



November 1, 2014

The Honorable Crisanta Duran, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Duran:

Enclosed please find the Department's response to the Joint Budget Committee's Request for Information #2 regarding Cost Effective Care for Medicaid Members.

FY 2014-15 Request for Information #2 states:

The Department is requested to submit a report to the Joint Budget Committee, by November 1, 2014, identifying when clients may be experiencing difficulty accessing cost-effective care. As part of the report, the Department is requested to submit a plan for improving the metrics with a dual goal of developing and implementing intervention procedures where appropriate and providing quantifiable data to support rate setting decisions.

The report contains information on how the Department identifies when clients may be experiencing difficulty accessing cost-effective care, current and future intervention procedures that we anticipate will improve access to care for our members, and metrics the Department will use to track the success of our efforts.

Legislative Request for Information #2 also includes a request for "...providing quantifiable data to support rate setting decisions". The Department is concurrently responding to Legislative Request for Information #1, regarding a plan for an ongoing annual process to address disparities in Medicaid rates that limit client access to cost effective care. The Department respectfully directs the Joint Budget Committee to this response to address the final component of LRFI #2.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at zach.lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

A handwritten signature in black ink that reads "Susan E. Birch".

Susan E. Birch, MBA, BSN, RN
Executive Director
SEB/mec



CC: Senator Pat Steadman, Vice-Chair, Joint Budget Committee
Representative Jenise May, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator Mary Hodge, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Erick Scheminske, Deputy Director, Office of State Planning and Budgeting
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Tom Massey, Policy, Communications, and Administration Office Director
Zach Lynkiewicz, Legislative Liaison
Rachel Reiter, Communications Director



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Executive Summary

The Department considers access to cost effective care critical to progress on achieving the Triple Aim, i.e. improving health outcomes, improving member experience of healthcare, and lowering costs. Healthcare reform, while moving us in the right direction, has also put pressure on Colorado's healthcare system in general and on Medicaid provider capacity specifically. Overall, the Department believes that access to cost effective care is available for many Medicaid members, especially those in the Front Range and larger metro areas. Access to both primary and specialty care is more difficult in other parts of the state.

We know in general where provider shortages are, who our enrolled providers are, and where our members are. What we don't know specifically is the extent to which our providers are accepting Medicaid members and how often they add new Medicaid members to their patient panels. We do not know which providers are preparing to retire and which work only part-time. Our data on specialty providers is also not as detailed or accurate as it could be. The information that we do not know, however, provides us with opportunities to dig deeper, work more closely with communities, and identify resources to address issues that are discovered.

In some areas of Colorado, primary and specialty care are not available, regardless of payer. Even Coloradans with commercial insurance plans face access challenges in some areas, and have long wait times for non-urgent appointments. As the Single State Agency for Medicaid, our goal is not necessarily to exceed commercial access standards for Medicaid members, but to strive for parity for Medicaid members. As a healthcare agency serving Colorado, we also strive to improve access to care for all Coloradans.

In our response, the Department will establish our definition of key terms and identify metrics by which we can identify potential difficulties in accessing cost effective care. We will also describe the many initiatives and activities, both within the Department and in collaboration with other stakeholders, intended to address current and anticipated access to care issues. As more claims data becomes available from the first round of Medicaid expansion, we will track our progress over time and initiate interventions informed by this data.

In developing these interventions, Department has researched other state Medicaid initiatives. Based on this research, the Department strongly believes that it is important to use a multi-pronged approach to identify access issues, develop effective interventions and track our results via a variety of metrics. All of our efforts are designed to align with the Governor's State of Health goal for Colorado to become the healthiest state in the U.S.

The Department is submitting a separate response to LRFI#1 which we believe addresses the final portion of LRFI #2, a request for "...providing quantifiable data to support rate setting decisions."

Key Definitions

Communicating about the complex components of healthcare delivery can be challenging. It is most successful when using a framework of common terminology. Words such as "access" and "effective" are subjective terms that can be interpreted differently, depending on perspective; however, they are vital to an understanding of which policies and programs are effective in getting people the care they need. The Department has selected the following definitions for use in identifying issues and measuring the success of interventions in the Colorado Medicaid program:

- **Access to health care** – "the timely use of personal health services to achieve the best health outcomes" (IOM, 1993). Attaining good access to care requires three discrete steps:
 - Gaining entry to the healthcare system (i.e. Medicaid eligibility)
 - Getting access to care sites where members can receive needed services (i.e. access to Medicaid providers)
 - Finding providers to meet member needs and with whom members can develop relationships (e.g. medical homes)

The Department chose this definition because it represents a common standard across all payer sources and provider types, and because it represents the standards of a nationally recognized provider organization.

- **Components of access to care** - the various factors that impact an individual's ability and willingness to obtain timely, appropriate health care. Reviewing access to care in terms of components helps to clarify what opportunities exist for intervention. Components include not only medical factors, such as the number and type of providers in an area, but non-medical factors, as well:
 - Geographic distribution of providers across Colorado
 - Number/type of providers who serve Medicaid members and size of their patient panels
 - Hours of operation and location within the community
 - Physical (ADA compliant) access and cultural sensitivity/competency
 - Member access to transportation, especially in rural areas
 - Member access to "enabling services", e.g. affordable child care, time off from work, access to technology
 - Member understanding of how to use the healthcare system
 - Member ability to afford co-pays and medications
 - Eligibility "churn" off/on Medicaid
 - Lack of health care provider education around concepts like team-based care, consistent screening and use of preventive services, patient-focused care, etc.

- **Cost effective care** - a measurement of healthcare delivery that focuses on overall health care value. Cost effective care is care that impacts the near and long-term health outcomes of a client. It addresses core factors of illness, reduces redundant services and the need for repeated visits to the doctor, decreases unnecessary or inefficient treatment, and enhances a client’s overall health. Care is made more cost effective through delivery system focus on:
 - Medical home level of care
 - Delivery of services in the appropriate (and least restrictive) setting by the appropriate providers
 - Appropriate utilization, e.g. using best practices for developing benefits standards
 - Coordinated care to streamline communication and reduce duplication
 - Integrated physical/behavioral health care
 - Access to non-medical services that support health
 - Member education and support for health behavior change

- **Intervention procedures:** initiatives, programs, or processes that are understood to positively impact access to cost effective care, without necessarily demonstrating a causal relationship.

IDENTIFYING ACCESS TO CARE ISSUES

As noted in our Executive Summary, our key tasks are to determine if Medicaid members are experiencing difficulty accessing cost effective care and, if so, identify in which areas difficulties are occurring. This may appear to be a simple question, but it’s not. Having accurate, reliable, and detailed provider data is critical to answering questions such as “Do we have enough providers, and are they in the right locations?” Currently, there is no central location for this key provider data. While Colorado licenses physicians, the state only recently began collecting information on where they practice, how many hours a week they work, how many patients they treat, if they take new patients, or whether they see patients at all. Further, because this data is only required on new license applications, providers who are revalidating their licenses seldom respond to these questions.

One question we can ask is “Is access to care declining based on Medicaid claims data?” Claims data has its limitations, e.g. a lag time between dates of service and claims processing. It can tell us what services are being provided, to whom and by whom (in general), but it can’t tell us who tried but could not get needed services. It also can’t tell us health outcomes based on those services or lack thereof. We can only use these data to make assumptions about the trends we identify. More information, as well as time, is needed to understand why rates of service utilization are going up or down and how the system is adapting to increased demand. It’s also important for us to recognize normal variability within any metric and determine if the information we have is statistically significant.

We can also use information from existing reports on Colorado healthcare workforce capacity, e.g. Health Professional Shortage Area (HPSA) data generated by the CDPHE Primary Care Office and the Colorado Health Institute’s 2014 Primary Care Workforce Report to identify potential access issues. Finally, we can use information from standardized surveys of member

experience as well as anecdotal Medicaid member concerns expressed to the Department via our Call Center, our contractors and advocacy organizations.

When possible, the Department chooses valid national standards for data; if these are not available, we review data sources that are well accepted in the healthcare industry. Including the member experience helps us check what claims and state data tell us and helps us prioritize our work.

