | 63 | $1,217 | 24 | $2,227 |
| Other | 671 | $1,609 | 443 | $1,529 |
| **Total** | **3,739** | **$1,157** | **2,250** | **$1,111** |

**Other Acute Care Services**

| | Number of Medicare Beneficiaries | Average Medicare Utilization per Beneficiary | Number of Medicaid Clients | Average Medicaid Utilization per Client |
|---|---|---|---|---|
| Home and Community-Based Services Waiver | 17,573 | $1,020 | 16,769 | $141 |
| Persons with Developmental Disabilities (Waiver) | 2,905 | $410 | 2,847 | $87 |
| Persons with Developmental Disabilities (Non-Waiver) | 1,477 | $1,486 | 1,463 | $169 |
| Serious Mental Illness | 2,995 | $1,029 | 2,849 | $141 |
| Nursing Facility (Residential) | 7,924 | $932 | 7,345 | $142 |
| End-Stage Renal Disease | 383 | $4,348 | 383 | $494 |
| Substance Use Disorder | 383 | $671 | 381 | $83 |
| Chronic Physical Condition | 4,633 | $554 | 4,619 | $77 |
| Other | 15,327 | $360 | 13,580 | $153 |
| **Total** | **53,600** | **$779** | **50,236** | **$138** |

## Appendix E: Individual Utilization of Medicare and Medicaid Services by Dual Eligible Clients (cont'd.)

**All Services**

| | Number of Medicare Beneficiaries | Average Medicare Utilization per Beneficiary | Number of Medicaid Clients | Average Medicaid Utilization per Client |
|---|---|---|---|---|
| Home and Community-Based Services Waiver | 17,718 | $1,423 | 17,718 | $1,471 |
| Developmental Disabilities (Waiver) | 2,907 | $466 | 2,907 | $5,907 |
| Developmental Disabilities (Non-Waiver) | 1,481 | $1,787 | 1,481 | $2,037 |
| Serious Mental Illness | 3,009 | $1,432 | 3,009 | $2,163 |
| Nursing Facility (Residential) | 8,112 | $1,483 | 8,112 | $3,156 |
| End-Stage Renal Disease | 383 | $4,407 | 383 | $865 |
| Substance Use Disorder | 383 | $693 | 383 | $298 |
| Chronic Physical Condition | 4,636 | $597 | 4,636 | $260 |
| Other | 15,492 | $440 | 15,492 | $308 |
| **Total** | **54,121** | **$1,055** | **54,121** | **$1,567** |

## Appendix F: Colorado Population by RCCO

| ACC Program Region | State Population[9] | Percent of State Population | Total State Medicaid Population | Percent of State Medicaid Population | Total Fully Dual Eligible Individuals | Percent of Fully Dual Eligible Individuals |
|---|---|---|---|---|---|---|
| RCCO 1 | 808,170 | 16% | 95,983 | 15% | 10,627 | 15% |
| RCCO 2 | 340,944 | 7% | 50,866 | 8% | 5,256 | 8% |
| RCCO 3 | 1,299,071 | 25% | 154,354 | 24% | 13,371 | 19% |
| RCCO 4 | 396,420 | 8% | 72,839 | 12% | 11,450 | 16% |
| RCCO 5 | 600,158 | 12% | 105,629 | 17% | 12,326 | 18% |
| RCC0 6 | 899,528 | 18% | 73,706 | 12% | 9,692 | 14% |
| RCCO 7 | 684,905 | 14% | 79,084 | 12% | 7,065 | 10% |
| **Colorado** | **5,029,196** | **100%** | **632,460** | **100%** | **69,787** | **100%** |

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[9] State population information is based on 2010 U.S. Census Bureau data.

## Appendix G: Disenrollment for Cause

A client may request disenrollment from the Accountable Care Collaborative Program for cause at any time. Disenrollment for cause may occur if the client:

- Moves out of the Regional Care Collaborative Organization's (RCCO) service area.

- Receives poor quality of care.

- Cannot access the health care services needed.

- Cannot access providers with experience in dealing with the client's health care needs.

- Experiences administrative errors on the part of the Department or the RCCO.

- Finds that the RCCO does not, because of moral or religious objections, service the client's needs.

- Needs certain health care services to be performed at the same time, and those services are unavailable within the existing network, and performing those services separately would subject the client to unnecessary risk.

