SMART Hearing

January 4, 2018

Tom Massey, Interim Executive Director
John Bartholomew, Chief Financial Officer
Gretchen Hammer, Medicaid Director
Chris Underwood, Health Information Office Director
Judy Zerzan, Chief Medical Officer

https://www.colorado.gov/hcpf/legislator-resource-center

Our Mission

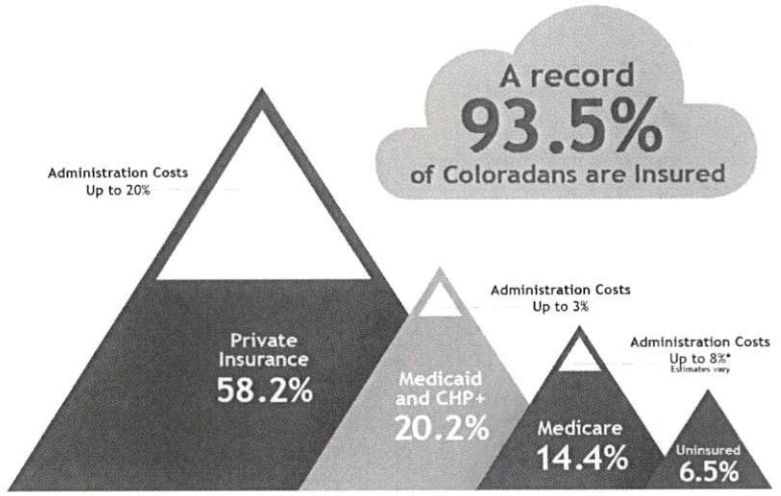
Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Presentation Agenda

- Department Overview
- Governor's Dashboard & Performance Plan
- Major Initiatives
- Hot Topics: Opioids, Colorado interChange, CHIP
- Budget Requests
- Legislative Agenda
- Regulatory Agenda & Required Statutory Updates
- Committee Questions

Department Overview

Coverage in Colorado



Source: Insurance coverage percentages are from the Colorado Health Access Survey, September 2017.

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Examples of Department Administered Programs

- Health First Colorado (Medicaid)
- Child Heath Plan *Plus* (CHP+)
- Old Age Pension (OAP) Medical Programs
- Colorado Indigent Care Program (CICP)

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Health First Colorado Members

41%
Age 20 & younger and qualifying former foster care youth

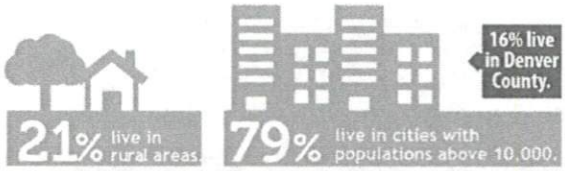
47%
Adults ages 21-64

6%
People with Disabilities all age groups

3%
Individuals 65 and older

2017 Federal Poverty Levels by Family Size*		
	Family of 1	Family of 4
133%	$16,044	$32,724
260% (CHP+)	NA	$60,625

Source Note: FY 2016-17 data, the sum does not equal 100% due to rounding and exclusion of individuals who receive partial coverage.



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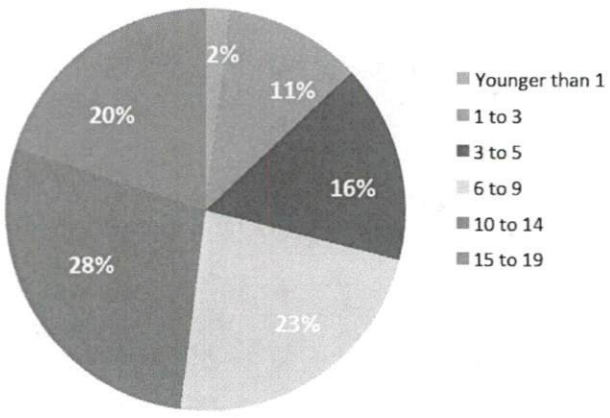
CHP+ Program Overview

CHP+ Kids by Age



CHP+ Caseload as of November 30, 2017

75,333
Kids

842
Pregnant Women

Data Note: Breakout by age is based on 2016 annual caseload, the latest monthly County by County Caseloads available at Colorado.gov/hcpf

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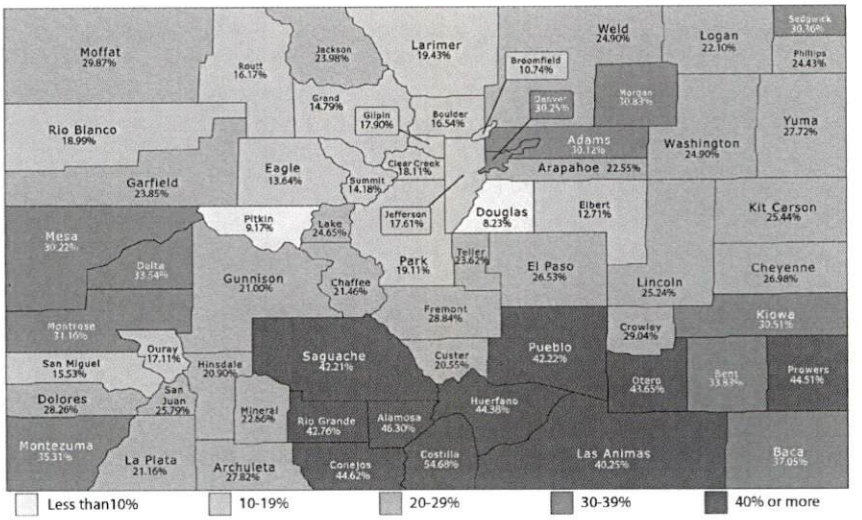
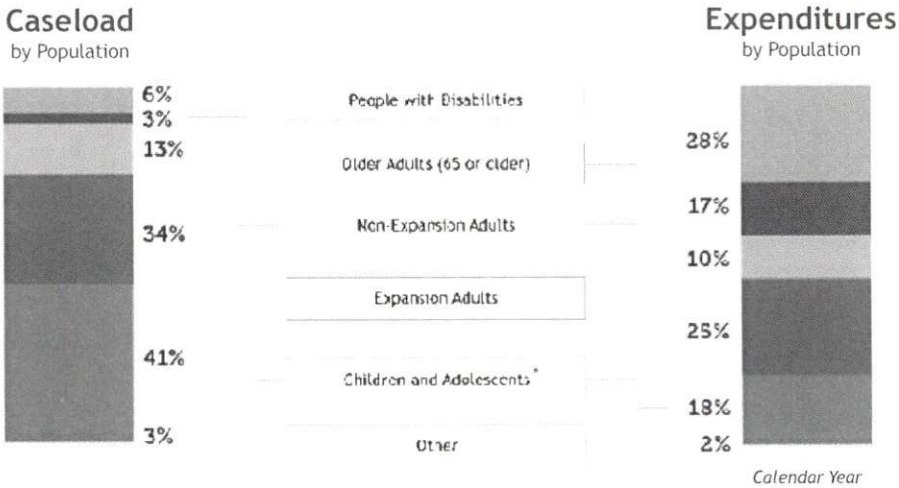
Medicaid & CHP+ Enrollment



