

**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**



**April 13, 2012**

**Draft for Public Comment**

## Table of Contents

Executive Summary .....	4
B. Background .....	6
i. Vision and rationale .....	6
ii. Description of the population.....	10
C. Care Model Overview .....	11
i. Delivery system elements .....	11
ii. Benefit design .....	16
iii. Ancillary and supportive services .....	17
iv. Evidence-based practices .....	18
v. Context of Medicaid services and other CMS initiatives .....	20
D. Stakeholder Engagement and Beneficiary Protections .....	22
i. Stakeholder engagement in the design phase.....	22
ii. Beneficiary protections .....	24
iii. Ongoing stakeholder input.....	26
E. Financing and Payment .....	26
i. State-level payment reforms .....	26
ii. Payment methodology .....	28
F. Expected Outcomes.....	29
G. Infrastructure and Implementation.....	31
i. Capacity to implement and oversee .....	31
ii. Need for waivers .....	32
iii. Expansion plans .....	32
iv. Overall implementation strategy and anticipated timeline.....	33
H. Feasibility and Sustainability.....	34
i. Potential barriers, challenges, and future actions.....	34
ii. Statutory or regulatory changes .....	36
iii. Funding commitments or contracting processes .....	36
iv. Scalability and replicability.....	36
v. Letters of support .....	37
J. Additional Documentation .....	38
K. Interaction with Other HHS/CMS Initiatives .....	38
Appendix A: Glossary of Terms and Acronyms .....	41
Appendix B: Stakeholder Engagement Activities .....	46

Appendix C: Map of Colorado Counties and RCCOs .....	48
Appendix D: Population by RCCO and Percent of State Population .....	49
Appendix E: Workplan and Timeline .....	50
Appendix F: Quality Measures for Medicare and Medicaid Clients .....	52
Appendix G: Budget Request .....	54
Appendix H: Letters of Support.....	55

## 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, increased costs, and less positive experiences of care from both client and provider perspectives. 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. 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 an array of care options in which clients can participate. The Department's Demonstration utilizes its established Accountable Care Collaborative Program (ACC Program), a managed fee-for-service (FFS) program already providing care for Medicaid clients throughout the state, and builds upon it 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.

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, medical homes, and data analytics through an existing program. Described in more detail elsewhere in this Demonstration, 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). In the realm of behavioral health, RCCOs will be 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.

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 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, focus groups, and data analyses. Finally, the Department will develop consumer-input processes as well as systems to monitor and measure the level of care provided to fully dual

eligible individuals. Table 1 below highlights the main features of the Department’s Demonstration.

**Table 1. Demonstration Proposal Features**

<b>Target Population</b>	All full-benefit Medicare-Medicaid enrollees
<b>Total Number of Full-Benefit Medicare-Medicaid Enrollees Statewide</b>	69,787 <sup>1</sup>
<b>Total Number of Beneficiaries Eligible for Demonstration (Estimated)</b>	59,982 <sup>2</sup>
<b>Geographic Service Area</b> (Statewide or listing of pilot service areas)	The model is statewide.
<b>Summary of Covered Benefits</b>	<ul style="list-style-type: none"> <li>• Medicare Parts A, B, &amp; 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>
<b>Financing Model</b>	Managed FFS
<b>Summary of Stakeholder Engagement/ Input</b> (See Section D for more details.)	<ul style="list-style-type: none"> <li>• 5 stakeholder meetings hosted in Denver with toll-free call-in options (June 2011 – March 2012)</li> <li>• 5 ongoing workgroups regularly meeting in Denver with toll-free call-in options (December 2011 – March 2012)</li> <li>• 9 area meetings across the state (February 2012 – March 2012)</li> <li>• 45 presentations to and conversations with individual stakeholders and specific organizations (June 2011 – March 2012)</li> <li>• Dual Eligible Demonstration Contract web page on the Department’s Web site</li> <li>• Toll-free question/comment hot line</li> </ul>
<b>Proposed Implementation Date(s)</b>	2013

<sup>1</sup> 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.

<sup>2</sup> The difference between 69,787 and 59,982 is attributable to the approximate number of dual eligible clients who are 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. The difference also includes the approximate number of dual eligible clients currently enrolled in a Special Needs Plan (SNP) but does not include the number of dual eligible clients in nursing facilities.

## **B. Background**

### **i. Vision and rationale**

The Department envisions creating a fully integrated model of care for those dually eligible for Medicare and Medicaid by using its existing managed FFS program, the ACC Program. Colorado, like other states, has been struggling to manage the complex needs of dual eligible clients in a fragmented delivery system that lacks integration of benefits and services from client and provider perspectives. This fragmented system also lacks integration of data and payment from provider and payer perspectives. Incentives 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 medical home that proactively coordinates the health needs of each member and is designed to meet the needs of dual eligible clients.