# Appendix H: RCCO Relationships - Strengthening Capacity in the Communities

| Topic | RCCO 1 | RCCO 2, 3, 5[10] | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **RCCO Advisory Board Composition** | • Participating providers (e.g., Community Mental Health Center)<br>• Community-based care coordinators<br>• Hospital representatives<br>• Convening organizational leadership and RCCO leadership<br>• Stakeholders including members, family members, and advocates | • Participating providers (e.g., Colorado Behavioral Health Council, Aurora Health Access, Metro Community Provider Network)<br>• University and Children's Hospital representatives<br>• Health care legal advocates<br>• Convening organizational leadership<br>• Stakeholders including members, family members, caregivers, and advocates | • Representatives from local Single Entry Points (SEP) agencies<br>• Stakeholders including members, family members, caregivers, and advocates | • Health care professionals, including behavioral health<br>• Community resource leaders<br>• Non-profit children's health advocacy group representatives<br>• Representatives from Centura Health | • Health care professionals, including behavioral health<br>• Hospital representatives<br>• Health Care partners (e.g., Colorado Springs Health Partners, Peak Vista, and Rocky Mountain Health Care Services)<br>• University of Colorado representatives |

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[10] RCCOs 2, 3, and 5 are operated by the same entity.

## Appendix H:  RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Involvement of Dual Eligible Individuals** | • Inviting and encouraging participation in both community advisory meetings and oversight committees<br>• Inviting and encouraging participation in both forums by coordinators, providers, and advocates serving dual eligible individuals | • Extending advisory meeting invitations to dual eligible members upon enrollment<br>• Maintaining a strong presence in programs for dual eligible individuals and Medicare beneficiaries through existing Medicare Special Needs Plan for dual eligible individuals | • Extending advisory meeting invitations to dual eligible members upon their enrollment<br>• Working with dual eligible individuals by some current advisory council members<br>• Working to understand SEP agencies and the referral process<br>• Identifying over or underutilization of certain medical services | • Working to include a representative from either a long-term care facility or a SEP to provide insight into the needs of dual eligible individuals<br>• Utilizing a long history working with the Medicare population to gain a greater perspective of the needs and resources for dual eligible individuals | • Extending invitations to dual eligible members to participate in the advisory council upon enrollment<br>• Working to identify knowledgeable representatives to participate on the current advisory council<br>• Currently in the planning process for the enrollment of dual eligible individuals |

## Appendix H: RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Ancillary Provider Relationships** | • Local hospital representatives<br>• Behavioral health providers<br>• Home health agencies | • SEPs in each region<br>• A RCCO seat on Long-Term Care Options' Community Advisory Board<br>• Area Agencies on Aging in each region<br>• Denver Regional Council of Governments, Community Care Transition Programs | • Area Agency Aging<br>• Pueblo Advisory Council on Aging<br>• Adult Resources for Care and Help<br>• Home Instead Senior Care<br>• Senior Service Network<br>• Golden Gate Transportation<br>• Bluesky Enterprises<br>• Pueblo Step-up<br>• InnovAge<br>• Community Mental Health Centers<br>• Community Health Centers | • SEPs<br>• Local continuing care residents<br>• Skilled Nursing Facilities<br>• Multiple non-profits serving seniors (e.g., the Senior Resource Center, the Action Center, Dominican Sisters)<br>• Multiple home health agencies<br>• Hospice care providers | • Medical services providers<br>• Single Entry Point<br>• Peak Vista (Federally Qualified Health Center)<br>• Colorado Springs Health Providers<br>• Rocky Mountain Health Care Services' PACE program<br>• All local safety-net clinics<br>• El Paso County Health Department<br>• Aspen Pointe<br>• Local hospital systems<br>• Pikes Peak Hospice & Palliative Care<br>• Colorado Regional Health Information Organization |

## Appendix H:  RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Medicare Population Outreach** | • Establishing Care Coordination Teams (CCT) in communities throughout the region<br>• Engaging with PACE providers, developmental disability providers, Area Agencies on Aging, local DHS, and home health and hospice providers<br>• Utilizing a lengthy history of work with dual eligible clients to understand how to better outreach and engage them | • Maintaining relationships with Medicare providers and senior and disability advocacy communities<br>• Utilizing the part-time practices of the RCCO's two medical directors who are geriatricians to outreach to current clients<br>• Holding regular discussions in community meetings about the potential enrollment of dual eligible individuals<br>• Participating in the Department's Dual Eligibles stakeholder meetings | • Developing a community resource guide for RCCO members<br>• Increasing expansion efforts to include the Medicare sector<br>• Continuing agreements with PCMPs who serve dual eligible individuals<br>• Leveraging data management team to analyze claims data<br>• Applying stratification methodology to identify Medicare members with high service utilization | • Maintaining affiliation with Physician Health Partners, who manages Medicare members<br>• Establishing Care Management programs to address the needs of the Medicare population<br>• Establishing relationships within the Medicare beneficiary community<br>• Accepting an awarded contract from CMS to be a Pioneer Accountable Care Organization | • Engaging with partners who currently interact with dual eligible individuals (e.g., Pikes Peak Hospice, the Area Council on Aging) |