Most healthcare falls into three major categories: primary care, specialty care, and long-term services and supports. Everyone needs primary care, and a subset of the population needs specialty care. A high percentage of Medicaid members have complex and/or chronic health conditions and participate in all three service areas. Long-term services and supports are particularly important for Medicaid members who can live successfully in their communities with appropriate supportive services. Without these services, far more members would live in long-term care facilities or other institutional settings, with a reduced quality of life and at a higher annual cost.

The following sub-sections describe ways that the Department may identify potential access to care issues in each of these categories, utilization and process measures that we can use to monitor our progress, and resources for capturing anecdotal information and member experience related to accessing care.

PRIMARY CARE

I. Needs assessment

- **CHI Colorado Primary Care Workforce Report (2014):** The Colorado Health Institute recently undertook an analysis of primary care workforce capacity in Colorado, both statewide and for Medicaid enrollees. In some regions, the ratio of Primary Care Physician FTEs (full-time equivalents) to patients is quite reasonable. Not surprising, the ratio in most rural and frontier counties is not as good, and a few Colorado counties have no access to primary care physicians within county borders. Colorado's primary care "hot spots", in which 30% to 197% growth in primary care physician capacity is needed, include: El Paso, Cheyenne, Elbert, Kit Carson, Lincoln, Eagle, Garfield, Grand, Pitkin, Summit, Chaffee, Custer, Fremont, Lake, Clear Creek, Park, Gilpin and Teller counties. These counties also need to improve their capacity to serve Medicaid members. Counties in the Front Range tend to have the best primary care FTE to patient ratios. It should be noted that this study defines a reasonable primary care provider to Medicaid patient ratio as 1:1500. Colorado averages a primary care physician to Medicaid patient ratio of 1:1853. Ratios vary from a low of 1:694 in Jackson, Moffat, Rio Blanco and Routt counties, to a high of

1:3500 in Cheyenne, Elbert, Kit Carson and Lincoln counties.¹

Nurse Practitioners (NPs) and Physician Assistants (PAs) are a critical and expanding component of Colorado's primary care workforce. CHI's workforce report breaks NPs and PAs out separately from primary care physicians, and estimates that 56% of NPs and 38% of PAs work in a primary care setting. Some NPs serve as the only source for primary care in a geographic area. Colorado licensed NPs may, under certain conditions, practice independently; however, the requirements for independent practice are sufficiently stringent to constrain growth.

- **HPSA reports:** A Health Professional Shortage Area (HPSA) is defined as a geographic area, a population group (such as low-income), a correctional facility, a state or county mental health hospital, or a private public or nonprofit facility that can demonstrate a shortage of health professionals in the service area. The Primary Care Office within the Colorado Department of Public Health and Environment (CDPHE) is responsible for approving Health Professional Shortage Areas within Colorado and reports annual updates to the federal Health Resources and Services Administration (HRSA). HPSA designation is used by more than 30 federal and state programs to determine program eligibility or funding preference. HPSAs are also designed either as geographic (i.e. impacting all populations) or low income. In May 2014, twenty-one Colorado counties were either partially or entirely designated as geographic HPSAs. Twenty-eight counties were either partially or entirely designated low income HPSAs, and fifteen counties were either partially or entirely not designated as shortage areas. One county, Larimer, includes all three designations, with the northwest portion of the county designated a geographic HSPA, the northeast portion designated a low income HPSA, and the southern portion of the county not designated as a shortage area at all.
- **Medicaid Managed Care Contract Deliverables:**
 - Accountable Care Collaborative (ACC) Program – The Department's contracted Regional Care Collaborative Organizations (RCCOs) are required to maintain access to care standards for primary care. The expectation is that every ACC client will have a choice of at least two ACC Primary Care Medical Providers (PCMPs) within a 30-minute drive. For rural and frontier areas, the Department may adjust the requirement based on the number and location of available providers. Currently, six Colorado counties have no enrolled PCMP, although a practice in one of these counties (Sedgwick) was in the process of contracting as of October 1st. The remaining five counties without a PCMP are: Jackson, Pitkin,

¹ Colorado's Primary Care Workforce: A Study of Regional Disparities, Colorado Health Institute, February 2014.

Clear Creek, Gilpin, and San Juan. Other ACC access to care standards require that each regional network provides for:

- Extended primary care hours on evenings and weekends
 - Access to urgent care as an alternative to emergency room visits for after hours
 - Access to urgent care appointments within 48 hours
 - Access to non-urgent, symptomatic care within ten (10) days
 - Access to specialty care
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- Denver Health Medicaid Choice (DHMC) – The Department receives quarterly network adequacy reports from Denver Health’s managed care plan that reflect the ratio of enrolled members to Primary Care or Specialty Providers by geographic area. Up to early 2014, these reports indicated that DHMC met or exceeded all contract requirements for network adequacy. With the influx of new Medicaid members during the 2013-2014 Open Enrollment period, many new DHMC members were placed on a “waitlist” for non-emergent care appointments. However, Denver Health has recently made significant progress in reducing this backlog using a combination of hiring new staff and executing care agreements with non-Denver Health providers to care for members who were unable to be served within the DMHC network. The Department is confident that Denver Health is prepared for the upcoming Open Enrollment period beginning November 17, 2014.
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- **Provider Enrollment** – The Department committed to expanding access to Medicaid prior implementation of federal health care reform. Shortly thereafter, the number of Medicaid provider applications received by the Department’s fiscal agent began to rise. Over the past twelve months, the number of provider applications (of all types) increased an average of 5% for each of the first three quarters, and increased 10% between Q3 and Q4 of FY2013-14. This increase will be noted in the Department’s Performance Plan, in which actual provider enrollment at the end of FY2013-14 exceeded estimated enrollment by ~1,000 providers. This represents significant growth in Medicaid provider participation.

 - **Nurse Advice Line (NAL)** - The Department contracts with Denver Health to administer a 24-hour call line so that Medicaid members can ask a nurse about health concerns and be directed to the appropriate level of care, if needed. The toll-free number is published on the Department’s website and is printed on Medicaid member ID cards. Utilization of the NAL was already increasing steadily in 2013 (30% from August to December); however, call volume increased more dramatically in January with the influx of newly eligible Medicaid members. Between January and June 2014,

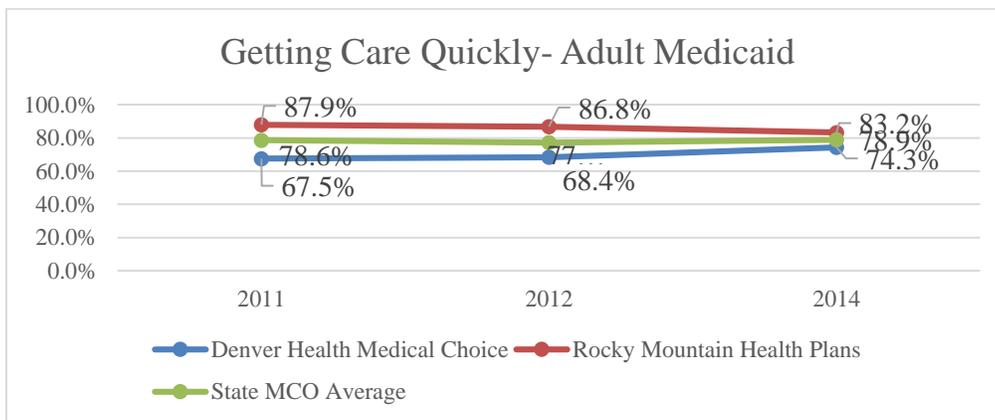
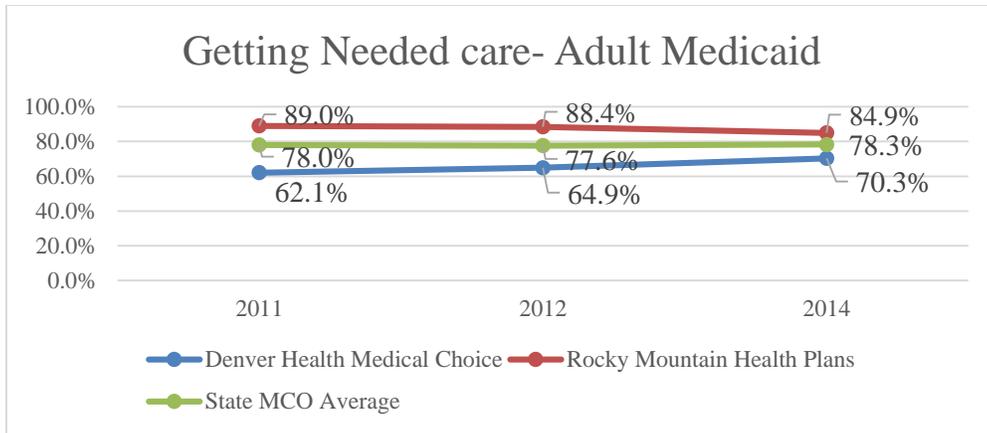
the NAL handled an average of 2,591 calls each month. More importantly, of the calls triaged by RNs, only 23-29% of callers were referred to an emergency department for care. The remainder were referred to urgent care facilities, directed to seek an appointment from their primary care provider, or provided advice for self-care.