The 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.

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. 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 began in May 2011.

The ACC Program's two central goals are to improve health outcomes of Medicaid clients through a coordinated, client/family-centered system by proactively addressing clients' health needs, whether simple or complex, and to control costs through reducing avoidable, duplicative,

variable, and inappropriate use of health care resources. The Department recognizes that significant changes to the delivery of health care services to Medicaid clients are essential to maximize their health, functioning, and independence. 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.

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform. Its design supports a paradigm 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 FFS system.

Differing from a capitated managed care program, the ACC Program is designed to directly invest in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The 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 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

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.

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); 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.

One of the core tenets of the ACC Program is collaboration, including collaboration between the Department and the RCCOS, collaboration among the RCCOS, and collaboration among the different delivery systems that serve Medicaid clients, such as behavioral health and LTSS. This collaboration is supported by the Department, and the RCCOs and PCMPs are held accountable for collaboration in their contracts.

The Department continues to engage stakeholders through the ACC Program Improvement Advisory Committee and its four subcommittees: Delivery System Integration, Quality Health Improvement, Provider and Community Relations, and Payment Reform. 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.

Additionally, two monthly operations meetings 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. By including dual eligible individuals in the ACC Program, the Department will be able to leverage existing resources to meet new challenges.

## **ii. Description of the population**

Currently, 620,542 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). 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. Total state expenditures for fully dual eligible individuals in Colorado exceeded \$1.1 billion in 2011.

The Department’s Demonstration focuses on integrating care for fully dual eligible individuals. In fiscal year 2011,<sup>3</sup> 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%).

---

<sup>3</sup> Colorado’s fiscal year refers to each twelve-month period beginning on July 1 and ending on June 30.

- 42,033 individuals (58%) were over the age of 64; 27,615 individuals (41%) 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” (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.

**Table 2. Size of Demonstration’s Target Population**

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings	Individuals with no LTSS utilization
Overall Total	69,787 (100%)	10,533 (15%)	23,081 (33%)	36,174 (52%)
Individuals age 65+	42,033 (100%)	9,161 (22%)	11,941 (28%)	20,931 (50%)
Individuals under age 65	27,754 (100%)	1,375 (5%)	11,138 (40%)	15,242 (55%)
Individuals with serious mental illness	5,256 (100%)	545 (10%)	2,212 (42%)	2,500 (48%)

## C. Care Model Overview

### 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.

#### Enrollment Method

The Department envisions the Demonstration as part of an array 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. Also, the Department is still exploring if it is possible to exclude all clients enrolled in a Special Needs Plan (SNP) from the Demonstration and if nursing facility clients will be included in 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. Critical to the passive enrollment process is that all individuals receive advance notice and have sufficient time and opportunity to make an informed choice. 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 period every year.

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, behavioral health, and LTSS. 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. 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. RCCOs will continue to develop awareness of which community providers are relevant to persons with physical and developmental disabilities and how their services can be 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 care 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.

#### 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 Demonstration 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 will amend RCCO contracts to facilitate 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.

### 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. Currently, 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 cover prescription drugs needed to treat a behavioral health condition.

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 relationship 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. Such a model will be simple for the Department to implement quickly. Contractual arrangements between RCCOs and BHOs will also address the inclusion of behavioral health providers as part of the broader health care team along with the Primary Care Medical Provider (PCMP).

Other protocols can enhance the medical home model by including behavioral health providers as part of all primary care teams. For example, such protocols could be 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.

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 at 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.

### Long-Term Services and Supports (LTSS)

Unlike the population comprising current ACC Program enrollment, a percentage of dual eligible individuals will be significant users of LTSS. Particularly at transition points between Medicaid and Medicare and during transitions in care settings, many opportunities exist to improve coordination of LTSS and other care, client outcomes, and client experience of care.

For example, at transition points between acute Medicare and post-acute Medicaid care, LTSS is critically important. Opportunities exist to achieve the goals of improved care coordination, outcomes, and client experience of care while reducing unnecessary costs at these transition points. As part of this Demonstration, the Department will work with RCCOs to implement initiatives and activities that help achieve these goals. As an example, the Department will work with RCCOs to develop and implement more streamlined processes to assist clients with Medicaid eligibility applications.

Clients accessing Medicare post-acute services in Skilled Nursing Facilities (SNFs) are another point for providing LTSS in the most appropriate, least restrictive setting. Discharging residents to the community requires early intervention because, by the time many residents become eligible for Medicaid, the odds of community reintegration are low. 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. For example, including Single Entry Points (SEPs), Community Centered Boards (CCBs), Area Agencies on Aging, and home health providers could support ongoing monitoring activities for clients to prevent emergency department visits as well as hospital admissions or readmissions. 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 clients' health and experience of care. Already, RCCOs are working to assist providers in communicating effectively, for example, by 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.