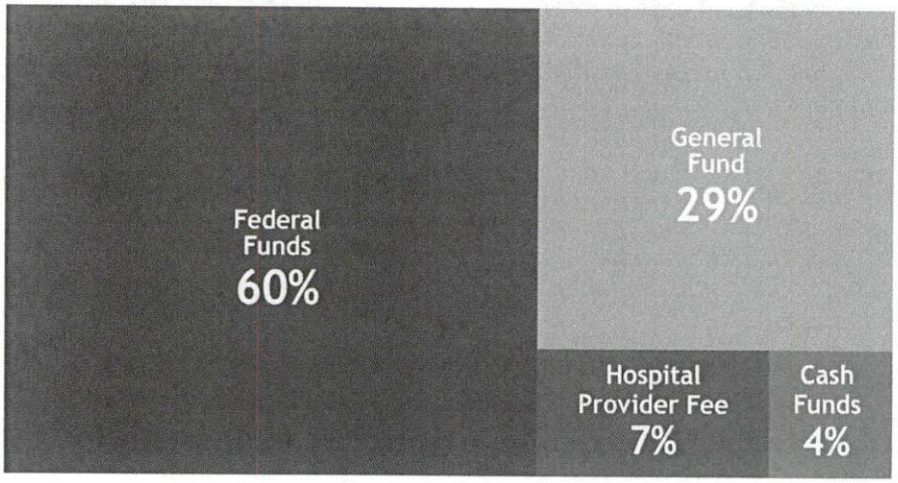
Caseload & Costs Overview



*Age 20 & younger and qualifying former foster care youth

Calendar Year 2016 Data

Medicaid Funding



FY16-17 Data

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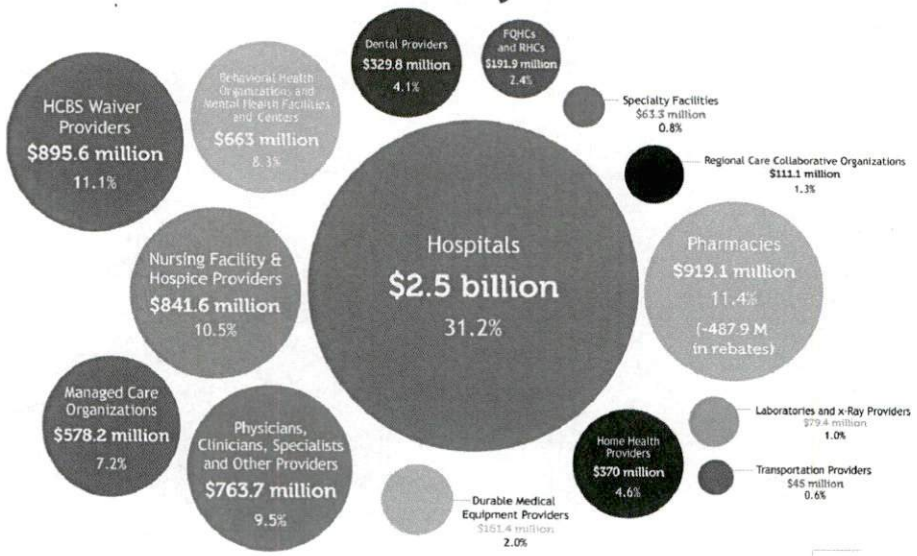
Who Gets Paid for Services?



Calendar Year 2016 Data

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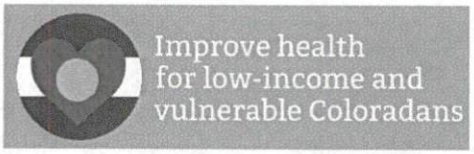
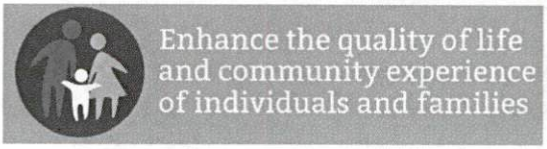
Governor's Dashboard and Department Performance Plan

Governor's Health Goals

- Support healthy weight of kids and adults
- Reduce substance use disorder
- Reduce impact on daily life of mental illness
- Increase immunization rate
- Improve health coverage
- Improve value in health care service delivery

Department Performance Plan Long-Range Goals





Department Performance Plan Strategic Policy Initiatives

1 Delivery Systems Innovation

Medicaid members can easily access and navigate needed and appropriate services

2 Tools of Transformation

The broader health care system is transformed by using levers in the Department's control such as maximizing the use of value-based payment reform and emerging health technologies

3 Partnerships to Improve Population Health

The health of low-income and vulnerable Coloradans improves through a balance of health and social programs made possible by partnerships

4 Operational Excellence

The Department is a model for compliant, efficient and effective business practices that are person- and family-centered

Improving Customer Service: Enhanced Provider Search

https://www.healthfirstcolorado.com/find-doctors/

Major Initiatives

Accountable Care Collaborative

Accountable Care Collaborative Key Concepts

To improve health and life outcomes for Members

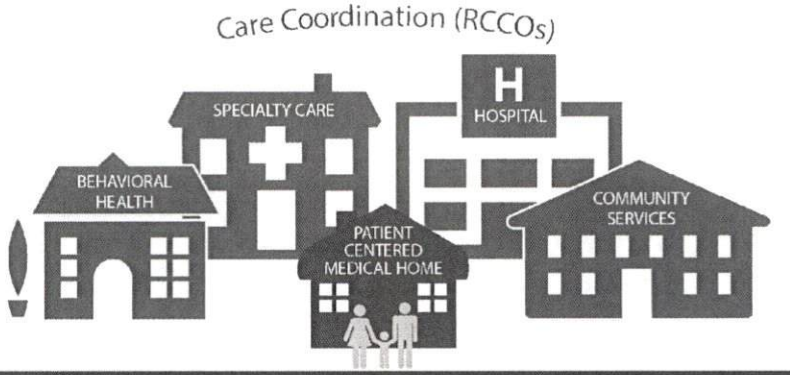
To use state resources wisely

- Single regional administrative entity for physical health care and behavioral health services
- Strengthen coordination of services by advancing health neighborhood
- Population health management approach
- Payment for integrated care and value
- Greater accountability and transparency

Regional Accountable Entities

Region	Vendor	Ownership Structure
1	Rocky Mountain Health	United HealthCare Services [Inc., a Minnesota corporation, which is a wholly owned subsidiary of UnitedHealth Group Incorporated, a Delaware corporation.]
2	Northeast Health Partners	Corporate members: Plan de Salud de Valle Inc., North Range Behavioral Health, Centennial Mental Health Center, Sunrise Community Health (Own 25% each)
3	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network
4	Health Colorado, Inc.	Owners: Valley-Wide Health Systems, Inc., Health Solutions, Beacon Health Options Inc., San Luis Valley Behavioral Health Group, Solvista Health Group, Southeast Health Group (Own 16 2/3 % each)
5	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network.
6	Colorado Community Health Alliance	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.
7	Colorado Community Health Alliance	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.