# Appendix H: RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Hospital Relationships and Involvement** | • Local hospital participation on community Oversight Committees<br>• Financial or facility support of community-based CCT<br>• Hospital-based case managers assisting in arranging care for current members | • Children's Hospital Colorado<br>• University of Colorado Health Systems, including Poudre Valley Hospital, University of Colorado Hospital, and soon Memorial Health Systems<br>• Representation on Advisory Board and in RCCO oversight<br>• Contractual relationships with all systems statewide<br>• Development of real-time emergency room and hospitalization data to support care management | • Hospitals in each population center, including the Emergency, Admissions, Discharge, and Case Management departments<br>• Shared Emergency Room and PCP data between the Community Mental Health Center and PCMPs on shared client rosters using File Connect<br>• Data management process and care coordination support at the provider level, including hospitals, and program reporting at the RCCO level | • Largest hospital network in Colorado<br>• Pledged use of specialists with slots open specifically for RCCO clients<br>• Emergency Room and inpatient admission data feeds to RCCO three times per day for all hospitals<br>• Arrangements with Exempla and Health One hospitals<br>• Arrangement between Salud Family Health Center and Longmont United Hospital for Salud care managers to do hospital rounds to support care transition efforts | • Local hospital systems<br>• Partnering with transition of care program and Emergency Room diversion and referral program<br>• Representation on RCCO management committees |

## Appendix H: RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Community Engagement and Other Advisory Board Activities** | • Partnering with Quality Health Network, St. Mary's Hospital, and the Mesa County Physician's IPA<br>• Participating in the Comprehensive Primary Care Initiative<br>• Conducting quarterly open Community Advisory forums<br>• Participating in the Department's dual eligible stakeholder and workgroup meetings<br>• Participating in the Adults without Dependent Children Advisory Committee meetings | • Marketing outreach projects such as at the Salute-to-Seniors event<br>• Participating with Community Based Organizations focused on health<br>• Creating a stakeholder group for providers for Medicaid, CHP+, and the uninsured<br>• Partnering with the Board of Alliance to develop a community-based care management program<br>• Working with Aurora Health Access<br>• Exchanging ACC member lists with CMHC and BHO providers | • Participating in the Triple Aim Steering Committee<br>• Hosting meetings for Court-Appointed Special Advocates<br>• Participating on committees for the County, the Health Department, Senior Service Network, Centers for Improving Value in Health Care, Colorado Health Foundation, state-level advisory committees<br>• Supporting the development of Community Care Coordination and Case Management Teams | • Participating in the Department's dual eligible stakeholder meetings, the Adults without Dependent Children initiative, and the Colorado Department of Health and Environment Medical Home Initiative<br>• Working philanthropically with The Action Center<br>• Participating in health care organizations throughout the metro area, such as CIVHC, Colorado Business Group on Health, Colorado Health Care Strategy and Management, | • Participating in the Healthy Community Collaborative initiative of the local health department |

# Appendix H:  RCCO Relationships - Strengthening Capacity in the Communities (cont'd.)

| Topic | RCCO 1 | RCCO 2, 3, 5 | RCCO 4 | RCCO 6 | RCCO 7 |
|---|---|---|---|---|---|
| **Community Engagement and Other Advisory Board Activities** | • Participating in statewide RCCO Care Coordination and leadership meetings<br>• Reaching out and being responsive to community providers, advocates and other key community players | • Maintaining a relationship with the state's network of FQHCs | • Developing a Community Resource database | • Colorado Health Foundation, and Colorado Health Institute<br>• Undergoing a community resource outreach campaign | |

# Appendix I: Community Centered Boards and Single Entry Points

| Topic | Community Centered Boards (CCBs)[11] | Single Entry Points (SEPs) |
|---|---|---|
| **Population(s) Served** | • Adults and children with developmental disabilities | • Current or potential long-term care clients |
| **Geographic Service Areas** | • Statewide<br>• 20 CCBs (each CCB serves a non-overlapping region) | • Statewide<br>• 23 Agencies (each SEP serves one or more counties) |
| **ACC Program Areas** | • Seven RCCO regions (covering all CCB service areas) | • Seven RCCO regions (covering all SEP service areas) |
| **Function(s)** | • Provides a single point of entry to Home and Community-Based Services (HCBS)<br>• Provides Targeted Case Management (TCM)<br>• Offers services including but not limited to intake, eligibility determination, development of a Service Plan, arrangement for services, delivery of services (either directly and/or through purchase), and monitoring of clients | • Provides a single point of entry to long-term care information, screening, assessment, and referral to appropriate long-term care program and case management services<br>• Provides Administrative Case Management<br>• Offers services including but not limited to intake, screening, referral, assessment of client need, determination of functional eligibility, development and implementation of a Service Plan, client monitoring, reassessment, and case closure |
| **Reporting Requirements** | • Reports and provides follow-up action to critical incidents<br>• Provides quarterly data on the number and type of complaints received and resolved through TCM and on the number and type of reportable incidents<br>• Reviews compliance with program requirements and conducts surveys to determine compliance with administrative requirements on an annual basis<br>• Surveys a random sample of clients annually to determine clients' level of satisfaction with services | • Provides litigation reporting within ten days after being served with any pleading in a legal action filed with a court or administrative agency<br>• Provides quarterly reports to the Department specifying the number and type of Medicaid Long-Term Care clients and applicants served and the specific services provided per month<br>• Reviews compliance with program and administrative requirements on an annual basis |

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[11] Some CCBs function as SEPs.