### **ii. Benefit design**

The Department's Demonstration will include the full array 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 duplication of medications and polypharmacy, taking more medications than needed. The Department is working with CMS to obtain Medicare Part D data for its dual eligible clients. In addition, the Department will continue to collaborate with CMS and other partners and stakeholders to explore proactive solutions in this area for the purposes of improving care coordination, health outcomes, and quality of care for dual eligible clients in the Demonstration.

### **iii. Ancillary and supportive services**

The Department does not anticipate offering different services. 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.”<sup>4</sup> This includes care coordination to fill gaps in the current health care delivery system by identifying the range of clients’ medical, behavioral, and social service needs and removing barriers to meeting those needs that exist in current systems of care.

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. Each dual eligible individual in the Demonstration will have access to a multidisciplinary, team-based approach to care with the individual’s input vital to assembling the appropriate care team.

---

<sup>4</sup> 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.

A typical care team may consist of a lead primary care or behavioral health clinician, other supporting providers such as home health organizations, as well as community-based organizations such as Single Entry Points (SEPs), Community Centered Boards (CCBs), and other LTSS agencies as appropriate. This typical care team will be adjusted or expanded to support the individual's person-centered care plan. RCCO infrastructure and systems support expanded care teams. Each care team member will have a defined role appropriate to licensure and relationship to the client. Collectively, the team will share responsibility for coordinating care that meets 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 within existing systems of care to achieve a more effective and streamlined approach.

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 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 care team to arrange all necessary community-based LTSS and other community services, such as housing.

#### **iv. Evidence-based practices**

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.

A major 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 implement a global readmission program to offer provider incentives to support the goal of reducing readmissions.

RCCOs are already beginning to implement care transition programs that incorporate evidence-based processes and programs that aim to reduce preventable readmissions. As part of this Demonstration, the Department will continue to encourage increased use of these types of initiatives and programs.

Since early 2011, a work group 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. 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 Measure (CTM)* consists of 15 one-dimensional items to assess care transition quality. The primary objective is the development of a measure that is substantively and methodologically consistent with the concept of person-centeredness and is useful for performance measurement and public reporting.
- *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.
- *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:
  - 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;
  - assisting clients with making and keeping follow-up appointments and organizing post-discharge services;
  - ensuring that medication plans are correct and that the client fully understands the plans;
  - ensuring that discharge plans are aligned with national guidelines;
  - ensuring that complete and accurate discharge paperwork is provided to discharge physicians and other providers quickly; and
  - 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.

Additionally, the Department will continue to measure readmissions and changes in readmission rates. The Department is incorporating an incentive payment into the ACC Program's payments that will include readmission rates as one measure.

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

##### 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. Like other Medicaid clients, dual eligible clients will receive their behavioral health services through a Behavioral Health Organization (BHO) as authorized under a 1915(b) waiver.

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 the following 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.

- *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 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, 7 days a week, 365 days a year. ACT teams provide case 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.

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, are 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 state plan but may 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. Also, the Department is still exploring if it is possible to exclude all clients enrolled in a Special Needs Plan (SNP) from the Demonstration and if nursing facility clients will be included in or excluded from the Demonstration. The Department envisions the Demonstration to be part of an array of care 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.

#### Other CMS Payment and Delivery Initiatives

The Demonstration incorporates elements from other CMS initiatives, such as the Money Follows the Person 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 September 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**

### **i. Stakeholder engagement in the design phase**

The Department is committed to ongoing stakeholder and partner engagement to inform further development and the eventual implementation of the Demonstration. Currently, more than 550

individuals representing over 200 organizations comprise the primary stakeholder list. As the Department moves to finalize the proposal for submission to CMS, it will continue to engage stakeholders and partners in a variety of ways.

#### Stakeholder Engagement in the Initial Phases

The Department has utilized a variety of mechanisms to engage a wide range of stakeholders and partners throughout the initial stages of proposal development. Many types of meetings have been convened, including five large public meetings for all interested stakeholders hosted in Denver with a toll-free call-in option. These meetings were intended to bring any and all stakeholders together to hear the same information and have an opportunity to be part of a larger group conversation about the project. 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. Additionally, the Department held nine regional meetings in areas across the state and made 45 presentations to individual stakeholders and specific organizations.