Accountable Care Collaborative



Data & Analytics (SDAC)

Long Term Services & Supports

What are Long-Term Services and Supports?

At Home (e.g. personal or family home; group homes; assisted living facilities)

In Community (e.g. day programs; supported employment)

Within Institutions (e.g. nursing homes; intermediate care facilities)

Who Receives LTSS?

7%	44%	49%
		
Children & Adolescents *ages 20 & younger & qualifying former foster care youth*	**Adults** *ages 21-64*	**Older Adults** *65 or older*

Source Note: CY 2016 data; Data represent percentage of people receiving Medicaid LTSS in various age groups

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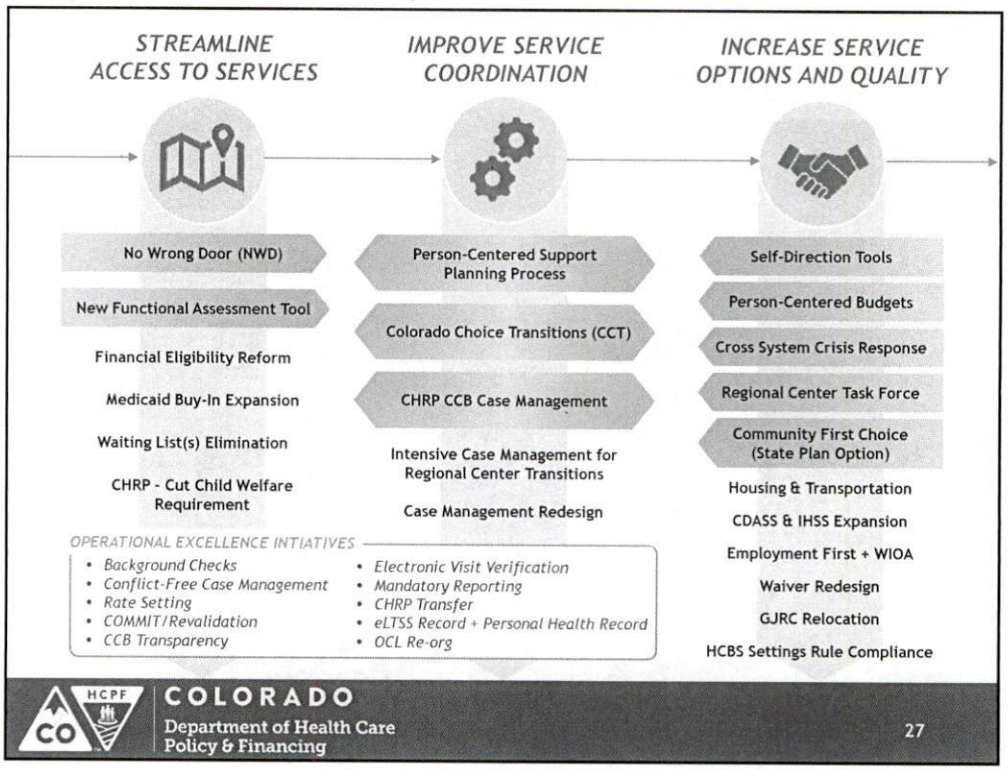
Medicaid Waivers for Home and Community Based Services (HCBS)

- Brain Injury Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver
- Children's Habilitation Residential Program Waiver
- Children's Home and Community-Based Services Waiver
- Community Mental Health Support Waiver
- Elderly, Blind, and Disabled Waiver
- Spinal Cord Injury Waiver
- Children's Extensive Support Waiver
- Persons with Developmental Disabilities Waiver
- Supported Living Services Waiver

Certain federal rules for the Medicaid State Plan can be waived so we can provide additional services so members can live in the community.


STREAMLINE ACCESS TO SERVICES
IMPROVE SERVICE COORDINATION
INCREASE SERVICE OPTIONS AND QUALITY
No Wrong Door (NWD)
New Functional Assessment Tool
Financial Eligibility Reform
Medicaid Buy-In Expansion
Waiting List(s) Elimination
CHRP - Cut Child Welfare Requirement
Person-Centered Support Planning Process
Colorado Choice Transitions (CCT)
CHRP CCB Case Management
Intensive Case Management for Regional Center Transitions
Case Management Redesign
Self-Direction Tools
Person-Centered Budgets
Cross System Crisis Response
Regional Center Task Force
Community First Choice (State Plan Option)
Housing & Transportation
CDASS & IHSS Expansion
Employment First + WIOA
Waiver Redesign
GJRC Relocation
HCBS Settings Rule Compliance
OPERATIONAL EXCELLENCE INTIATIVES
• Background Checks
• Conflict-Free Case Management
• Rate Setting
• COMMIT/Revalidation
• CCB Transparency
• Electronic Visit Verification
• Mandatory Reporting
• CHRP Transfer
• eLTSS Record + Personal Health Record
• OCL Re-org
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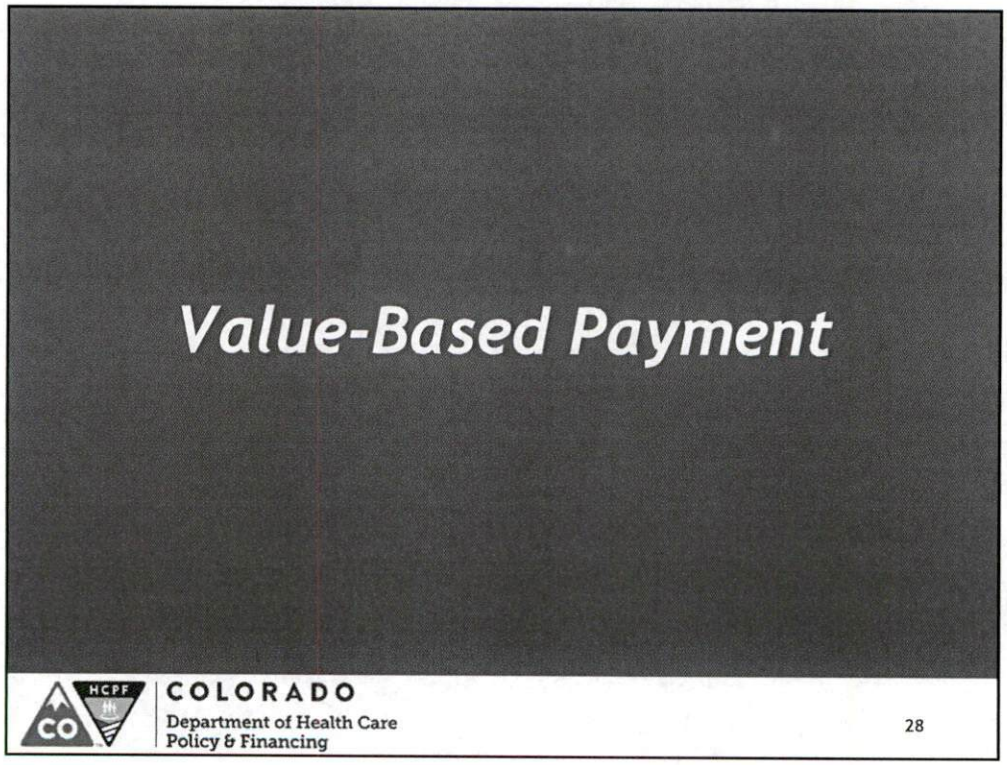
Value-Based Payment
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Value- Based Payment: Current Initiatives