# Appendix J: Evidence-based Practices

The Colorado Department of Public Health and Environment, in collaborative efforts with the Colorado Department of Human Services' State Unit on Aging, the Central Colorado Area Health Education Center, and the Colorado School of Public Health, developed a series of workshops offered in counties across Colorado. The workshops are designed to help those with chronic health conditions feel better and maintain more active, independent lives. The program is based on the following proven, outcomes-based curriculum:

- *Chronic Disease Self-Management* workshops, developed at Stanford University in 1991, teach concrete steps to participants such as setting goals, creating action plans, eating healthily, exercising, and improving communication skills. Workshops are led by peers, encourage participation and mutual support, and build participants' confidence. Research conducted by the Agency for Healthcare Research and Quality indicated that graduates of the program felt more energy and less fatigue, exercised more, and talked more comfortably about their health with family and health care providers. The program has been shown to reduce health care costs, hospitalizations, and physician visits, saving up to four dollars for every dollar invested.

In other efforts, a workgroup comprised of members of the Department, the Colorado Hospital Association, the Provider Fee Oversight and Advisory Board (OAB), and other stakeholders has been focused on identifying and encouraging the use of evidence-based practices to reduce hospital readmissions, measure success, and provide incentive payments in this area since early 2011. As a result of that work, in May 2011, this group made recommendations regarding some evidence-based practices to be considered for implementation in Colorado. The Department will work with RCCOs, PCMPs, and hospitals to explore the feasibility and utility of implementing these as part of this Demonstration and as part of the evolution of the ACC Program for all clients. These initiatives include, but are not limited to, the following or combinations of these programs:

- *Care Transitions Program*, developed by Dr. Eric Coleman, University of Colorado Denver, School of Medicine, is designed to specifically improve care transitions. The model's components include the use of a personal health record, a discharge preparation checklist, a pre-discharge session with a Transitions Coach, and follow-up visits with a Transitions Coach. The intervention focuses on empowering clients and their caregivers through ensuring that clients:
  - are knowledgeable about their medications;
  - understand and are able to utilize their personal health record;
  - are active participants in their care; and
  - are able to recognize and respond when their condition worsens.
  In addition to the intervention, the program includes care transition measures that are comprised of 15 one-dimensional items to assess care transition quality. The primary objective is the development of a measure that is substantively and methodologically

# Appendix J: Evidence-based Practices (cont'd.)

consistent with the concept of person-centeredness and is useful for performance measurement and public reporting.

- *Project Re-Engineered Discharge (RED)* is founded on 11 discrete, mutually reinforcing components and has been proven to reduce re-hospitalizations and yield high rates of client satisfaction. These include practices such as:
    - o making sure the client fully understands his or her diagnosis, tests, test results, medications, discharge plans, the importance of following the plan, and what to do if problems arise;
    - o assisting clients with making and keeping follow-up appointments and organizing post-discharge services;
    - o ensuring that medication plans are correct and that the client fully understands the plans;
    - o ensuring that discharge plans are aligned with national guidelines;
    - o ensuring that complete and accurate discharge paperwork is provided to discharge physicians and other providers quickly; and
    - o following up by telephone with clients within two to three days of discharge.

- *Transitional Care Model (TCM)* provides comprehensive in-hospital planning and at-home follow-up for chronically ill, high-risk older adults hospitalized for common medical and surgical conditions. The model's core is a Transitional Care Nurse, who follows clients from hospital to home and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. TCM is a nurse-led, multidisciplinary model that includes physicians, other nurses, social workers, discharge planners, home health providers, pharmacists, and additional members of the health care team. TCM implements tested protocols specifically designed to increase clients' and caregivers' ability to self-manage care.

## Appendix K:  Mandatory 1915(b)(3) Waiver Services

- **Vocational Services** are designed to assist adult and adolescent members who are ineligible for state vocational rehabilitation services and require LTSS in developing skills consistent with employment and/or in obtaining employment.

- **Intensive Case Management** is a community-based service averaging more than one hour per week, provided to adults with serious mental illness (SMI) who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Services are designed to provide adequate supports to ensure community living. Services are assessment, care plan development, multi-system referrals, assistance with obtaining wraparound services and supportive living services, monitoring and follow up.