The Department has placed significant emphasis on stakeholder and partner involvement through developing and facilitating workgroups. Workgroup participants have collaborated since December 2011 to share ideas and to develop recommendations for the Department throughout the planning phase. Participants' diverse backgrounds and experiences have contributed to thoughtful conversations and productive recommendations. Workgroups have been organized into the following five categories:

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

Thus far, each workgroup has met four to five times, for a total of 24 meetings. Appendix B provides a table to summarize all stakeholder activities that have occurred in the Demonstration's initial phases.

#### A Narrative Timeline

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 Department hosted a third full stakeholder meeting, which was primarily devoted to listening to and considering stakeholder input. The Department then solicited voluntary stakeholder participation for five workgroups whose tasks included sharing ideas, developing input, and making specific recommendations to inform the proposal for CMS.

In January 2012, during the fourth full stakeholder meeting, stakeholders reviewed the summary of workgroup input and recommendations to date in addition to discussing a preliminary draft of the Demonstration proposal. By the end of February 2012, the Department had conducted nine regional meetings across the state in frontier, rural, and other urban areas. During that time, the Department also continued to solicit comments, feedback, and additional recommendations from workgroups, regional meeting participants, individuals, and organizations.

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 continue to dialogue with the Department about the Demonstration.

Finally, the Department is posting the Demonstration proposal for a thirty-day public comment period on its Web site and distributing the proposal draft to all persons on its stakeholder list. The Department will review all comments and incorporate them, as appropriate, into the final Demonstration proposal prior to submission to CMS.

#### Web Site and Toll-Free Number

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 is also hosting 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.

#### **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 they be amended or corrected.

In addition to these 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

As do all participants in the ACC Program, fully dual eligible individuals will have the option to select their 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 participant, 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, establishing informal agreements with ancillary providers is a high priority for the RCCOs.

#### Complaints, Grievances, and Appeals Process

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

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 have 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 when CMS decides to do so.

### **iii. Ongoing stakeholder input**

The Department will continue to gather and incorporate input from stakeholders and partners during the implementation and operational phases of this Demonstration. All existing infrastructure, such as the Department's Web site and toll-free number, will remain in place to help inform individuals about the Demonstration.

Additionally, the Department will continue to host stakeholder and workgroup meetings and conduct statewide outreach. The ACC Program Improvement Advisory Council is expanding its membership to include one representative from the dual eligible stakeholder community. To find additional ways to foster collaboration and mutual understanding, the Department will continue to work with stakeholders to evolve its activities around the Demonstration.

When the Demonstration is approved for implementation, the Department will work with stakeholders and CMS to develop relevant public outreach, education, and training materials. The Department will ensure that all materials and communications are reflective of and sensitive to the diverse needs of the clients.

## **E. Financing and Payment [Additional Detail To Be Added]**

### **i. State-level payment reforms**

Numerous projects that directly and indirectly address payment reform are currently in progress. 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. Additionally, the ACC Program provides the framework for the Demonstration to integrate care for dual eligible clients, reduce redundancies, and achieve savings in the system. This section outlines the current state of payment reform and the projected payment model the Department intends to pursue.

#### Colorado Hospital Quality Incentive Payment (HQIP)

The Colorado Hospital Oversight and Advisory Board (OAB) voted to implement an HQIP program for participating Medicaid providers in the spring of 2011. The HQIP program promotes quality, reduces cost, and creates more efficient processes. The proposal presented by the Colorado Hospital Association (CHA) and the Department was the result of collaboration between the two organizations and hospital representatives with expertise in quality measurement and hospital payment. The proposal developed by the HQIP Committee was the result of its efforts to identify measures and methodologies that apply to care provided to Medicaid clients, adhere to the Value-Based Purchasing (VBP) principles, as established by CHA, maximize participation in the Medicaid program, and minimize the number of hospitals that would not qualify for selected measures. The proposed HQIP measures for the first payment year included (1) Central Line Associated Blood Stream Infections (CLABSI), (2) Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT), (3) Elective Delivery Prior to 39

Weeks, and (4) Structured Efforts to Improve Care Transitions and Reduce Readmissions. The expected payments for fiscal year 2013 are \$32 million.

#### Nursing Facility Pay for Performance (P4P) Programs

In fiscal year 2009, the Department made a transformational change in the way it pays nursing facility providers for performance. The Department adopted a P4P program, which offers financial incentives to providers that offer high levels of quality of life and care. During calendar year 2011, 109 nursing home providers submitted P4P applications, up 39.7% from the previous year total of 78.

#### The Accountable Care Collaborative (ACC) Program

The two central goals of the ACC Program are to improve 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 ACC Program focuses 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; and (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.