II. Member Experience

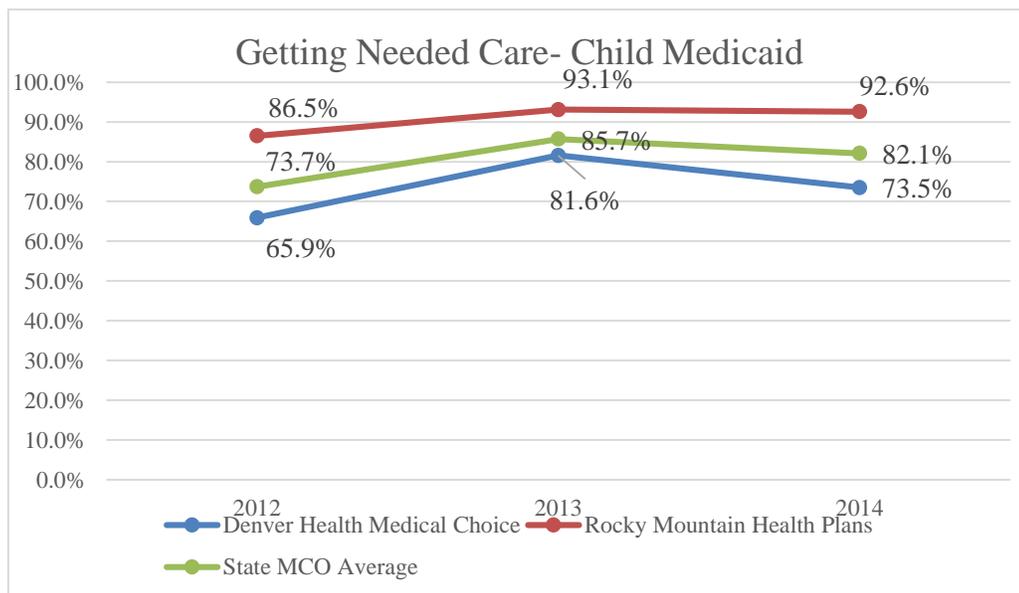
- **CAHPS[®] data** - The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in fee-for-service (FFS), Denver Health Medicaid Choice (DHMC), and Rocky Mountain Health Plans (RMHP). The Department contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys**. The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall client satisfaction.

In FY2013-14, a modified version of the CAHPS that included questions related to Patient-Centered Medical Homes (PCMHs) was administered to adults enrolled in FFS Medicaid. This was also the first year that members enrolled in the ACC program were included in the survey. With over half a million ACC enrollees at the time of the survey (March-May 2014), results for FFS respondents should be considered a baseline and not compared directly with past years in which ACC enrollment was low or non-existent. Respondents were asked two questions to assess how often it was easy to get needed care, and two questions to assess how often members received care quickly. For ACC adult enrollees: 76.1% reported being able to access needed care and 79.7% reported getting needed care quickly. For ACC-enrolled children: 81.6% (of caregivers) reported being able to access needed care and 87.4% reported getting care quickly.

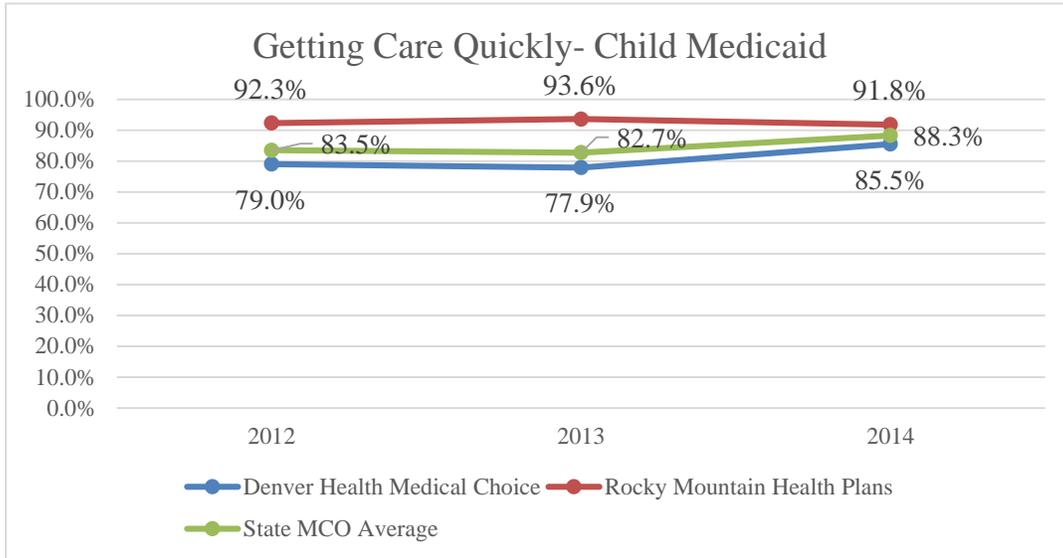
For DHMC and RMHP managed care plan adult members, data may be compared across survey years. Between 2012 and 2014, positive responses regarding both access to needed care and getting care quickly shifted slightly upward for DHMC and slightly downward for RMHP. Overall, the statewide average rose slightly.



Survey results for DHMC and RMHP child members differed somewhat. Positive responses related to getting needed care rose for both plans between 2012 and 2013 and dropped for both plans between 2013 and 2014, although the drop for DHMC was more significant, resulting in a drop of 3.6% in the average score.



Results for accessing needed care quickly for children more closely mirrored the adult survey results, with a slightly higher overall average in 2014.



- **Anecdotal reports**

- HCPF Customer Contact Center: From March to August 2014, clients requesting help finding a provider ranged from 175/month to almost 400/month. Peak call months were April through July, which may relate primarily to the influx of newly eligible Medicaid members beginning in January 2014. The data does not specifically indicate that clients were denied access to care, only that they requested provider information.
- Medicaid Ombudsman for Managed Care: The Ombudsman contractor submits monthly reports to the Department summarizing the number, type, and resolution of member concerns/inquiries received by their office. While the total number of calls is relatively low compared to the Department’s call center, the majority of member concerns are regarding access to care and quality of care. Monthly reports do not provide detail on exactly what type of access issues are being experienced by the members. Over the past twelve months, the number of calls related to access to care has ranged from 2 to 10 a month, with a mean of 6.41 calls/month. The percentage of calls related to access issues ranged from 33% to 89% during that time. Interestingly, the number of monthly calls after Open Enrollment in January 2014 seems similar to the monthly calls logged in 2013.
- Colorado Coalition for the Medically Underserved (CCMU): CCMU’s primary focus for 2014 is access to care for underserved populations. Their “Health is Local” initiative looked at changes in health coverage and access in four Colorado communities (Summit County, Yuma County, Montrose

County, and the city of Colorado Springs). Community information and resident stories are available online at: www.healthislocal.org. CCMU's "Colorado HealthStory" project captures personal health stories across the system, including specific issues with access to care. While not all participants are Medicaid members, this project helps inform CCMU and the Department of specific areas in which access to cost effective care may be especially difficult. <http://coloradohealthstory.org/stories/by-topic/access-to-care/>

III. Service Utilization & Process Metrics

The Department expected that the cohort of newly enrolled Medicaid members would not immediately begin accessing care at the same rate as the existing Medicaid population. Many factors may be involved in this delay, including lack of sufficient understanding of the healthcare delivery system, lack of resources to help them overcome barriers to access, and simply not being used to having health coverage. Over time, the Department anticipates that the newly enrolled will start to use services at the same or a higher rate than current users. Therefore, a standardized and nationally recognized measure such as HEDIS, that measures the number of services delivered per 1000 members per year (PKPY), can serve as a reasonable proxy for measuring and tracking access.