- Hospitals
- Federally Qualified Health Centers
- Primary Care
- Pharmacy

Hot Topics: Opioids, Colorado InterChange & Children's Health Insurance Program

Opioids: Our Work to Date

Pre-2012:
Quantity limits on long-acting opioids; Made Suboxone a covered benefit without a limited time of coverage

2012:
National Governor's Association Prescription Drug Abuse Reduction Policy Academy

2013:
Colorado Consortium for Prescription Drug Abuse Prevention

2014:
Pain resource page on Department's website; Tightened policy on short-acting opioids

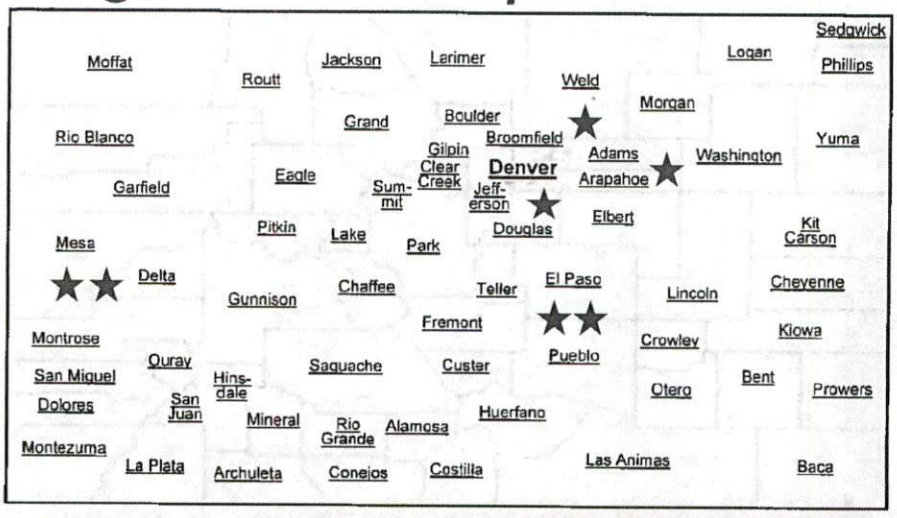
2015:
DUR letters to prescribers; Consultation services through DUR contractor; Project ECHO; Physical Therapy Rate Increase

2016:
MME policy; Buprenorphine Project ECHO program

2017:
Quantity limit on short-acting opioids for treatment naïve members; Reducing MME

Combating the Opioid Crisis

Colorado interChange: Regional Field Representatives



Update on CHIP

	Medicaid CHP (MCHIP)	Child Health Plan *Plus* (CHP+)
# of Kids and Pregnant Women Covered	67,024 children 2,391 pregnant women	75,333 children 842 pregnant women
Family Income Limits ($ Estimate is for a Family of 4)	MCHIP Kids: Up to $2,911/month MCHIP Pregnant: Up to $3,998/month	Up to $5,330/month
Current Federal Match Rate	88%	88%

Source: November 2017 Caseload Data

Budget Requests

- R6 - Electronic Visit Verification
- R7 - HCBS Transition Services Coordination
- R8 - Medicaid Savings Initiatives
- R9 - Provider Rate Adjustments
- R10 - Drug Cost Containment Initiatives
- R11 - Administrative Contracts Adjustments
- R12 - Children's Habilitation Residential Program Transfer
- R13 - All Payer Claims Database (APCD) Funding
- R14 - Safety Net Program Adjustments
- R15 - CHASE Administrative Costs
- R16 - CPE for Emergency Medical Transportation
- R17 - Single Assessment Tool Financing
- R18 - Cost Allocation Vendor Consolidation
- R19 - IDD Waiver Consolidation Administrative Funding

Legislative Agenda

- Achieve Cost Savings Through Transition Services & Community Living
- Align Managed Care Statute with Federal Regulations
- Implement Conflict-free Case Management for SEPs
- Redesign of Children's Habilitation Residential Program Waiver
- Remove Outdated Waiver Language from Statute

Regulatory Agenda

- Began Regulatory Review Process in 2013
- 2017 final year of initial 5-year review cycle
- 1,400 sections have been reviewed
- In 2018, Department will review Long Term Care Rules

Statutorily Required Updates

- **HB 13-1196:** Reducing waste through the Accountable Care Collaborative
- **SB 17-121:** Improve Medicaid Client Correspondence

Legislator Resource Center: Staying Engaged

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Thank You

Strategic Policy Initiatives

The Department of Health Care Policy and Financing identified several strategic policy initiatives, or SPIs, to be accomplished in FY 2016-17 as part of its annual performance plan. Due to data sources with reporting lag time, data is available at varying intervals. Alphabetical footnotes beneath each table describe performance; numeric footnotes provide technical information. Additional detail about the Department's SPIs is available in the Department's Performance Plan.

SPI 1: Delivery Systems Innovation: Medicaid members can easily access and navigate needed and appropriate services

Work supporting this SPI focuses on strengthening delivery systems such as the Accountable Care Collaborative (ACC), Behavioral Health Organizations, and Home and Community Based Services for the Elderly and Disabled. In addition, we are working to increase integration of physical and behavioral health services.

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
% ACC members with an enhanced primary care medical provider [a]	60%	57%	65%
# Benefits modified to align with new data, research, or evidence-based guidelines	35	102	85
# Colorado providers serving Medicaid [b]	51,673	50,466	41,008
# Colorado primary care providers serving Medicaid [b]	23,145	31,235	21,616
% Nurse Advice Line calls referred to more appropriate level of care	56%	50%	55%
# PEAK App users	34,644	79,399	50,000
% New mothers receiving maternal depression screening [c]	20%	25%	13%
# Members in practices that receive behavioral health integration incentives [d]	163,770	155,500	375,000
# Community Living Advisory Group recommendations fully or partially implemented	15	18	5

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
% Persons receiving HCBS services expressing social inclusion or connectedness to the community [e]	58%	45%	59%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services [e]	74%	67%	75%

a The decline in ACC members attributed to a PCMP is likely due to provider revalidation and implementation of the new interChange. The Department is working with RCCOs to ensure members are appropriately attributed to a PCMP, and will continue assisting providers in becoming certified as enhanced PCMPs.
b Provider enrollment methodology was updated in March 2017 due to launch of Commit and BIDM. Historical data restated.
c Methodology adjusted in FY 2016-17 to include screenings not in the billing system. Historical data restated.
d Progress delayed by changes to implementing timeline of SIM Cohort 2 from winter 2016 to fall 2017.
e The NCI-AD (Aging and Disabled) and NCI-IDD (Individuals with Developmental Disabilities) Consumer Surveys are used to assess this measure. Data is up to 18 months in arrears. The Department is focusing on training case managers and providers on person-centered supports to ensure members are receiving the highest quality services.