#### Readmission Reduction Program

As mentioned in the subsection on evidence-based practices, the Department will continue to work with hospitals to explore investment in programs like Care Transitions Measure (CTM), Project Re-Engineered Discharge (RED), and/or Transitional Care Models (TCMs) to reduce readmissions. Additionally, as part of the ACC Program, the SDAC will work to publicly report data critical to the success of preventing hospital readmissions. The ACC Program, and, therefore, this Demonstration, may implement a payment incentive for facilities that exhibit favorable readmission rates, and SDAC data will be leveraged for this purpose. Additionally, the Department is exploring implementing a Community Care Transition Program (CCTP) within each RCCO. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measureable savings to the Medicare program.

#### Emergency Department Diversions

The Department is also focusing on emergency department diversions. The ACC Program and the data provided by the SDAC provide the necessary structure to enable the Department, RCCOs, and providers to monitor emergency department use across the state. RCCOs are developing emergency department diversion programs that incorporate best practices. Over the next year, the Department will continue to work with the RCCOs to explore and implement additional initiatives to reduce unnecessary emergency department usage. Additionally, beginning in fiscal year 2011-2012, the Department will be paying an incentive to RCCOs and Primary Care Medical Providers (PCMPs) based on reductions in unnecessary emergency department usage and other measures.

### Hospital Medicaid Rate Reform

The Department has outlined an ambitious rate reform schedule and implemented a rate reform effort for Medicaid hospital services in January 2011. Specifically, the Department is looking to (1) convert from the CMS Version 24 Diagnosis-related group (DRG) system to an all-patient refined (APR) DRG model for inpatient acute services; (2) update the current cost-based outpatient methodology to a model based on ambulatory payment classifications (APCs) or enhanced ambulatory patient groups (EAPGs); and (3) rebase critical access hospitals (CAHs), pediatric hospitals, long-term acute care (LTAC) hospitals, and inpatient rehabilitation facilities (IRFs). Inpatient hospital rates should be updated during fiscal year 2013 and outpatient hospital rates during fiscal year 2014.

#### **ii. Payment methodology**

##### Managed Fee-For-Service (FFS) Approach

The Department will pursue a managed FFS model for the Demonstration. In this model, all Medicare-covered benefits for acute physical care and post-acute care are provided in accordance with existing Medicare FFS rules. Medicaid-covered acute care wraparound services, as well as LTSS, are provided in accordance with the requirements in the approved Medicaid state plan and applicable HCBS waivers. This approach builds upon the existing FFS delivery system, including the significant investment of resources to organize the delivery system to provide coordinated care for Medicaid clients through the ACC Program.

##### Cost Savings

Cost savings for the Demonstration will be achieved by adopting the principles of the ACC Program. The Department anticipates incorporating gain-sharing payments into the ACC Program contingent upon funding sources, which is similar in concept to the ACO shared savings model in Section 3022 of the Affordable Care Act (ACA). The RCCOs, serving as Accountable Care Organizations (ACOs), are charged with network development, provider support, and medical management. By implementing structured care coordination approaches, the Department has established a system that will lead to better quality and lower cost. The same cost-saving philosophy will be applied to the Demonstration. Savings as a result of the improvement in quality and cost for dual eligible clients may be shared across the two payers; may be utilized to generate provider incentives to continually improve care, outcomes, and client satisfaction with care; and/or may pay for additional client benefits.

Cost savings will be defined by calculating the actual expense of the program under traditional FFS payment methods versus payments under the new rate and reimbursement structure. This will require demonstrating what the payments would be for Medicare and Medicaid under the traditional FFS program. This expense amount will be compared to the actual payments made under the Demonstration. 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.

##### Cost Sharing between Medicare and Medicaid

For Medicaid-only participants, the ACC Program is financed through anticipated savings to the Medicaid program. For dual eligible clients, the Department envisions a similar financing

strategy that relies on both Medicaid and Medicare savings to finance the cost of the ACC Program model for dual eligible enrollees.

The Department envisions a shared risk model, where both the Medicaid program and Medicare program provide a share of the upfront cost of running the Demonstration. The Department assumes the savings will exceed the limited cost of operations and assumes that savings will be pooled between the Medicare and Medicaid programs and returned to each commensurate with the investment each has made in those costs of operations.

#### Risk Adjustment across RCCOs

Data related to the dual eligible population will be risk scored to identify variation among RCCOs and providers. The SDAC currently uses 3M's Clinical Risk Groups (CRGs) to identify acute care risk scores for individuals and providers. Additionally, the Department plans to integrate functional assessment data from LTSS systems as well although it recognizes that this may not happen immediately.