- **Prevention/Early Intervention** activities include screening and outreach to identify at-risk populations, proactive efforts to educate and empower members to choose and maintain healthy life behaviors and lifestyles that promote mental and behavioral health. Services can be population-based, including proven media, written, peer, and group interventions, and are not restricted to face-to-face interventions.

- **Clubhouse and Drop-in Centers** are peer support services for persons who have mental illnesses, provided in settings in which members utilize their skills for clerical work, data input, meal preparation, providing resource information, or reaching out to fellow members. Staff and members work side by side in a unique partnership. In drop-in centers, members with mental illnesses plan and conduct programs and activities in a club-like setting.

- **Residential Services** are defined as 24-hour care, excluding room and board, provided in a non-hospital, non-nursing home setting and are appropriate for adults and older adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Residential services are a variety of clinical interventions that, individually, may appear similar to traditional Medicaid State Plan services. By virtue of being provided in a setting where the client is living, in real-time (i.e., with immediate intervention possible), residential services become a unique and valuable service that cannot be duplicated in a non-structured community setting. These clinical interventions, coupled together, in real time, in the setting where a client is living, become a tool for treating individuals in the most cost effective manner and in the least restrictive setting.

- **Assertive Community Treatment (ACT)** is a service delivery model providing comprehensive, individualized, locally based treatment to adult members with serious mental illness. ACT services are provided by a multidisciplinary treatment team and are available 24 hours a day, seven days a week, 365 days a year. ACT teams provide case

# Appendix K:  Mandatory 1915(b)(3) Waiver Services (cont'd.)

management, initial and ongoing mental health assessments, psychiatric services, employment and housing assistance, family support and education, and substance abuse services to individuals with co-occurring diagnoses of mental illness and substance use disorder.

- **Recovery-Oriented Services** promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches, or other community locations. Services include but are not limited to peer counseling and support services, peer-run employment services, peer mentoring for children and adolescents, recovery groups, telephone support lines, and advocacy services. The Department expects contractors to utilize the competency-based guidelines for training peer support specialists distributed to all contractors in June 2007.

- **Respite Care** is temporary or short-term care of a child, adolescent, or adult provided by adults other than the birth parents, foster parents, adoptive parents, family members, or caregivers with whom the member normally resides, and is designed to give the usual caregivers some time away from the member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

## Appendix L: Stakeholder Engagement Activities[12]

| Stakeholder Engagement Activities | June 2011 | July 2011 | Aug 2011 | Sept 2011 | Oct 2011 | Nov 2011 | Dec 2011 | Jan 2012 | Feb 2012 | Mar 2012 | Apr 2012 | May 2012 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Statewide Stakeholder Meetings[13] | 1 | | | | 1 | | 1 | 1 | | 1 | 1 | | 6 |
| Meetings with organizations, individuals, and Department personnel | | | 1 | 1 | 5 | 4 | 11 | 11 | 6 | 7 | | | 58 |
| Workgroup: Communication (Outreach and Information) | | | | | | | 2 | | 1 | 1 | | | 4 |
| Workgroup: Coordination of Care | | | | | | | 2 | 1 | 1 | 1 | | | 6 |
| Workgroup: Behavioral Health | | | | | | | 1 | 2 | 1 | 1 | | | 6 |
| Workgroup: Developmental Disabilities | | | | | | | 2 | 1 | 1 | 1 | | | 6 |
| Workgroup: Financing Strategies and Quality Medical Outcomes | | | | | | | 2 | 1 | 1 | 1 | | | 6 |

[12]The number provided in each cell indicates the number per month.

[13] These two-hour meetings were hosted in Denver but included a toll-free call-in and/or webinar option for individuals unable to attend in person.

## Appendix L: Stakeholder Engagement Activities (cont'd.)

| Stakeholder Engagement Activities | June 2011 | July 2011 | Aug 2011 | Sept 2011 | Oct 2011 | Nov 2011 | Dec 2011 | Jan 2012 | Feb 2012 | Mar 2012 | Apr 2012 | May 2012 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Regional meetings across Colorado conducted by the Department and its consultant, The Public Consulting Group[14] | | | | | | | | | 9 | | | | 9 |
| Posting of the first two drafts of the proposal to the Department's Web site for stakeholder feedback | | | | | | | | 1 | | 1 | | | 2 |
| Posting and discussion of a 23-page document of stakeholder feedback and Department responses | | | | | | | | | | 1 | | | 1 |
| Posting of the third draft of the proposal for the 30-day public comment period | | | | | | | | | | | 1 | | 1 |

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[14] Meetings were held in Burlington, Colorado Springs, Durango, La Junta, Limon, Montrose, Pueblo, Sterling, and Trinidad.