SPI 2: Tools of Transformation: The broader health care system is transformed by using levers in our control such as maximizing the use of value-based payment reform and emerging health technologies

Medicaid, like Medicare, is an influential payer and policy maker nationwide. This makes it possible to use levers within our control to impact the broader health care system. For example, by implementing provider payment incentives to improve health outcomes in the Accountable Care Collaborative, we align with other payers in Colorado to use and improve upon these incentives. The same applies to the use of advanced health information technology and data analytics to improve quality and continuity of care. Work supporting this SPI focuses on increasing the impact of Colorado Medicaid investments and innovations to transform the broader health care system.

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
$ Provider payments tied to quality or value through innovative payment methods [a]	$424,606,261	$447,025,667	$262,722,933
$ Total costs avoided from ACC and Medicaid (in millions)	$75	$83	$62
$ Medicaid per-capita total cost of care [b]	$6,092	$5,902 [1]	$6,046
# Medicaid professionals demonstrating meaningful use of electronic health records [c]	7,878	8,393	10,924

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
Providers with a quarterly report card; % of expenditures	28%	24%	29%
# Primary care providers who log in to SDAC/BIDM portal	533	661 [2]	600

1 Estimate. Data not yet available.
2 SDAC—State Data Analytics Contractor; BIDM – Business Intelligence and Data Management system.

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a Provider payments tied to quality methodology was updated in July 2017 to align with the Centers for Medicare and Medicaid Services' standard definition for measuring value-based purchasing efforts.
b Per-capita expenditures are lower than previously estimated due to lower than normal payments to providers after the transition to the new MMIS system in March 2017; the Department anticipates making payments in FY18 for claims that were unable to be paid in FY17. FY18 per capita is projected to increase due to these expenditures and higher hospital supplemental payments, as authorized under SB 17-267.
c The Electronic Health Records Demonstration Project completed the new provider enrollment phase in 2016. The project will cease in 2021. The Department is discontinuing reporting on this measure.

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

The Department seeks to improve the health and well-being of Coloradans served by the Medicaid program and of the population as a whole. Appropriate health care must be complemented by addressing additional determinants of health – social, economic, and geographic among them. This SPI focuses on our efforts to advance community-based health supports in partnership with entities including other state agencies, local public health organizations, non-profits, health care providers, and community centers.

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
# Members in counties with a RCCO-LPHA relationship	814,606	846,355 [1]	827,799
# SIM education activities targeted toward PCMPs and community partners	13	26 [2]	28

1 RCCO – Regional Care Collaborative Organization; LPHA – local public health agency.
2 SIM – State Innovation Model project for physical/behavioral health integration and payment reform; PCMPs – primary care medical providers.

SPI 4: Operational Excellence: We are a model for compliant, efficient and effective business practices that are person- and family-centered

To achieve this SPI we are redesigning our information technology infrastructure, improving data analytics capacity, advancing a culture of continuous improvement, and nurturing a well-trained, satisfied workforce.

Performance Measures	FY16 Actual	FY17 Actual	FY17 Goal
% Favorable responses to employee survey "We get work done more efficiently..."	47%	46%	50%
% Employee retention for 36 months or more	58%	58%	45%
% Electronically submitted clean claims processed within 7 business days	N/A	N/A [1]	95%
% Providers notified of missing or incomplete enrollment information within 5 business days	N/A	N/A [1]	100%
$ Dollar equivalent of Lean efficiency gains (cumulative)	$345,959	$479,057	$505,885
% First call resolution by Member Contact Center	75%	89%	86%
# Items vetted through person-centered advisory councils	77	59	65
% Persons receiving HCBS services with person-centered goals identified in their service plan	53%	54%	55%
$ Dollars recovered from overpayments to providers [a]	$14,125,130	$6,662,965	$9,000,000
$ Dollars recovered from third party liability	$76,333,409	$72,058,987	$66,000,000
% Existing Office of State Auditor recommendations resolved	90%	N/A [2]	90%
# Individuals enrolled in Medicaid/CHP+	1,348,695	1,411,157	1,444,761
% Eligibility determinations processed timely	98%	98%	98%
% Real time eligibility (RTE) applications [b]	62%	55%	62%

1 Data not available due to COMMIT-related system changes.
2 Audit recommendations data unavailable.

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a Claims-driven recoveries in FY17 were delayed by change in COMMIT implementation date
b Data reflects all applications submitted that receive an RTE determination. Not every application is eligible for an RTE determination.

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MAGI MEDICAID
Monthly Maximum Income Guidelines[1]
Effective April 1, 2017

Family Size	Parents & Caretaker Relatives 68% Poverty Level	Adults (Ages 19-65) 133% Poverty Level	Children (Ages 0-18) 142% Poverty Level	Pregnant Women 195% Poverty Level
1	684	1,337	1,428	1,960
2	921	1,800	1,922	2,639
3	1,158	2,264	2,417	3,319
4	1,394	2,727	2,911	3,998
5	1,631	3,190	3,406	4,677
6	1,868	3,654	3,901	5,356
7	2,105	4,117	4,395	6,036
8	2,342	4,580	4,890	6,715
9	2,579	5,043	5,385	7,394
10	2,816	5,507	5,879	8,073

[1] Co-payments may apply; no co-pays for American Indians, Alaska Natives, or for a pregnant woman and her household.

COLORADO
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CHILD HEALTH PLAN *PLUS*
Monthly Maximum Income Guidelines
Effective April 1, 2017

		Enrollment Fee: 1 Child $25.00 2 or More $35.00					**Enrollment Fee:** 1 Child $75.00 2 or More $105.00		
Poverty Level	**143-156% F-**	**157-159% F+**	**160-170% G-**	**171-185% G+**	**186-200% J**	**201-213% K**	**214-225% L**	**226-235% M**	**236-260% O**
Family Size									
1	1,429 – 1,568	1,569 – 1,598	1,599 – 1,709	1,710 – 1,860	1,861 – 2,010	2,011 – 2,141	2,142– 2,262	2,263 – 2,362	2,363 – 2,613
2	1,923 – 2,112	2,113– 2,152	2,153 – 2,301	2,302– 2,504	2,505 – 2,707	2,708 – 2,883	2,884 – 3,045	3,046 – 3,181	3,182 – 3,519
3	2,418 – 2,655	2,656 – 2,706	2,707 – 2,893	2,894 – 3,149	3,150 – 3,404	3,405 – 3,625	3,626 – 3,829	3,830 – 3,999	4,000– 4,425
4	2,912 – 3,198	3,199 – 3,260	3,261 – 3,485	3,486 – 3,793	3,794 – 4,100	4,101 – 4,367	4,368– 4,613	4,614– 4,818	4,819 – 5,330
5	3,407– 3,742	3,743 – 3,814	3,815 – 4,078	4,079– 4,437	4,438 – 4,797	4,798 – 5,109	5,110– 5,397	5,398 – 5,637	5,6381– 6,236
6	3,902– 4,285	4,286 – 4,368	4,369 – 4,670	4,671 – 5,082	5,083– 5,494	5,495 – 5,851	5,852 – 6,180	6,181 – 6,455	6,456 – 7,142
7	4,396– 4,829	4,830 – 4,922	4,923 – 5,262	5,263 – 5,726	5,727 – 6,190	6,191 – 6,593	6,594 – 6,964	6,965 – 7,274	7,275 – 8,047
8	4,891 – 5,372	5,373 – 5,475	5,476 – 5,854	5,855– 6,371	6,372 – 6,887	6,888 – 7,335	7,336 – 7,748	7,749 – 8,092	8,093 – 8,953
9	5,386– 5,915	5,916 – 6,029	6,030 – 6,446	6,447 – 7,015	7,016– 7,584	7,585 – 8,077	8,078 – 8,532	8,533 – 8,911	8,912– 9,859
10	5,880 – 6,459	6,460 – 6,583	6,584 – 7,038	7,039 – 7,659	7,660 – 8,280	8,281 – 8,819	8,820 – 9,315	9,316 – 9,729	9,730 – 10,764