## **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. The Department expects to see reduced hospital admissions and readmissions, reduced use of emergency rooms, greater use of medical homes, reductions in 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, 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<sup>5</sup>**

Categories	Principles
Desired Effects of Measurement	<ul style="list-style-type: none"> <li>• Promoting Integrated Care</li> <li>• Ensuring Cultural Competence</li> <li>• Health Equity</li> </ul>
Measurement Design	<ul style="list-style-type: none"> <li>• Assessing Outcomes Relative to Goals</li> <li>• Parsimony</li> <li>• Inclusivity</li> <li>• Avoiding Undesirable Consequences of Measurement</li> </ul>
Data Platform Principles	<ul style="list-style-type: none"> <li>• Data Sharing</li> <li>• Using Data for Multiple Purposes</li> <li>• Making the Best Use of Available Data</li> </ul>

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 F. 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

<sup>5</sup> 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](http://www.qualityforum.org/Setting_Priorities/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx).

adjust claims data, define appropriate quality metrics, and create a collaborative data-sharing environment. Based on agreements with CMS, the Department will receive historical and prospective Medicare data. 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 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 and its expected reduction of Medicare and Medicaid expenditures.

## **G. Infrastructure and Implementation**

### **i. Capacity to implement and oversee**

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 robust 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
- Teri Bolinger, MA, MPA, Dual Eligibles Project Manager
- Kirstin Michel, MPA, Dual Eligibles Policy and Stakeholder Specialist
- 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. Additionally, the Department's Medicaid Director Suzanne Brennan provides support to the Demonstration.

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

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.

## **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 the differences between Medicare and Medicaid remain confusing and problematic for those individuals who are dual eligible. Two frequently cited examples are home health and behavioral health, 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.

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.

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.

## **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**

From May 2011 through March 2012, the Department has enrolled more than 110,000 persons in its ACC Program. After CMS approves the Demonstration’s implementation, the Department will begin to gradually enroll dual eligible individuals in 2013. 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, or Rocky Mountain Health Plan. Also, the Department is still exploring if it is possible to exclude all clients enrolled in a Special Needs Plan (SNP) from the Demonstration and if nursing facility clients will be included in or excluded from the Demonstration.

The voluntary passive enrollment process means that clients will be automatically enrolled into the ACC Program but can choose another program or delivery system if they wish as required by 42 CFR Section 438.52. Critical to the passive enrollment process is that all individuals receive advance notice and have sufficient time and opportunity to make an informed choice. 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 period every year.

The Department anticipates no additional infrastructure to be required in 2012. However, the Department will submit a request to CMS for infrastructure funding to support implementation, which is contingent upon approval of its Demonstration proposal by CMS.

The following table lists key activities related to the Demonstration, including those of the ACC Program, and demonstrates a unique position to be successful in integrating care. All key activities are identified as Department responsibilities except for those CMS responsibilities related to processing the Demonstration.

**Table 3. Timeline and Activities**

<b>Timeframe</b>	<b>Key Activities</b>
2008	ACC Program planning process
November 2008	ACC Program formal budget action submission
March – June 2009	ACC Program public stakeholder meetings

<b>Timeframe</b>	<b>Key Activities</b>
April 2009	Passage of the Colorado Health Care Affordability Act
July 2009	RFI for RCCOs
August 2010	RFP for RCCOs
September 2010	RFP for the SDAC
December 2010	Selection of RCCOs
January 2011	Selection of the SDAC
April 2011	CMS contract with the Department for the Demonstration Proposal to Integrate Care for Dual Eligible Individuals
May 2011	Enrollment of the first Medicaid clients into the ACC Program
August 2011	The SDAC's release of the first ACC Program data
March 2012	ACC Program expansion to 79 primary care practices with over 1,500 providers and more than 110,000 enrolled clients
April 2012	Demonstration Proposal's posting for 30-day comment period by the Department
May 2012	Demonstration Proposal's revisions based on public comment and submission to CMS
May 2012	Demonstration Proposal's posting for thirty-day comment period by CMS
Late Summer and Fall 2012	Evaluation of the Demonstration Proposal by CMS, the Innovation Center, and the Coordinated Health Care Office, negotiation of a Memorandum of Understanding, and issuance of a Contract Implementation Amendment upon approval
2013	Implementation (pending CMS approval)

## **H. Feasibility and Sustainability**

### **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.

- *Coordination with existing systems of care* - Other 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* – The Department and stakeholders are in the early stages of exploring the inclusion of nursing facility clients in the Demonstration. The Department is beginning meetings with nursing facilities 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 would like to discuss supports the Demonstration and the ACC Program could provide to gerontologists and nursing facilities relative to additional care coordination efforts. In the month ahead and on an ongoing basis, the Department and stakeholders will continue to address concerns 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 is excluding from 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 that would need to be considered within the context of assuring the continued financial viability and success of the overall 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 110,000 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 provides for excellent replicability to other states. The model is designed to meet the varying needs of different communities as it has been doing across Colorado, which is 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 program 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 in Appendix H.