## Appendix M: Initial Measurement Areas

| Measurement Area | Performance Target | Incentive Payment Methodology |
|---|---|---|
| **Emergency room visits** per 1,000 full-time enrollees | Percentage improvement compared to the RCCO's own regional FFS baseline for the fiscal year or most recently available twelve-month period<br><br>Targets and baselines are developed using historical data. The SDAC establishes a RCCO-specific baseline using actual fiscal year FFS experience from previous year data.<br><br>**Level 1 Target:** Utilization below baseline but less than 5% improvement<br><br>**Level 2 Target:** Baseline utilization minus 5% or more | **Level 1:** 66% of full amount<br><br>**Level 2:** 100% of full amount<br><br>The full amount available for this measure is $.33 PMPM for the RCCO and $.33 PMPM for the PCMPs. |
| **Hospital re-admissions** per 1,000 full-time enrollees | Percentage improvement compared to the RCCO's own regional FFS baseline for the fiscal year or most recently available twelve-month period<br><br>Targets and baselines will be developed using historical data. The SDAC will establish a RCCO-specific baseline using actual fiscal year FFS experience from previous year data.<br><br>**Level 1 Target:** Utilization equal to or below baseline but less than 5% improvement<br><br>**Level 2 Target:** Baseline utilization minus 5% or more | **Level 1:** 66% of full amount<br><br>**Level 2:** 100% of full amount<br><br>The full amount available for this measure is $.33 PMPM for the RCCO and $.33 PMPM for the PCMPs. |
| **High-cost imaging** per 1,000 full-time enrollees | Percentage improvement compared to the RCCO's own regional per full-time enrollee utilization of Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, and X-rays for the fiscal year or most recently available twelve-month period<br><br>**Level 1 Target:** Utilization equal to or below baseline but less than 5% improvement<br><br>**Level 2 Target:** Baseline utilization minus 5% or more | **Level 1:** 66% of full amount<br><br>**Level 2:** 100% of full amount<br><br>The full amount available for this measure is $.33 PMPM for the RCCO and $.33 PMPM for the PCMPs. |

# Appendix N: Quality Measures for Medicare and Medicaid Clients

| Screening and Assessment | NQF Number | Other Uses |
|---|---|---|
| Flu shots for Adults Ages 50-64 (Collected as part of HEDIS CAHPS Supplemental Survey) | 39 | HEDIS, NCQA |
| Adult Weight Screening and Follow-up | | HEDIS, NCQA |
| Breast Cancer Screening | 31 | HEDIS, MU, NCQA |
| Diabetes: LDL screening | 63 | HEDIS, MU, NCQA |
| Comprehensive Diabetes Care: Hemoglobin A1c testing | 57 | HEDIS, MU, NCQA |
| Annual Monitoring for Patients on Persistent Medications | 21 | HEDIS, NCQA |
| **Care Coordination** | | |
| Plan All-Cause Readmission | | HEDIS, AHRQ |
| Acute Hospital Admissions per 1,000 member months | | |
| Psychiatric Hospital Admissions per 1,000 member months | | |
| Number of Skilled Home Care Visits per member per month | | |
| Average number of Prescriptions filled per member per month (not OTC) | | |
| PQI 01: Admissions for diabetes, short-term complications | 272 | AHRQ |
| PQI 05: Admissions for chronic obstructive pulmonary disease | 275 | AHRQ |
| PQI 08: Admissions for congestive heart failure | 277 | AHRQ |
| PQI 15: Admissions for adult asthma | 283 | AHRQ |
| Follow-up after Hospitalization for Mental Illness | 576 | HEDIS, NCQA |
| Controlling High Blood Pressure | 18 | HEDIS, MU, NCQA |
| **Quality of Life** | | |
| CAHPS Health Plan Survey v 4.0 - Adult Questionnaire | 6,7 | AHRQ, HEDIS, NCQA |
| Falls:  Screening for Fall Risk | 101 | CMS |
| Percentage of participants with advance directives | | |

## Appendix N: Quality Measures for Medicare and Medicaid Clients (cont'd.)

| Screening and Assessment | NQF Number | Other Uses |
|---|---|---|
| **Mental Health and Substance Abuse** | | |
| Screening for Clinical Depression and Follow-up Plan | 418 | CMS |
| Antidepressant Medication Management | 105 | HEDIS, MU, NCQA |
| Adherence to Antipsychotics for Individuals with Schizophrenia | | CMS |
| Medical Assistance with Smoking and Tobacco Use Cessation | 27 | CMS, HEDIS, MU, NCQA |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | 4 | HEDIS, MU, NCQA |
| **Structural Measures** | | |
| Voluntary Disenrollment Rate (excluding death) | | |

NQF = National Quality Forum
AHRQ = Agency for Healthcare Research and Quality
HEDIS = Healthcare Effectiveness and Data Information Set
MU = Meaningful Use
NCQA = National Committee for Quality Assurance