- **Access to preventive/ambulatory care - Adults (HEDIS)**
Adults' access to preventive/ambulatory health services measure is used to assess the percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit within the measurement year. Measuring trends in access to preventive services, e.g. counseling on diet, exercise, smoking cessation, seat belt use, and risky behaviors allows us to make educated assumptions about whether or not barriers to access exist. Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.
- **Child/adolescent access to Primary Care – Children (HEDIS)**
The Children and Adolescents' access to primary care practitioners measure is used to assess the percentage of members 12 months to 24 months, 2-6 years, 7-11 years and 12-19 years of age who had a visit with a primary care practitioner (PCP). Children derive the same benefits from access to primary care as adults, perhaps even more so. Appropriate screening and access to preventive services for children is critical to early access to interventions and supports to either resolve or reduce the impact of developmental and/or disease processes early in life. Early intervention can result in better overall lifetime health outcomes and significant cost savings to the healthcare system.

- **Immunization rates – Children (HEDIS)**

The Childhood Immunization Status (CIS) rate is calculated using nine combination rates, as well as a rate for each of the ten individual vaccines given to children. This measure is used to assess the percentage of Medicaid-enrolled children who turned two years of age during the measurement year and who were continuously enrolled for 12 months prior to their second birthday.

Colorado Medicaid's childhood immunization rate for 2014 was 69.2%, which is lower than what might be expected for several reasons. A significant portion of Colorado's population voluntarily opts out of vaccinations and the Department is not able to extract this percentage when calculating program participation. In addition, many providers give vaccinations, but do not bill Medicaid, possibly because they feel they are not reimbursed well enough to bill for them. These vaccinations are not recorded in our system.

The Department recognizes the importance of childhood vaccinations. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars. Although our goal is to have 100% of all Medicaid-enrolled children vaccinated, that goal is likely unachievable. The Department will continue to promote vaccinations and uses the CIS measure to monitor our progress.

- **Timeliness of prenatal care – Pregnant women (HEDIS)**

This measure is used to assess the percentage of Medicaid-enrolled mothers who delivered live births over the course of the measurement year that received a pre-natal care visit in the first trimester or within 42 days of Medicaid enrollment. Preventive medicine is fundamental to pre-natal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have an optimal effect on outcomes. Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Lack of pre-natal care may result in poor outcomes, e.g. spontaneous abortion, low birth weight babies, large for gestational age babies and neonatal infection.

Ideally, a pregnant woman will have her first pre-natal visit during the first trimester of pregnancy. Some women enroll in a healthcare plan at a later stage of pregnancy; in these cases, it is essential for the health plan to begin providing pre-natal care as quickly as possible to maximize outcomes for the mother and baby.

SPECIALTY CARE

The Department currently spends over \$32 million dollars per year on services provided by obstetricians, oncologists, podiatrists, neurologists, urologists, cardiologists, and dermatologists. Emergency department visits and hospitalizations that may result from the lack of access to

specialty care are also very costly to the State. Similarly, unnecessary utilization of specialty care inflates costs and further reduces available access for critical needs. Therefore, the Department has identified specialty care payment reform as the next pivotal venture in achieving better health and better care for Medicaid members at lower cost to the State. Funding for facilitation of specialty payment reform was requested for FY2014-15 under Priority R-10. This request also included funding to support care coordination and care management strategies within the ACC program to promote access to, and coordination with, specialty care providers.

Access to detailed and accurate data regarding specialty care providers is one of the Department's major challenges. The Department requests specialty certification information from providers during the enrollment process, but failure to provide this data does not suspend the application process. Further, some providers list a specialty, e.g. internal medicine, but in reality specialize even further in an area not identified on the application.

Implementation of the new HP interChange provider enrollment module in 2015 will allow the Department to collect both NPI and taxonomy information on all enrolled providers. This will give us more accurate and detailed specialty provider enrollment data, as well as support development of key metrics to monitor utilization and access to specialty care. Until then, the Department must rely more heavily on anecdotal reports of access to care issues, as noted below.

I. Needs assessment

- **Specialist enrollment data** – As noted above, the Department's access to accurate information about its specialty providers is not considered reliable enough to inform policy direction at this time. This is partially due to providers choosing not to include specialty certification information in their provider applications. In early September 2014, the Centers for Medicare and Medicaid Services (CMS) published a crosswalk that links Medicare providers and suppliers with the appropriate Healthcare Provider Taxonomy Codes. This information, combined with access to the National Provider Identification (NPI) registry database, will allow the Department to better identify provider specialties based on information supplied for Medicare enrollment. The Department also anticipates that targeted rate increases implemented on July 1, 2014, will have an impact on specialist enrollment in Medicaid.
- **Mental Health Professional Shortage Area (MHPSA) reports:** A subset of HPSA reports identifies areas for which access to mental health treatment providers is limited. MHPSAs are also designed either geographic or low income. As of May 2014, the vast majority of Colorado counties were designated geographic MHPSAs and Weld County was designated a low income MHPSA, meaning that mental health provider shortages apply only to low income populations. The following Front Range counties were not

designated as MHPSAs: Denver, Adams, Arapahoe, Jefferson, Douglas, Boulder, Broomfield and Larimer. These reports signify a general shortage of mental health providers across the entire state, regardless of payer or health plan. However, the reports are based on ratios of licensed providers to general population and are not specific to Medicaid. Increased access to pediatric psychiatrists is acknowledged to be one of Colorado's greatest needs.

- **BHO contract deliverables** – Almost all Medicaid members are enrolled into a BHO when they are enrolled in Medicaid. BHO contractors have two quarterly contract deliverables related to access to care. The BHO Access to Care report includes data on: penetration rates (number of members accessing services), services provided within 45 days of intake, ER utilization, hospital readmissions, inpatient utilization, and access to routine, urgent and emergent care within contractual timeframes. A review of quarterly reports submitted pre- and post-January 2014 reveals some stress on the current provider network. The pent up demand from a large cohort of new Medicaid members with unmet behavioral health needs was anticipated, but provider enrollment generally takes longer than new member enrollment. Higher ED utilization might also be expected if new Medicaid members have predominantly used the ED for needed care prior to obtaining health coverage.

BHO's also submit quarterly Network Adequacy Reports that describe the number, type and geographic distribution of network providers compared to enrolled members. The program goal is to have qualified providers within 30 miles or 30 minutes of all members, although in some rural and frontier counties, this simply isn't possible. Overall, the ratio of BHO members per practitioner has been rising since Medicaid expansion and the addition of substance use disorder (SUD) services to the BHO scope of work in January 2014. While the number of members has risen, the number of providers that do not accept new Medicaid members has remained stable. BHOs are being encouraged to make provider contracting a priority as Open Enrollment approaches in November. Departmental policy around supervision of Certified Addiction Counselors (CACs) is currently under review, as it may be creating unanticipated barriers to Medicaid enrollment for this provider group.

- **RCCO Specialist data** - As part of developing referral (medical neighborhood) protocols for the ACC, RCCOs are charged with assessing specialty care availability, service gaps, and barriers to access within their regions. In addition, RCCOs report semi-annually on provider network adequacy, including an assessment of specialty care. Through these various contract deliverables, RCCOs report the following:
 - Access to specialty care in rural and frontier areas continues to be a challenge, with wait times of up to three months when specialty care is present in a community, and

- long drives to a provider when specialty care is not available locally;
- Pain management, dermatology, urology, and orthopedics are consistently noted as specialty areas with large service gaps;
- Endocrinology, orthopedics, oral surgery, and optometric services² are service gaps in rural areas, but are accessible in urban areas;
- Many specialists in the Denver Metro area who accept Medicaid are underutilized, as primary care providers tend to refer to a limited number of specialty providers.