- Letters correspond to the rating codes in CBMS
- Co-payments may apply
- No enrollment fee or co-pays for American Indians, Alaska Natives, or for a pregnant woman and her household

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
www.colorado.gov/hcpf

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Department of Health Care Policy & Financing

2018 Legislative Agenda Overview

December 2017

The 2018 legislative session will convene on January 10, 2018. A brief overview of the Department of Health Care Policy & Financing's (the Department) legislative agenda is outlined below.

Department Legislative Agenda

Redesign of Children's Habilitation Residential Program (CHRP) Waiver:
The Children's Habilitation Residential Program (CHRP) Waiver provides residential services for children and youth in foster care who have a developmental disability and very high needs. CHRP is the last remaining Medicaid waiver administered by the Department of Human Services.

The current eligibility requirements for CHRP (namely the requirement that the child be in foster care) often force families to relinquish their custodial rights over their child so the child can qualify for the vital services and supports that the CHRP waiver provides. Once on CHRP, a child's services are case managed by counties which have repeatedly expressed they do not have the expertise or infrastructure to appropriately serve these children.

The budget request and corresponding legislation would modify the eligibility requirements of CHRP so a child does not need to be in foster care or deemed neglected or abandoned to qualify. The proposal would also move the administration of the waiver from the Department of Human Services to Health Care Policy and Financing and move case management duties from the counties to case management agencies.

Legislation is necessary to remove the statutory requirement that a child be involved in the foster care system, references to the Department of Human Services and county case management requirements. This proposal also has a corresponding budget request, which can be viewed here.

Conflict-free Case Management (CFCM) for Single-Entry Points:
In order to come into compliance with the Federal Home and Community Based Services (HCBS) Settings Rule, this bill would ensure conflict-free case management within the Single Entry Point (SEP) system and would align with HB17-1343, which ensured conflict-free case management within the Community Centered Board system.

Single Entry Points provide case management and eligibility determinations for persons who are 65 and older, blind or have other disabilities and who receive services through HCBS waivers. Some SEPs also provide direct services which is prohibited under the HCBS Settings Rule. This bill will require SEPs to separate case management from service provision.

Cost Savings through Transition Services & Community Living:
The Department has saved over $2.8 million by transitioning 274 individuals out of long-term care facilities back into home and community-based settings since April 2013 through Colorado Choice Transitions (CCT), a federally-funded demonstration program of the national Money Follows the Person Initiative.

The federally-funded demonstration is ending in 2018 and the Department wants to build upon the transition process infrastructure created by the CCT demonstration and continue to fund some of the transition services that proved most effective during the demonstration. Investment in transition services is a cost-containment initiative that improves health outcomes and client quality of life.

Legislation is needed to allow General Fund to pay for transition services previously funded through grant dollars and modify the list of benefits outlined in statute in some of the home and community-based waivers. This proposal also has a corresponding budget request, which can be viewed here.

Align Managed Care Statute with Federal Regulations:
This bill will align the Department's managed care statute (Article 6, Part 4) with the new federal managed care rule. Some of the statute is outdated and uses terms no longer in existence. Last year's ACC bill (HB17-1353) included a reporting requirement on how we plan to update this part of the statute with the new rule and align terms for ACC Phase II. This report was submitted to the Legislature on December 1, 2017 and can be found here on our website.

Remove Outdated Waiver References from Statute:
The Department is working with the Statutory Revision Committee to remove references to the Persons Living with AIDS Waiver from statute. In 2014, the Department consolidated this waiver and transferred the clients enrolled to the Elderly, Blind and Disabled waiver. The Centers for Medicare and Medicaid Services (CMS) approved this consolidation and Colorado lost its federal authority to continue operating it. As a result, this will be a "clean-up" bill.

###

COLORADO
Department of Health Care Policy & Financing

FY 2018-2019 Budget Agenda

Focus on Compliance, Cost Savings & Program Improvements

Below is a summary of the Department of Health Care Policy and Financing's discretionary budget requests submitted to the Colorado General Assembly for consideration as part of the Governor's Fiscal Year (FY) 2018-19 budget. The state Fiscal Year runs from July 1, 2018 – June 30, 2019.

Budget Requests 1-5 are directly related to caseload and impact Medical Services Premiums, Behavioral Health, Child Health Plan *Plus* (CHP+), MMA and Office of Community Living, Individuals with Developmental Disabilities budget lines. These budget lines are "trued up" throughout the year as actual caseloads and per capita costs are reconciled with projections. The below outlines other budget requests not related to caseload. The 2018 budget requests focus **on ensuring program compliance**, **achieving cost savings** and **targeted program improvements** supporting member experience. In many cases, these requests reduce General Fund expenditure in FY 2018-19, and they are budget negative in total with the exclusion of the rate increases proposed in R-9.

Each request is summarized below, additional detail as well as the caseload requests, is available at Colorado.gov/hcpf. The budget becomes final after it has been passed by the Colorado General Assembly and signed into law by the Governor.

Budget Requests

R6 | Electronic Visit Verification

Summary: The 21st Century Cures Act mandates all states implement an Electronic Visit Verification (EVV) for Personal Care services by January 1, 2019 and Home Health services by January 1, 2023. The federal law calls for reductions in federal matching funding for states that do not implement an EVV.

Colorado currently does not have an EVV system. An EVV system would require attendants to clock-in and clock-out when they begin and finish providing services using a combination of telephone and internet-based resources. Colorado currently relies on providers to bill for services rendered based on an attendant's self-reported hours. The request would fund implementation of an EVV system across multiple service types and include contracting with an EVV system vendor to create a system that interfaces with the Colorado interChange. It would fund provider training on the new system and staff

to provide oversight of the execution of the EVV implementation. States implementing an EVV system have experienced budget savings.

FY 2017-18 Budget Impact: $420,959 total funds, including $42,096 General Fund
FY 2018-19 Budget Impact: Reduction of $777,203 total funds, including $1,200,233 General Fund

R7 | HCBS Transition Services Continuation

Summary: The Colorado Choice Transitions (CCT) grant program provides services to help members interested in moving out of an institution and into the community. Community living options are more cost effective and help the Department meet the Supreme Court's Olmstead requirements. The CCT grant expires on December 31, 2020.