## Appendix O: Timeline and Activities

| Timeframe | Key Activities/Milestones | Responsible Parties |
|---|---|---|
| 2008 | Beginning of ACC Program planning process | The Department |
| November 2008 | Submission of formal budget action for ACC Program | The Department |
| March – June 2009 | Public stakeholder meetings on the ACC Program | The Department |
| April 2009 | Passage of Colorado Health Care Affordability Act | Colorado Legislature |
| July 2009 | Creation of scope of work and RFI for RCCOs | The Department |
| August 2010 | First posting of RFP for ACC Program | The Department |
| November 2010 | Posting of RFP for SDAC | The Department |
| April 2011 | Demonstration Contract awarded to Colorado to develop proposal to integrate care for dual eligible individuals | CMS |
| May 2011 | First enrollment of persons in ACC Program | The Department |
| August 2011 | Release of first round of ACC Program data | SDAC |
| January 2012 | ACC Program capacity expansion to 79 enrolled primary care practices with 1,600 providers and 75,000 enrolled clients | The Department, RCCOs, PCMPs |
| April – May 2012 | Dual Eligibles Demonstration proposal posted for 30-day comment period | The Department |
| May 2012 | Demonstration proposal revisions based on public comment and submission to CMS | The Department |
| Ongoing | General education and outreach to the public<br><br>• Regional, organizational, and individual meetings | The Department |
| Ongoing | Regional Care Collaboration Organization Outreach<br><br>• Preparation for enrollment of fully dual eligible individuals | RCCOs |
| June 2012 | Colorado's proposal posted for 30-day public comment period | CMS |
| June 2012 | Development of Dual Eligible Advisory Committee | The Department |
| July – August 2012 | Development of Memorandum of Understanding | The Department, CMS |

# Appendix O: Timeline and Activities (cont'd.)

| Timeframe | Key Activities/Milestones | Responsible Parties |
|---|---|---|
| September 2012 | Signing of Memorandum of Understanding | The Department, CMS |
| May – September 2012 | State Data Analysis <br> • Budget analysis <br> • Shared savings methodology <br> • Evaluation measures (RTI) | The Department, CMS, RTI |
| September 2012 | Public Notice (Tribal Leaders) | The Department |
| October 2012 | Final Agreement/State Plan Amendment | The Department, CMS |
| October – November 2012 | Readiness Review <br> • System testing | The Department, CMS |
| October – December 2012 | RCCO Contract Amendment Process | The Department, RCCOs |
| January 2013 | Beginning of Implementation Phase | The Department |

# Appendix P: Letters of Support

Letters of support will be compiled and accompany the proposal's submission to CMS in a separate Adobe Portable Document Format (PDF) file.

# Appendix Q: Implementation Support

Dedicated Department employees required to manage the Demonstration:

- **Project Manager** to oversee daily operation of the Demonstration
- **Program Specialist** to work with contractors, providers, and others to resolve program and client problems
- **ACC/Dual Eligibles Contract Manager** to work with RCCOs, behavioral health providers, and LTSS providers to manage contracts and ensure quality
- **Program Specialist** to conduct training and outreach, coordinate communications, and assist the first Program Specialist and Contract Manager
- **Program Assistant** to provide assistance to all areas of the Demonstration and its staff
- **Project Fiscal Officer** to analyze and maintain budget and accounting information, generate state and federal reports, and coordinate audit activities
- **Rates and Analysis Specialist** to manage the SDAC relative to dual eligible clients and provide oversight on analytics, data reports, and data quality
- **Systems Specialist** to manage changes to claims systems

Contracted services also needed for the Demonstration:

- **Statewide Data and Analytics Contractor** to conduct utilization analyses for dual eligible clients enrolled in the Demonstration through the ACC Program, to identify opportunities to improve care and care coordination, and to foster accountability and ongoing improvement among RCCOs and providers serving dual eligible clients
- **Rate Reform Contractor** to align Medicare payments, assess impact on the Medicaid program, assist with integration of other associated rate reform initiatives, and provide actuarial support for rate development and analyses
- **Communications Contractor** to develop effective communications strategies and simple, clear materials for dual eligible clients participating in the Demonstration
- **Evaluation and Program Improvement Contractor** to assess all aspects of the Demonstration and prepare reports that allow findings to guide continuous improvement throughout the project

Additional resources needed to support the Demonstration:

- **Convening Conferences and Travel** at statewide and regional levels to bring together clients, stakeholders, and partners with Departmental and ACC Program personnel to develop collaborative solutions to Demonstration implementation issues and to conduct appropriate outreach
- **Communications Materials** to support broad and ongoing outreach to all clients, stakeholders, partners, and providers
- **Education Materials** to provide information and training to all clients, stakeholders, partners, and providers