Although RCCO data does not represent the entire Medicaid population, the Department is focusing its analysis on the ACC as Medicaid’s primary healthcare delivery system. The Department anticipates that by the end of FY 2016-17, the vast majority of Medicaid members will be served in the ACC.

- **Colorado Medicaid Specialist Survey Results** – In September 2014, Colorado Medical Society (CMS) specialist providers were surveyed on willingness to accept Medicaid patients, on the severity of problems with Medicaid patients and the Medicaid system in general, and on potential solutions. Of the 52% who responded, attitudes about Medicaid varied widely, but all agreed that access to specialty care for Medicaid members presents both safety and quality problems. Patients who cannot access specialty care often end up in the ED or the hospital, at higher costs and lower value to the patient and the healthcare system. Medicaid system issues included: reimbursement, administrative burden, patients lacking PCPs and patient support requirements. Concerns about taking Medicaid patients included: the “floodgates” opening to new Medicaid members, non-compliance with treatment, late or missed appointments, patients who are medically and/or socially complicated, patients with behavioral health issues, and litigiousness. Overall, the willingness of specialty providers to accept Medicaid was low, but when providers saw Medicaid patients themselves as the biggest problem, acceptance was even lower.

II. Member Experience

- **CAHPS data** –In 2013 and 2014, the CAHPS included one question specifically related to members’ perception of timely access to specialty care. The 2013 Medicaid aggregate responses for members who “Usually” or “Always” got an appointment with a specialist as soon as they needed was 79.3% for adult members and 83.33% for child members. The 2014 aggregate responses were 75.26% for adults and 75.61% for children, representing a downward “trend” over the two years. It should be noted that the survey period for the CAHPS is from July to December of each year, with results reported the following year. Therefore, the 2014 survey responses are from surveys administered between July and

² Optometry rates were increased significantly on July 1, 2014, as part of the Department’s targeted rate increase package. The Department is meeting with the Colorado Optometric Association to collaborate on strategies to increase Medicaid enrollment of Association members.

December 2013, prior to the major influx of newly enrolled Medicaid members in January 2014.

- BHO MHSIP and YSS-F surveys – Until this year, the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey and the Youth Services Survey for Families (YSS-F) have been administered annually to a sample of Medicaid members enrolled in each BHO. Survey questions fall into five general domains: Access, Quality/Appropriateness of care, Outcomes, General Satisfaction, and Participation. A comparison of responses between 2010-11 and 2013 shows very little change in these five domains in the two year period preceding the influx of newly eligible Medicaid members in January 2014. Overall, the majority of respondents indicated that their perceptions of Access, Quality/ Appropriateness, Participation and General Satisfaction were generally satisfactory. The Outcomes domain indicated the lowest levels of agreement; however, the overall response was still at 66% agreement. Not surprisingly, members with multiple disabilities showed a lower level of agreement with the Outcome Domain statements than those members with no disability.

Beginning this year and moving forward, the Department will capture member experience using the AHRQ *Experience of Care & Health Outcomes (ECHO)* surveys. The ECHO Surveys include standardized questionnaires and optional supplemental items for adults and children who have received behavioral health care and services within the previous 12 months. Survey questions address: getting treatment quickly, how well clinicians communicate, getting treatment and information from the BHO, member perception of their own improvement, information about treatment options, and overall rating of counseling and other treatment.

- **Anecdotal reports**
 - HCPF Customer Contact Center: Contact Center data is not categorized by primary, specialty or long-term care requests. Please see the Department’s response in section I. Primary Care, Member Experience.
 - Medicaid Ombudsman for Managed Care: As noted in Section 1 of this report, monthly Ombudsman reports do not include details on what types of access issues members experienced or what efforts they had made to resolve their concerns prior to contacting the Ombudsman. A large percentage of concerns come from members with behavioral health issues, partly because the statewide BHO contract covers almost all Medicaid members. These members are often unaware of how to use the BHOs as resources to find providers and their issues can be resolved with a referral back to their BHO.
 - Colorado Coalition for the Medically Underserved (CCMU): CCMU’s initiatives are not exclusive to Medicaid members and data is not categorized by types of access issues. Please see the Department’s response in Section I, Primary Care, Anecdotal Reports, on page 6 of this report.

III. Utilization & Process Measures

- **PQI data** – The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs can be used as a surveillance tool to help flag potential healthcare quality problem areas that need further investigation; provide a quick check on primary care access or outpatient services in a community by using patient data found in a typical hospital discharge abstract; and, help public health agencies, State data organizations, health care systems, and others interested in improving health care quality in their communities.³

The Department currently calculates scores for 14 individual conditions and composite scores for acute, chronic and overall PQI. Disease conditions include diabetes, asthma, COPD, hypertension, congestive heart failure, low birth weight babies, urinary infections, dehydration, and bacterial pneumonia. The Department monitors all of the PQI measures to identify opportunities for improvement in delivering appropriate preventive, primary, and chronic disease management care to Medicaid members.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

Children, the elderly and people with disabilities have comprised Medicaid's traditional population. With healthcare reform and a strong shift towards de-institutionalization, many Medicaid members who once were served in nursing facilities, mental health institutes and regional centers are now receiving the support they need to live in their communities. The Department has responded to a 2012 Executive Order by creating an Office of Community Living to oversee the delivery of LTSS, which includes facility-based services, home- and community-based services, across the spectrum of older adults and people living with one or more disabilities, including physical, mental health, and/or developmental/intellectual disabilities.

The Department has also responded to the 2012 Executive Order by establishing and coordinating the Community Living Advisory Group (Advisory Group), whose mission is to deliver recommendations to the Office of the Governor and the Executive Directors of the Departments of Healthcare Policy and Financing, and Human Services, by September 30, 2014. The Advisory Group obtained active participation by members, families, advocates, providers, legislators, communities, and several state agencies to ensure that necessary coordination and administration was achieved. The Department embedded many staff members

³ Agency for Healthcare Research and Quality 2014.

across the six Advisory Group Subcommittees and work groups created through this two-year process.

The Advisory Group approved its final report on September 22, 2014, including recommended changes to the LTSS system, and is on track to deliver this report by September 30. These recommendations include the following areas:

- Improve the coordination and quality of care provided by LTSS
- Streamline and simplify access to LTSS
- Harmonize and simplify LTSS regulations
- Simplify the State's HCBS Waivers
- Grow and professionalize the LTSS workforce
- Promote accessible, affordable, integrated housing
- Promote employment opportunities, regardless of age or disability

Similar to specialty care services, the Department does not always have access to detailed data that indicates problems in accessing cost effective long-term services and supports across the continuum of care. We have, however, identified several key areas in which access to care issues are clearly evident, as described below.

I. Needs assessment

- **Provider capacity for Children with Autism waiver recipients:**
In its FY2015-16 Change Request, Priority R-8, the Department requested funding to eliminate the Children with Autism (CWA) waiver enrollment cap, allow for a one-time increase to the expenditure cap and allow it to fluctuate, increase the enrollee age limit to eight, allow for three years stay, and continue the waiver effectiveness evaluation. The existing cap for the waiver is 75 children, leaving an estimated 320 children on a waitlist that could last for years. With the incidence of autism on the rise, the Department estimates that about 549 unique members would enroll within the first year of eliminating the enrollment cap, with the monthly average enrollment for the year totaling 370. To serve a larger caseload for a longer duration, current provider capacity would need to be maintained and approximately 125 additional waiver providers enrolled over the next two years. The Department is requesting to increase the service caps in order to increase reimbursement rates to providers without reducing services to children on the waiver. Providers serving this waiver have not received rate increases in years because of the cap on services and in order to get more provider participation the rates must be increased.
- **Provider capacity for the Children with Life Limiting Illness Waiver (CLLI):** The Department is aware that access to CLLI services is not sufficient based on the consistent low utilization of waiver services. Targeted rate increases for several waiver services were approved by the legislature in FY2014-15 and went into effect on July 1, 2014. The

Department is conducting outreach to several agencies and has received positive feedback on participation in the waiver. The Department expects to see waiver service utilization increase as additional waiver providers enroll.