### **I. CMS Implementation Support – Budget Request**

The Department's budget request for this Demonstration is detailed in Appendix G. Major funding areas are outlined below.

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 all RCCOs, long-term services and supports providers, and behavioral health 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 all Demonstration staff
- *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 personnel 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 provide actuarial support for rate development and analyses

- *Enrollment Broker* to develop new materials for dual eligible clients enrolled in the Demonstration, including welcome letters and new member materials, to support postage, and to provide enrollment assistance to clients

Additional resources in various media needed to support the Demonstration:

- *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

## **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 Medicare-Medicaid enrollees. The Department's goal is to align and synthesize various initiatives, directing these resources toward a single focus: providing high quality, coordinated, whole-person care. The lessons learned and relationships developed through these other initiatives are intangible but essential resources for this proposed project. Below is a description of the existing initiatives that the Department will build upon for this Demonstration.

### 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 September 2012. By offering a comprehensive array of benefits and services to Medicaid-eligible clients participating in the program, the Department is committed to transitioning 490 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. In the coming months, the Department will work to determine exactly how CPCI will intersect with the Demonstration.

#### 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.

## **Appendix A: Glossary of Terms and Acronyms [To be cross walked to document]**

**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, 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.

**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.

**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.

**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.

**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 array 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.

**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 a family-centered approach to providing quality, cost effective health care that offers comprehensive, continuous, coordinated, accessible, compassionate, and culturally competent care.

**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 automatically 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.

**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.

**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.

**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.

**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: Stakeholder Engagement Activities<sup>1</sup>

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 <sup>2</sup>	1				1		1	1		1	1		6
Meetings with organizations, individuals, and Department personnel			1	1	5	4	11	11	6	7			46
Workgroup: Communication (Outreach and Information)							2		1	1			4
Workgroup: Coordination of Care							2	1	1	1			5
Workgroup: Behavioral Health							1	2	1	1			5
Workgroup: Developmental Disabilities							2	1	1	1			5
Workgroup: Financing Strategies and Quality Medical Outcomes							2	1	1	1			5

<sup>1</sup>The number provided in each cell indicates the number per month.

<sup>2</sup> 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.

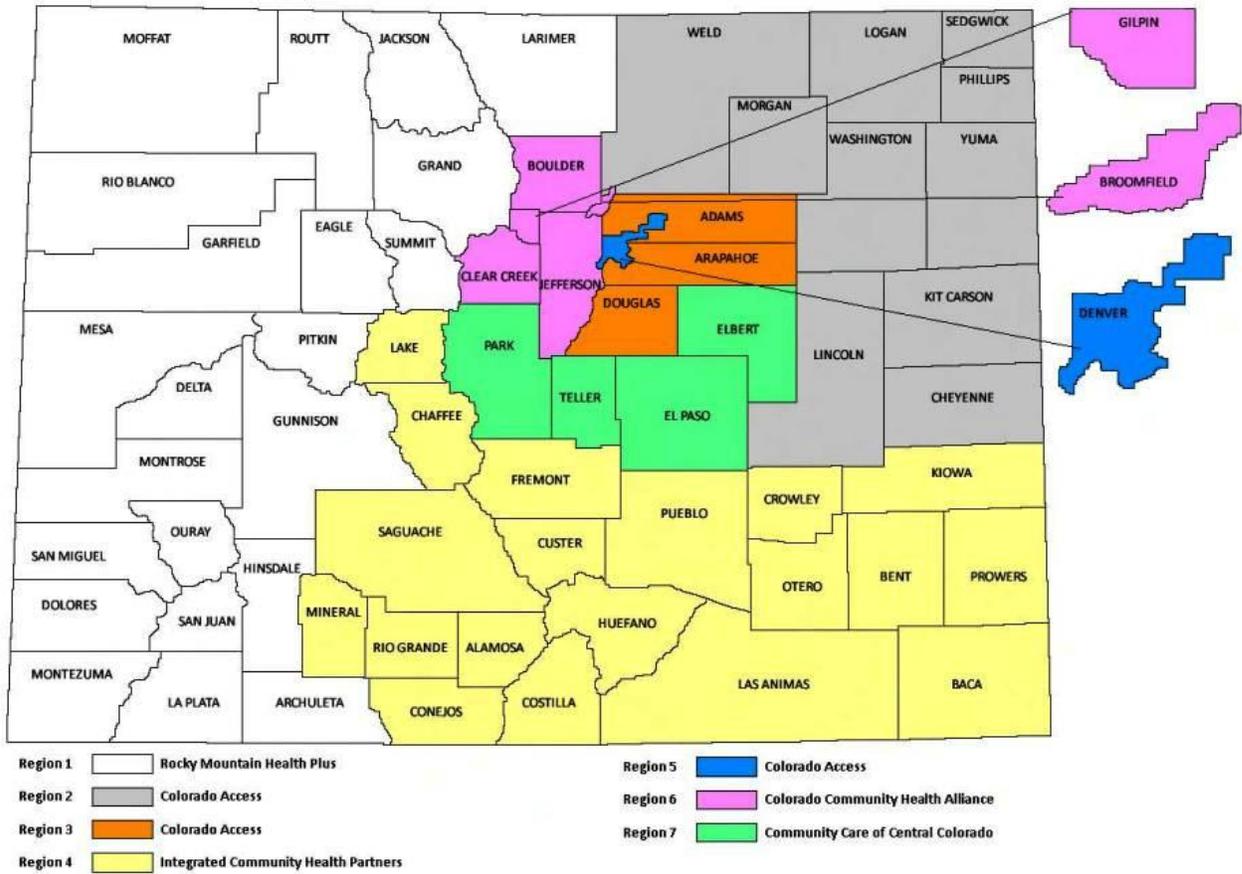
**Appendix B: Stakeholder Engagement Activities (cont'd.)**