## Appendix R: Other HHS/CMS Initiatives

Aging and Disability Resource Center (ADRC)
Aging and Disability Resource Centers are made possible through a grant from CMS. Colorado's ADRC, located in Larimer County, is the Adult Resources for Care and Help (ARCH). The program's main goal is to streamline access to information and services for persons age 60 and over, or age 18 and over with a disability, who need information about long-term services and supports options. The Department plans to keep ARCH informed of the services it is providing to dual eligible individuals through the Demonstration and the ACC Program. ARCH is a trusted community partner and can be an important referral source for the Department's programs. ARCH may be helpful in reaching potential clients and explaining different options for long-term services and supports available to Medicaid clients, including options that are not facility-based. In reaching Medicaid clients who do not yet need long-term services and supports but are at risk of needing them, ARCH may be able to provide information about the services offered through the Demonstration.

Colorado Choice Transitions (Money Follows the Person)
The Department was awarded a five-year $22 million federal grant to implement the Money Follows the Person (MFP) Rebalancing Demonstration Program, called the Colorado Choice Transitions (CCT) program in Colorado. MFP is a federal grant that supports states' efforts to build and improve the infrastructure that supports home and community-based services (HCBS) for persons of all ages with long-term care needs. CCT supports the federal vision to transform long-term care services and support from facility-based and provider-driven care to person-centered, consumer-directed, and community-based care. The program will begin in the fall of 2012. By offering a comprehensive continuum of benefits and services to Medicaid-eligible clients participating in the program, the Department is committed to transitioning nearly 500 individuals from facility-based care into community-based settings by the year 2016.

Comprehensive Primary Care Initiative (CPCI)
The Comprehensive Primary Care Initiative (CPCI) is a multi-sector initiative designed to improve the use of and access to higher quality, better coordinated, and client-centered primary care. Colorado has been selected to participate in this initiative, which will provide an additional opportunity for the Department to support more comprehensive care coordination and medical home services. To continue fostering the alignment and integration of Colorado's health care initiatives, the Department will also require practices selected for CPCI to be part of the ACC Program. Dual eligible clients in CPCI will be included in Medicare's payment and excluded from Medicaid's payment. Also, to maintain separation and accountability, dual eligible clients in CPCI will not be included in the Demonstration. In the coming months, the Department and CPCI providers will continue to work through additional details.

Partnerships for Patients
Sponsored by the U.S. Department of Health and Human Services, Partnerships for Patients is a public-private partnership with two primary goals: to reduce hospital-acquired conditions and to reduce hospital re-admissions. CMS implemented two initiatives through this Partnership, the Hospital Engagement Networks and the Community-based Care Transitions Program (CCTP). CCTP offers funding to community-based organizations to develop care transition models for

high-risk Medicare beneficiaries. Organizations in Colorado are planning to apply for funding under CCTP. In addition to the Department, numerous Colorado hospitals, clinicians, providers, health plans, consumers, communities, client advocacy groups, employers, unions, and local governments have already pledged their support for the program's goals. CCTP provides short-term support for Medicare enrollees who are leaving the hospital. If funding is received, the Department will encourage the organizations providing the Care Transitions Intervention to refer Medicaid-Medicare enrollees to the services and supports available through the Demonstration.

Pioneer Accountable Care Organizations (ACOs)
Pioneer ACOs are an initiative of the CMS Innovation Center. In Colorado, Physician Health Partners, along with its strategic partner independent practice associations, was selected to participate in the Pioneer ACO model. As an alternative to the traditional ACO model, the Pioneer ACO model was designed for organizations with experience in providing high-quality, client-centered, coordinated care. Colorado's Pioneer ACO currently serves approximately 28,000 Medicare fee-for-service clients.  Of that population, a number of those individuals are expected to be fully dual eligible. In continuing to develop this Demonstration, the Department will work with Physician Health Partners to explore potential areas of collaboration.

Section 2703 of the Affordable Care Act: State Option to Provide Health Homes for Enrollees with Chronic Conditions
The Department is currently considering how to best utilize its Medicaid State Plan option to provide health homes for enrollees with multiple chronic conditions, as created by Section 2703 of the Affordable Care Act. The health homes benefit is an opportunity for states to better integrate and coordinate services for Medicaid beneficiaries with chronic illness. The State Demonstration to Integrate Care for Dual Eligible Individuals will include a number of persons with chronic illness. Almost 30,000 fully dual eligible clients in Colorado have one or more chronic conditions. The Department will consider the Demonstration during the planning process for the Section 2703 health homes option. One possible use of the health homes option would be to incorporate the new benefit into the existing ACC Program. As the ACC Program, the Demonstration, and other state initiatives continue to develop, the Department will evaluate how to incorporate the health homes option into the overall strategy for care coordination and integration.