This request would allow the Department to continue offering some of the most effective transition services from the Colorado Choice Transitions program. The funding would also be used to increase options counseling availability for the Aging and Disability Resources for Colorado (ADRC). The Department currently offers options counseling through Regional ADRCs but is unable to meet demand.

FY 2018-19 Budget Impact: Reduction of $1,136,406 total funds, including $703,203 General Fund
FY 2019-20 Budget Impact: Reduction of $6,323,180 total funds, including $3,161,590 General Fund

R8 | Medicaid Savings Initiatives

Summary: The Department has identified savings opportunities but does not have sufficient administrative resources to implement these initiatives. The projects would require dedicated personnel and changes to complex IT systems.

This request would implement 5 savings initiatives:

- Increased utilization management
- Automating public assistance reporting information system matching
- Increased trust unit recoveries
- Increased access to public transportation benefits
- Parental fee for eligibility in Children's HCBS waiver for higher income families

FY 2018-19 Budget Impact: Reduction of $1,391,380 total funds, including $2,187,948 General Fund
FY 2019-20 Budget Impact: Reduction of $4,136,489 total funds, including $4,160,948 General Fund

R9 | Provider Rate Adjustments

Summary: The Department proposes to adjust provider rates in three ways:

1. Provide an across-the-board rate increase of 0.77% to all providers not targeted by the other components.
2. Implement a decrease to anesthesia rates and an increase to alternative care facility rates; and
3. Reduce the allowable growth factor on nursing facility per diem rates down to one percent in FY 2018-19 only. Beginning in FY 2019-20, the allowable growth factor would revert to three percent.

FY 2018-19 Budget Impact: $27,826,226 total funds, including $10,274,899 General Fund
FY 2019-20 Budget Impact: $30,391,853 total funds, including $11,103,734 General Fund

R10 | Drug Cost Containment Initiatives

Summary: Prescription drug expenditures have increased significantly in the last few years. Utilization management of Physician Administered Drugs and alternative payment models are tools the Department can use to manage benefits and lesson pressure on the state's financial resources. The funding would be used to procure a utilization management vendor for physician administered drugs and for administrative resources to set up alternative payment models for prescription drugs.

FY 2018-19 Budget Impact: $132,777 total funds, including a reduction of $24,407 General Fund
FY 2019-20 Budget Impact: A reduction of $1,512,798 total funds, including $390,093 General Fund

R11 | Administrative Contracts Adjustments

Summary: The Department is requesting funding to adjust asset verification cost estimates, rebalance appropriations between fund sources in the Professional Services Contracts line item rates, and to prepare for disallowance of external quality review organization (EQRO) claims made at an enhanced match rate not allowed by CMS.

FY 2017-18 Budget Impact: $177,606 total funds, including $88,803 General Fund
FY 2018-19 Budget Impact: $1,716,842 total funds, including $1,251,367 General Fund $831,237 in Cash Funds

R12 | Children's Habilitation Residential Program (CHRP) Transfer

Summary: The Department of Human Services oversees one home and community based waiver, known as the CHRP waiver, that provides treatment and out-of-home services for foster children with intellectual and developmental disabilities (IDD). The

current eligibility requirement that a child be involved in the foster care system can force families to surrender custody of their child to get them the services they need.

The Department is requesting funding to transfer the waiver administration to HCPF and remove the eligibility requirement that a child be involved in the foster care system.

FY 2018-19 Budget Impact: $210,455 total funds, including $105,230 General Fund
FY 2019-20 Budget Impact: $535,213 total funds, including $267,607 General Fund

R13 | All Payer Claims Database (APCD) Funding

Summary: The All Payer Claims Database (APCD) collects claims data from over 21 commercial health insurance companies and builds a more comprehensive picture of health care in Colorado. The APCD takes claims data and turns it into actionable information that provides insights about Coloradans' health, quality of care, utilization, outcomes and cost. A majority of the current grant funding received by CIVHC for the APCD is time-limited and will sunset at the end of FY 2017-18, as the need for funding to maintain the APCD is increasing. The Department is requesting funding to pay for the Medicaid share of claims within the APCD system, plus additional funding to support the end of grant funding for the APCD.

FY 2018-19 Budget Impact: $2,818,558 total funds, including $1,684,280 General Fund
FY 2019-20 Budget Impact: $2,826,570 total funds, including $1,688,287 General Fund

R14 | Safety Net Program Adjustments

Summary: The Department is requesting funding to allow for increased oversight of the Department's safety net programs and allow additional available funding to be directed towards these programs, instead of going unused. The request asks for funding for three changes to safety net programs:

- Spending authority to expend the surplus funds available in the Primary Care Fund and increase funding towards participating providers for uncompensated care of primary care services to indigent patients.
- Increased spending authority for the Senior Dental Program to allow for the reallocation of recoveries and increase the access of dental services for low-income seniors.
- Compliance audits of the Primary Care Fund Program and Colorado Indigent Care Programs to improve effectiveness and efficiencies of the programs.

FY 2018-19 Budget Impact: $81,324 in cash funds and no General Fund
FY 2019-20 Budget Impact: $138,361 cash funds and no General Fund

R15 | CHASE Administrative Costs

Summary: This request is for staff to administer and provide business services in accordance with the relevant sections of SB17-267. It is also for anticipated increases in legal costs and contracting with health care consultants to produce informative reports and analytics on the impact of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) on the greater health care marketplace.

FY 2018-19 Budget Impact: $1,192,262 total funds, including $596,132 cash funds, and no General Fund
FY 2019-20 Budget Impact: $1,200,040 total funds, including $600,018 cash funds, and no General Fund

R16 | CPE for Emergency Medical Transportation

Summary: Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. The uncompensated expenditures cannot be claimed or reimbursed through Medicaid or any other program. The Department has an opportunity to partially offset the uncompensated costs through certification of public expenditures (CPE). EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider.

FY 2017-18 Budget Impact: $180,000 total funds, including $90,000 General Fund
FY 2018-19 Budget Impact: $18,807,725 total funds, including a reduction of $620,560 General Fund. The $9,547,069 in cash funds are from CPE.

R17 | Single Assessment Tool Financing

Summary: As a result of updated timelines, recent contractor work, and receipt of additional grant funding, the Department requires the shifting of funds between fiscal years to complete the development and implementation of the single assessment tool required by SB16-192. Without the proper movement of funds, the Department would revert funds that are essential to the infrastructure of the tool and could delay implementation of the single assessment tool which is required to begin as soon as practicable after the tool selection deadline of July 1, 2018

FY 2017-18 Budget Impact: A reduction of $830,699 total funds, including $526,944 General Fund
FY 2018-19 Budget Impact: A reduction of $6,112,924, including $3,056,462 General Fund

R18 | Cost Allocation Vendor Consolidation

Summary: The Department is required to comply with federal requirements of cost allocation of administrative costs to ensure that costs are allocated appropriately to various federal programs and to ensure no duplication of payments. Compliance has become more difficult over time due to increased complexity of Department operations, increased caseload and enhanced match rates. To date, the Department has absorbed costs related to compliance within existing appropriations. The Department is requesting to procure a cost allocation vendor to assist the Department in compliance of federal cost allocation requirements and to ensure that costs are appropriately allocated between programs.