- **Provider capacity for Spinal Cord Injury (SCI) Waiver** recipients: This 3-year pilot program serves adults (18+) with spinal cord injuries who live in Adams, Arapahoe, Denver, Douglas or Jefferson counties. The structure for enrollment as a SCI Alternative Therapy Provider has caused some access limitations. Currently, physician supervision is required for Alternative Therapy Providers who provide acupuncture, chiropractic, and massage. In addition, providers must offer all these therapies in one location. This has limited Alternative Therapy Providers enrollment. Currently, there are only two locations. This limitation will be addressed in the waiver renewal application to be submitted to CMS in March 2014.
- **Extending long-term care capacity for people with Traumatic Brain Injury (TBI):** Brain injury stakeholders, providers, case management agencies, and the Department believe a strong need exists for the expansion of brain injury specific services to meet the often complex needs of these individuals. Expansion of these specialized services to this population would reduce the incidence of increasingly lengthy and costly hospital stays, inappropriate nursing facility placement, and even incarceration or homelessness. Without this additional care, the State will continue to face problems finding affordable and appropriate services for some of Medicaid's more vulnerable members, especially in rural areas of Colorado.
- **Waiting lists for persons with intellectual and developmental disabilities** - There are currently waiting lists for Medicaid and state funded services for persons with intellectual and developmental disabilities which prevent access to much needed services and supports. Pursuant to 25.5-10-207.5(4), the Department is required to develop a strategic plan to ensure persons with intellectual and developmental disabilities have access to and are enrolled into programs at the time services and supports are needed. This strategic plan is being developed in collaboration with stakeholders and will be submitted to the General Assembly on November 1, 2014. Please refer to this strategic plan for the Department's strategies for assuring timely access to needed services for individuals with intellectual and developmental disabilities.

II. Member Experience

- **CAHPS data** – Survey data specific to long-term services and supports is not available at this time. However, the Department recognizes the need to improve access to care for individuals within this multi-faceted population. By identifying and integrating key principles, improved access of care is not only possible, but sustainable over time. Such guiding principles include:

- Integration of individuals, caregivers and direct care workers as essential members of the care team
- Focusing efforts on eliciting individual and caregiver preferences and goals about care delivery
- Adopting a longitudinal, cross-setting perspective of healthcare and LTSS needs for individuals and families

Throughout September and October 2014, the Department surveyed LTSS recipients using the *Testing Experience and Functional Tools (TEFT) Experience of Care* survey. This survey is administered to members either in person or by phone and asks specific questions related to access to care. The survey domains are wide-ranging, but there is a strong emphasis on choosing and receiving needed services, transportation, and communication. These domains are closely tied to access to care.

The Department intends to implement an additional survey of LTSS recipients from June to September 2015. The primary aim of the *National Core Indicators - Aging and Disabilities (NCIAD)* initiative is to collect and maintain valid and reliable data that give states a broad view of how publicly funded services impact the quality of life and outcomes of service recipients. This survey strongly emphasizes domains such as self-directed supports, choice, and access to needed services. There is a relationship between these indicators and how they impact the clients' quality of life. The survey includes caregivers as they are a vital part of the client experience in relation to these domains.

- **Anecdotal reports**

- HCPF Customer Contact Center: Contact Center data is not categorized by primary, specialty or long-term care requests. Please see the Department's response in section I. Primary Care, Member Experience.
- Medicaid Ombudsman for Managed Care: Access to care inquiries from contractor reports are not categorized by which type of care was needed. Please see the Department's response under Section I, Primary Care, Member Experience, Anecdotal Reports.
- Colorado Coalition for the Medically Underserved (CCMU): CCMU's initiatives are not exclusive to Medicaid members and data is not categorized by types of access issues. Please see the Department's response in Section I, Primary Care, Member Experience, Anecdotal Reports.
- Full Benefit Medicare-Medicaid Enrollees Subcommittee: This subcommittee of the ACC Program Improvement Advisory Committee (PIAC) was established in 2012 to engage stakeholders in the Department's demonstration grant application for dually eligible individuals. Over the course of two years, stakeholders have consistently expressed concerns about access to culturally appropriate and accessible care for this population, particularly for the most vulnerable members with high and/or complex needs.

III. Utilization and Process Measures

- Timely access of CWA waiver services: Assuming funding of Priority R-8, the Department will track the time from waiver enrollment to members' access to waiver services identified in member service plans.
- HCBS quality performance: an annual measurement of Medicaid members' ability to access and receive waiver services identified in their personal care plans. The Department is required by CMS to monitor this information for all waiver recipients.

INTERVENTIONS TO ADDRESS ACCESS ISSUES

The Department is directly or indirectly involved in a significant number of initiatives focused on improving access to cost effective care. Increasingly, state and local government are coming together to develop solutions that are tailored to the needs of our communities. Government health agencies are recognizing the value and necessity of aligning publically funded health initiatives with commercial healthcare initiatives and payers. Not only do we benefit from our collective focus on these issues, but we reduce the administrative burden for providers who serve multiple payers. We also support continuity of care for members who move between Medicaid and other health insurance.

It is important to note that correlation does not equal causation when dealing with complex public health issues. Many factors are simultaneously influencing access to care across the state. Without scientifically controlled studies, it is impossible to pinpoint which specific interventions are independently effective and to what magnitude. Each of the following interventions are associated with at least one component of access noted previously in this report.

Current Department Interventions

- **ACC Program** – Medicaid's primary healthcare delivery system. With over 700,000 enrolled, ACC members are connected with Primary Care Medical Providers (PCMPs) that serve as medical homes. Contracted Regional Care Collaborative Organizations (RCCOs) contribute to Medicaid and PCMP provider recruitment, are developing medical neighborhoods (connect to specialty care) and care transition models to support members, and coordinate care for enrolled members. The ACC is also the crucible in which a variety of pilot projects (payment reform, ED utilization, community paramedicine, etc.) are being implemented. The ACC has a proven track record in improving overall health outcomes for members and creating cost savings.
 - **Intervention addresses:** medical home, care coordination, enabling services for members, member support/education, provider reimbursement, expanding existing access, provider support.

- **Provider rate increases**
 - Across the board rate increases were implemented in July 2013 and 2014
 - Targeted rate increases for high value services took effect July 2014; additional increases are under consideration for July 2015
 - Procedure codes were opened for “extended hours” access and advance directives counseling
 - Extended funding for 1202 supplemental payments to primary care providers through December 2015
 - Supported financial incentives for implementation of EHRs and meaningful use standards
 - **Intervention addresses:** provider recruitment, provider reimbursement, expanding existing access

- **Accountable Care Collaborative Medicare-Medicaid Program** – On September 1, the Department enrolled the first cohort of eligible Full Benefit Medicare-Medicaid recipients into the ACC program. Total enrollment is estimated at 32,000 individuals across the state. Supported by a federal demonstration grant, these individuals are connected with a primary care medical home and receive a personal service plan, extensive care coordination, and supports to help members achieve their personal health goals and reduce healthcare costs. As part of this program, a **Disability Competent Care Assessment Tool** was developed to assess the extent to which providers offer physical, cultural, and program access for Medicaid members with disabilities and complex conditions.
 - **Intervention addresses:** medical home, care coordination, enabling services, member support/education

- Creation of a **Provider Relations Division** to address provider recruitment, retention, and relations across all delivery models. The goal of this new division is to ensure that Colorado Medicaid has an adequate and comprehensive network of quality providers that meet high standards for physical, behavioral, dental and long-term services. Division staff work across the Department to identify effective provider outreach strategies, barriers to provider participation in Medicaid and/or the ACC program, opportunities for collaborating with other agencies on workforce development initiatives, and ways to engage providers, clients, families and communities on healthcare access issues. Outreach efforts thus far include personal networking, provider letters from the Department, work with provider associations, county and provider site visits, and presentations to community organizations and educational institutions. This Division also provides input to the development of policy, process and systems improvements, e.g. the new interChange provider enrollment system, that are designed to reduce administrative burden on Medicaid providers, as well as Department staff.
 - **Intervention addresses:** provider recruitment, provider reimbursement, expanding existing access, administrative improvements, improving provider data