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 <sup>3</sup>									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

<sup>3</sup> Meetings were held in Burlington, Colorado Springs, Durango, La Junta, Limon, Montrose, Pueblo, Sterling, and Trinidad.

# Appendix C: Map of Colorado Counties and RCCOs

Colorado's Accountable Care Collaborative  
Regional Care Collaborative Organization Map



## Appendix D: Population by RCCO and Percent of State Population

ACC Region	2010 Total State Population	Percent of State Population (2010)	Percent of State Dual Eligibles (FY2011)
<b>RCCO 1</b>	808,170	16.1%	15.7%
<b>RCCO 2</b>	340,944	6.8%	7.5%
<b>RCCO 3</b>	1,299,071	25.8%	18.6%
<b>RCCO 4</b>	396,420	7.9%	16.3%
<b>RCCO 5</b>	600,158	11.9%	18.4%
<b>RCCO 6</b>	899,528	17.9%	13.5%
<b>RCCO 7</b>	684,905	13.6%	10.0%
<b>Colorado</b>	<b>5,029,196</b>	<b>100.0%</b>	<b>100.0%</b>

Source of 2010 State Population Data: 2010 U.S. Census figures

## Appendix E: Workplan and Timeline [More Detail To Be Added]

Timeframe	Key Activities
2008	ACC Program planning process
November 2008	ACC Program formal budget action submission
March – June 2009	ACC Program public stakeholder meetings
April 2009	Passage of the Colorado Health Care Affordability Act
July 2009	RFI for RCCOs
August 2010	RFP for RCCOs
September 2010	RFP for the SDAC
December 2010	Selection of RCCOs
January 2011	Selection of the SDAC
April 2011	CMS contract with Colorado for the Demonstration Proposal to Integrate Care for Dual Eligible Individuals
May 2011	Colorado’s enrollment of the first Medicaid clients into the ACC Program
August 2011	The SDAC’s release of the first ACC Program data
March 2012	ACC Program expansion to 79 primary care practices with over 1,500 providers and more than 110,000 enrolled clients
April - May 2012	Demonstration Proposal’s posting for 30-day comment period by the Department

## Appendix E: Workplan and Timeline (cont'd.)

The following illustrates an approximation of work to be completed in the future. Additional details will be included in the final version of the Demonstration submitted to CMS.

<b>Timeframe</b>	<b>Key Activities</b>
May 2012	Demonstration Proposal's revisions based on public comment and submission to CMS
May - June 2012	Demonstration Proposal's posting for thirty-day comment period by CMS
Late Summer and Fall 2012	Evaluation of the Demonstration Proposal by CMS, the Innovation Center, and the Coordinated Health Care Office, negotiation of a Memorandum of Understanding, and issuance of a Contract Implementation Amendment upon approval
2013	Implementation (pending CMS approval)

## Appendix F: Quality Measures for Medicare and Medicaid Clients

<b>Screening and Assessment</b>	<b>NQF number</b>	<b>Other Uses*</b>
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
<b>Care Coordination</b>		
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
<b>Quality of Life</b>		
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 advanced directives		

**Appendix F: Quality Measures for Medicare and Medicaid Clients  
(cont'd.)**

<b>Screening and Assessment</b>	NQF number	Other Uses*
<b>Mental Health and Substance Abuse</b>		
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
<b>Structural Measures</b>		
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 G: Budget Request [Placeholder]**

**Appendix H: Letters of Support [Placeholder]**