- **Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)** – The Department recruited and hired a respected physician to serve as CMO in 2009 and created a Chief Nursing Officer position in 2014. Both of these positions provide outreach and valuable connections to physician and nursing provider associations and have been instrumental in promoting Medicaid provider participation.
 - **Intervention addresses:** provider recruitment, expanding existing access, provider support

- **Specialty Physicians Workgroup** – This stakeholder group was developed to obtain specialist input on how to improve specialty care access for Medicaid members. Among other topics, the workgroup has discussed: (1) identification of new programs the Department could implement to increase specialty access; (2) how to improve relationships between the ACC program and specialist providers, and (3) how the Department can better message the benefits of Medicaid participation and make policy changes that would encourage more specialists to become Medicaid providers.
 - **Intervention addresses:** provider recruitment, expanding existing access, provider support

- **Medical Neighborhood Referral Protocols** in the ACC program – Developed by ACC Regional Care Collaborative Organizations (RCCOs), medical neighborhood protocols can help providers and members find Medicaid specialists, coordinate needed care, access non-medical community resources, and work collaboratively to address a patient’s overall health.
 - **Intervention addresses:** medical home, care coordination, member support/education, expanding existing access, provider support

- **C-PACK** – Colorado Psychiatric Access and Consultation for Kids is a consultation model developed by Medicaid behavioral health providers to offer real time pediatric psychiatry support to primary care providers with the goal of increasing the capacity of primary care providers to deliver mental health care independently and team with local specialists when needed. This model allows children and families to obtain needed psychiatric care in the setting in which they are most comfortable, and supports coordinated care.
 - **Intervention addresses:** expanding existing access, provider support

- **Colorado Choice Transitions (CCT)** – The CCT program, Colorado’s Money Follows the Person initiative, provides Colorado Medicaid members who use long-term services and supports with choices about how, when and where they want to receive services. Services are intended to promote independence, improve the transition process, and support members in the community in the most appropriate and least restrictive setting. Implemented in March 2013, CCT has helped 52 Medicaid members transition to

community living to date, and anticipates completing approximately 450 additional member transitions over the life of the current grant.

- **Intervention addresses:** care coordination, enabling services for members, member support/education, expanding existing access
- **Creative Solutions workgroup** – This Department-sponsored workgroup was established in January 2014 to address access to care issues for children and youth with exceptionally high needs. As these children are involved with multiple systems, the workgroup includes parents, as well as representatives from the Department of Human Services, the Department of Education, the Department of Youth Corrections, Community Centered Boards, Behavioral Health Organizations, hospitals and residential services providers, guardians ad litem, and advocates. The group meets whenever a difficult case is referred. Currently 17 cases are under review, all of which were accompanied by a request for out-of-state placement. Although some cases may be resolved more quickly, the average time for resolution is two to three months and some cases take much longer. By working together, pooling resources and communicating directly on coordinated care plans for these children, fewer than 5% of the cases reviewed are referred out-of-state. This results in significant savings to the state and better overall outcomes for our children and families.
 - **Intervention addresses:** care coordination, enabling services for members, member support/education, expanding existing access

Department Interventions in Development

- **Project ECHO** – funded by budget action in FY13-14, designed to provide training and support for primary care providers in specialty care areas (e.g. pain management). The Department is currently recruiting ACC providers to participate in Project ECHO Colorado.
 - **Intervention addresses:** expanding existing access, provider support
- **Tele-medicine** – CMS defines telemedicine as seeking to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. While not considered a distinct service, telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient).The Department requested funds for FY2014-15 under Priority R-10 to implement telemedicine technology as a means to expand access to care in rural and under-served areas, as well as to provide specialty care (as appropriate) such as counseling for people who use American Sign Language.
 - **Intervention addresses:** provider reimbursement, expanding existing access, provider support

- **Doc2Doc / eConsult model** – a form of tele-medicine, funding was requested under FY2014-15 R-10 for implementation of an eConsult model of care. Doc2Doc is a web-based application created by physicians to enhance communication and collaboration between medical care providers. The Doc2Doc program uses digital technology to allow primary care providers to exchange patient information with specialists without the need for an in-person visit with the specialist. The technology allows specialists to virtually screen members to see if specialty care is necessary for their case. This model has been used successfully in Oklahoma’s Department of Corrections to reduce specialist visits by as much as 70%, and they have maintained this success for over a decade. The Department anticipates that implement of Doc2Doc or a similar model in the ACC program would expand access to specialists, encourage specialist participation in Medicaid, improve communication between primary and specialty care, and reduce unnecessary costs.
 - **Intervention addresses:** provider reimbursement, expanding existing access, provider support, administrative improvements

- **interChange Provider Enrollment Module** – Beginning summer 2015, all Medicaid providers will be re-enrolled and revalidated via the new HP interChange system. Provider enrollment will be done online, instead of on paper, and will offer real time notice to providers of any errors in an enrollment application. The system will permit providers to save an application and return to it later, will support online updates of provider demographic information, and will allow licensing and other documents to be uploaded digitally. The Department believes that the interChange system will result in significant reduction of administrative burden for providers and support more efficient and rapid provider enrollment. It will also collect provider data at an unprecedented level to support Department data analysis and inform policy and reimbursement decisions.
 - **Intervention addresses:** provider recruitment, provider support, administrative improvements, improve provider data

- **New Business Intelligence Decision Module (BIDM)** – will provide 24/7 access to provider and member enrollment data, Prior Authorization Request (PAR) and claims data; permit collaboration between primary care, specialty care, and other providers on a patient’s team; support online communication between Medicaid members and their providers; and permit implementation of policy decisions more rapidly and efficiently. These efficiencies will reduce administrative barriers to provider participation in Medicaid, as well as administrative burden on Department staff. Full implementation of the new system is scheduled for January 2017.
 - **Intervention addresses:** provider recruitment, provider support, administrative improvements, improve provider data

- **FY2015-16 R-8 Change Request** – The Department’s R-8 request includes funding to perform the Children’s with Autism (CWA) waiver program evaluation on a yearly basis.

This evaluation would allow for more data collection and for current research on children with autism spectrum disorder (ASD) to be solidified with larger sample sizes. The request also includes funding for rate increases to enroll at least 93 additional providers to maintain the current ratio of three clients to one provider. Ongoing review of this program is essential to ensure clients are receiving the most cost effective care while improving outcomes.

- **Intervention addresses:** provider recruitment, provider reimbursement, expanding existing access
- **Churn reduction strategy** – In FY2015-16, Priority R-6, the Department has submitted a request to address gaps in eligibility resulting from seasonal or inconsistent monthly income. Replacing monthly income determination with an annualized income determination would permit members who have an annual income below the income threshold to stay on Medicaid continuously throughout the year. Members could maintain benefits without having to continuously reapply and enduring coverage gaps or potential churn between Medicaid and the Marketplace. Closing coverage gaps improves member access to care, helps improve member experience, and has the potential to improve member health outcomes, which could lower per capita costs. Absent a change in methodology, populations with seasonal income will continue to churn on and off of Medicaid, and high income populations would remain enrolled.
 - **Intervention addresses:** expanding existing access, administrative improvements
- **Customer Contact Center training** - In preparation for the upcoming Open Enrollment period in November 2014, Contact Center staff are being trained to use the key phrase “access to care” in their notes if clients are encountering difficulties with provider access, versus simply asking for help locating a provider that accepts Medicaid. The Department changed databases in March 2014. The new CRM software program will allow more in depth analysis of call volume and issue trends in the future.
 - **Intervention addresses:** administrative improvements, improve provider data
- **State Innovation Model (SIM) grant** – Colorado’s multi-agency proposal to integrate physical and behavioral health care for better outcomes and lower costs. The Department presented a defense of its proposal in early October and hopes to be notified a SIM grant award by December 2014.
 - **Intervention addresses:** integrated care, expanding existing access, administrative improvements

Collaborative Interventions Underway

- **NGA Healthcare Workforce Technical Assistance Grant** – administered by the

Governor's Policy Office, this statewide initiative brings multiple state agencies together to develop and implement a plan for expanding Colorado's healthcare workforce capacity.

- **Intervention addresses:** provider recruitment, expanding existing access, improve provider data
- **Healthcare Workforce Data Group** – lead by the CDPHE Primary Care Office, this multi-agency workgroup is determining how to develop a more accurate and detailed database of workforce data that can be shared and maintained by participants. Data will be used to inform policy decisions, educational program development, budget requests, grant applications, and other initiatives.
 - **Intervention addresses:** provider recruitment, expanding existing access, improve provider data
- **Colorado Health Services Corp (CHSC)** - administered by the CDPHE Primary Care Office, the CHSC is a state educational loan repayment program that supports providers to live in and serve rural and under-served communities across Colorado. CHSC is now the top program of its kind in the U.S., administering over \$4 million in loan repayment funds annually.
 - **Intervention addresses:** provider recruitment, expanding existing access, provider support
- **Bureau of Primary Health Care FY15 New Access Point applications** – The Department is supporting six Colorado applications for new clinic locations or Community Health Center status for an existing location were submitted in September 2015. Each applicant is strongly encouraged to participate in the ACC program.
 - **Intervention addresses:** provider recruitment, expanding existing access
- **NPATCH** – multi-provider scope of practice initiative for Nurse Practitioners (NPs), whose goal is to modify current requirements for NPs in a way that encourages more NPs to practice independently, expanding access to primary care. A formal proposal from this workgroup should be submitted by mid-October 2014.
 - **Intervention addresses:** expanding existing access, provider support
- **Colorado Access to Care Dashboard:** The Colorado Health Institute (CHI), in partnership with the Colorado Coalition for the Medically Underserved, is developing a data dashboard to examine whether the increase in insurance coverage translates to an increase in access to needed medical, behavioral and dental care. The dashboard will include indicators designed to measure, over time, the potential access to care, the realized access to care, and the barriers to receiving care experienced by Coloradans at both statewide and regional levels. CHI is aiming to make the dashboard available on its

website early in 2015.

- **Intervention addresses:** improve provider data
- **Development of lay health workers**, e.g. Community Health Workers, Patient Navigators, Promotoras – lay health workers are being used successfully in many state Medicaid programs to provide patient education, promote use of preventive services, support health behavior changes, and provide a culturally appropriate connection between patients and their health care teams. A statewide initiative is currently developing core competencies and recommendations on training curricula for these providers. The Department is working on implementation of Community Health Workers within the ACC program to provide critical “boots on the ground” support for ACC members in their communities.
 - **Intervention addresses:** care coordination, member support/education, expanding existing access, provider support
- **Community para-medicine initiatives** – Ten or more community para-medicine modes are currently deployed in Colorado, including two pilot projects under the ACC program. These models use EMTs and paramedic teams in the community in a variety of ways, including emergency department diversion and provision of basic primary care health services in areas where no primary care providers exist or capacity is extremely limited. The Colorado Commission for the Medically Underserved (CCMU) has been studying these programs to determine ways that such models can become financially sustainable and integrated into the larger healthcare system.
 - **Intervention addresses:** member support/education, expanding existing access, provider support
- **Colorado Area Health Education Center (AHEC) programs** – These regional initiatives promote healthcare professions to youth with the goal of participants returning to serve their communities following healthcare profession training. Some AHECs are actively tracking the rate at which participants actually enter healthcare professions and how many are still interested although not engaged yet.
 - **Intervention addresses:** provider recruitment
- **Certification of behavioral health peer support specialists** – Peer support specialists provide cost-effective prevention services, education and support to Medicaid members with behavioral health conditions. Peer support specialists have been part of Medicaid’s Behavioral Health Organization workforce for several years. The Department worked with stakeholders to develop a set of core competencies for these workers within BHO provider networks, but an initiative to support certification of peer specialists who can work across all payers and programs is now underway.
 - **Intervention addresses:** enabling services for members, member support/education, provider recruitment, expanding existing access

CONCLUSION

Concern about access to cost effective care for Colorado Medicaid members is not new. Since Colorado committed to expanding Medicaid, the Department has focused on expanding access to a medical home level of care for Medicaid members through the ACC program. The ACC has continued to evolve, with 70% of Medicaid members now enrolled. Further, over 70% of ACC enrollees are connected to a Primary Care Medical Provider (PCMP) that serves as the member's medical home.

The initial focus of the ACC was on primary care. Focus is now shifting to integration of behavioral health into the ACC, recognizing the importance of behavioral health to overall health. The Department also strongly supports integrated treatment sites, in which physical and behavioral health are provided to Medicaid members in one location. We anticipate that the SIM grant, once awarded to Colorado, will move us forward significantly in this area.

Some of the most complex Medicaid members are those who have both Medicare and Medicaid, many of whom also use long-term services and community supports. The Department's ACC Medicare-Medicaid Program enrolled its first members on September 1, 2014. In this program, individuals with both Medicare and Medicaid will receive care coordination, assistance with accessing needed services, and many additional resources to promote their health and wellbeing, despite being members of two complicated healthcare delivery systems.

In addition to development of the ACC program, the Department has also:

- Created a Provider Relations Unit to focus resources on provider recruitment and addressing barriers to provider participation in Medicaid.
- Expanded the Department's Quality & Health Improvement Unit to include multiple partnerships with our sister health agencies.
- Actively participated in multi-agency stakeholder meetings focused on healthcare workforce capacity and data.
- Begun identifying non-Medicaid data sources that can inform our work on provider capacity.
- Continued to develop and implement improvements to provider reimbursement.
- Supported efforts to allow providers to work at the top of their scope of practice.
- Explored options for using technology to help extend provider capacity and improve quality of care.
- Developed a mobile app to help Medicaid members locate providers.
- Supported a program evaluation position funded by the Colorado Health Foundation and Rose Foundation to evaluate the ACC program and to work with other groups that might be interested in performing program evaluations for the Department.
- Established close ties with the University of Colorado Medical School and School of Nursing to ensure that provider training includes a focus on publicly funded healthcare, team-based care, and patient-centered care.
- Developed innovative pilot projects to extend access to care based on community needs
- Continued to expand and enhance the ACC program as Colorado Medicaid's primary system for delivery of cost effective care to Medicaid members. The ACC and the RCCOs are a

testament to the success of this model and our November 1, 2013 ACC report shows the continued success of this program for our members and for the state.⁴

As mentioned earlier, in some areas of Colorado (both rural and urban underserved), primary and specialty care are not available, regardless of payer. Even Coloradans with commercial insurance plans face access challenges in some areas and have long wait times for non-urgent appointments. The Center for Improving Value in Health Care (CIVHC) administers the Colorado All Payer Claims Database (APCD) which currently includes 2009-2012 historical claims data from commercial payers' individual and large-group fully-insured lines of business, plus Colorado Medicaid.

As part of its overall data collection strategy, the Department will work with CIVHC to compare the claims history of individuals insured in the commercial market versus members covered by Colorado Medicaid. The Department can compare the information gathered through the needs assessments for both primary care and specialty care to the claims history in the same geographic locations. This will help the Department understand where access to care in its Medicaid program is lacking because providers do not participate with Colorado Medicaid versus geographic areas throughout the state where access to primary and specialty care are simply not available to any Coloradans. The Department can then define and develop the strategies needed to target a demonstrable increase in access to care in those geographic areas through increased provider outreach and enrollment, versus strategies being used to extend existing provider capacity, such as Project ECHO, telemedicine, and Doc2Doc/eConsult models.

Colorado is recognized as a forerunner in healthcare reform and a leader in promoting accountable (coordinated?) care. Significant effort will continue to be focused not only on provider recruitment and retention, but on physical, social, economic and cultural access for Medicaid members and ways that technology can support these initiatives. The Department is committed to ongoing collaborations with our sister health agencies, local government and communities, and stakeholders to strengthen the health and wellbeing of all Coloradans.

⁴ This report is the Department's response to the FY 2013-14 Legislative Request for Information #2.