FY 2018-19 Budget Impact: $366,400 total funds, including $120,050 General Fund
FY 2019-20 Budget Impact: $373,728 total funds, including $122,451 General Fund

R19 | IDD Waiver Consolidation Administrative Funding

Summary: The Department was unable to implement a consolidated adult IDD waiver by July 1, 2016 due to obstacles that were discovered through the stakeholder process and additional research identified through contractor work that require resources and time to resolve. The Department is requesting additional funding to hire contractors to continue work related to redesigning the HCBS-DD and HCBS-SLS waivers and submit the waiver application to CMS for review by July 2019.

FY 2018-19 Budget Impact: $478,500 total funds, including $239,250 General Fund
FY 2019-20 Budget Impact: $177,000 total funds, including $88,500 General Fund

For more information contact

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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

To: Joint Budget Committee, Joint Technology Committee and Health Committee Members

Cc: Eric Kurtz, JBC Analyst & Jean Billingsley, JTC Analyst

From: Chris Underwood, Health Care Policy & Financing, Health Information Office Director

Subject: COMMIT Project Update

Date: December 20, 2017

Joint Budget Committee, Joint Technology Committee and Health Committee Members:

Below is the December 30-day update on the COMMIT project launch from the Department of Health Care Policy & Financing (the Department). As you will recall, we launched our new claims payment system, the Colorado interChange, on March 1, 2017. Our new fiscal agent is DXC Technology (DXC).

This update includes data which demonstrates we are approaching normal operations; the volume of interim payments is going down and providers are beginning to repay those payments and referrals to our escalation process are declining.

The Department recognizes some system issues remain, and as always these are archived on our Known Issues and Updates web page, so we continue to develop resources for providers based on feedback from our provider stakeholders. Most recently, the Department conducted a live webinar about revalidation and used questions from the participants to update its revalidation FAQs. We also added FAQs to provide additional information about Timely Filing.

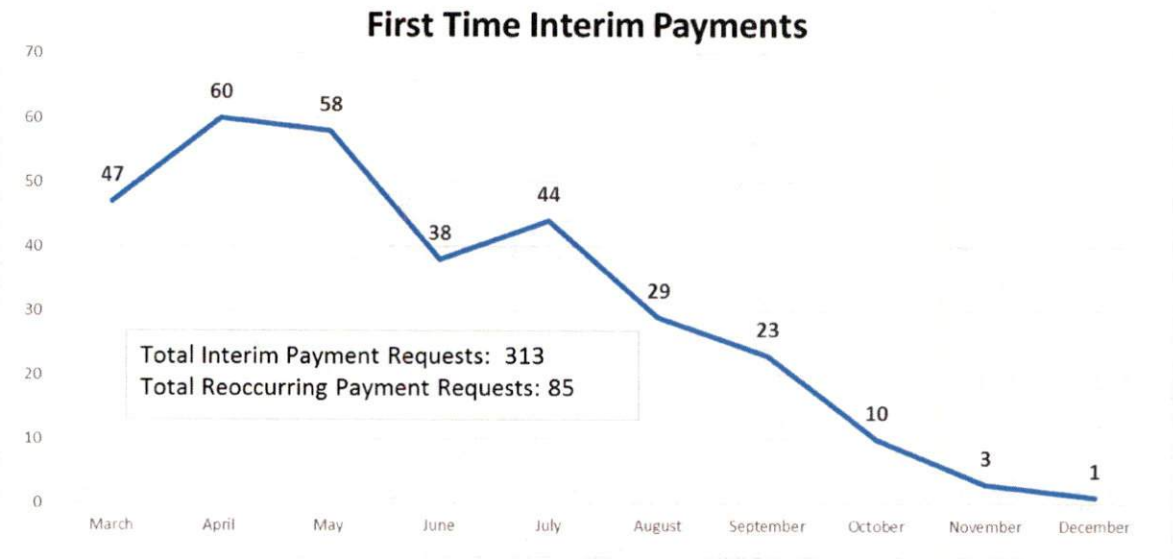
Colorado interChange by the numbers (as of 12/18/2017)

- 54,125 providers enrolled and growing every day
- $6.3 billion paid to providers
- Nearly 40 million claims processed

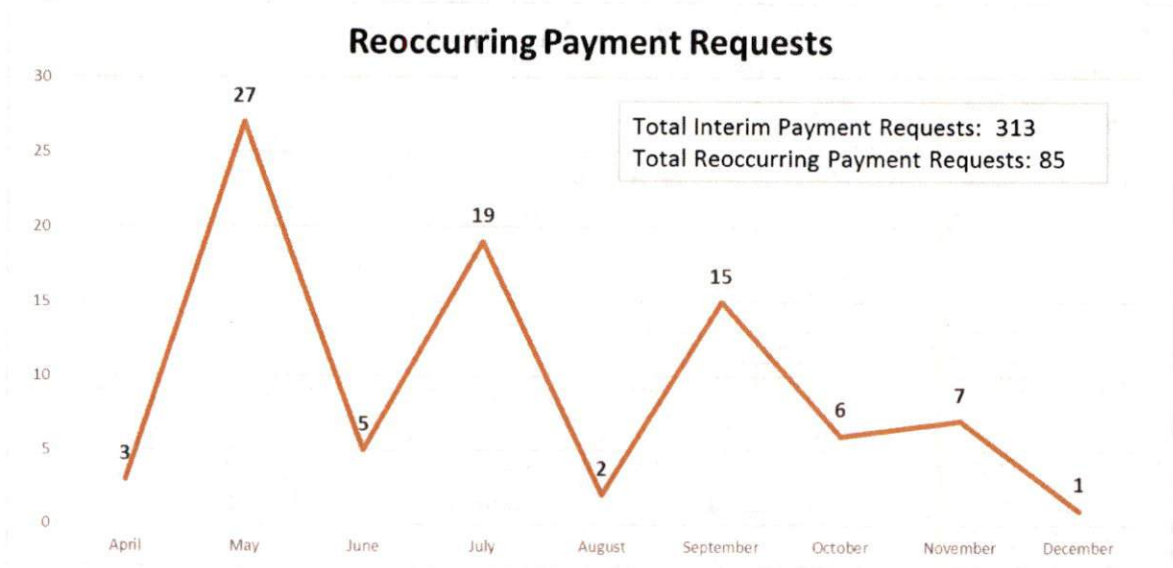
Trends in Interim Payment Offers

The Department offers financial assistance to providers experiencing financial difficulties in the form of interim payments. Interim payments are meant to provide temporary relief to providers until their claims are processed correctly, not to pay an outstanding balance. Interim payments are available to every provider regardless of the volume of members they serve.

To date, 313 providers have received interim payments. The chart below demonstrates the downward trend for interim payments. Not only have requests gone down, we have had 47 providers begin or repayment (more than $3.5 million has been repaid).

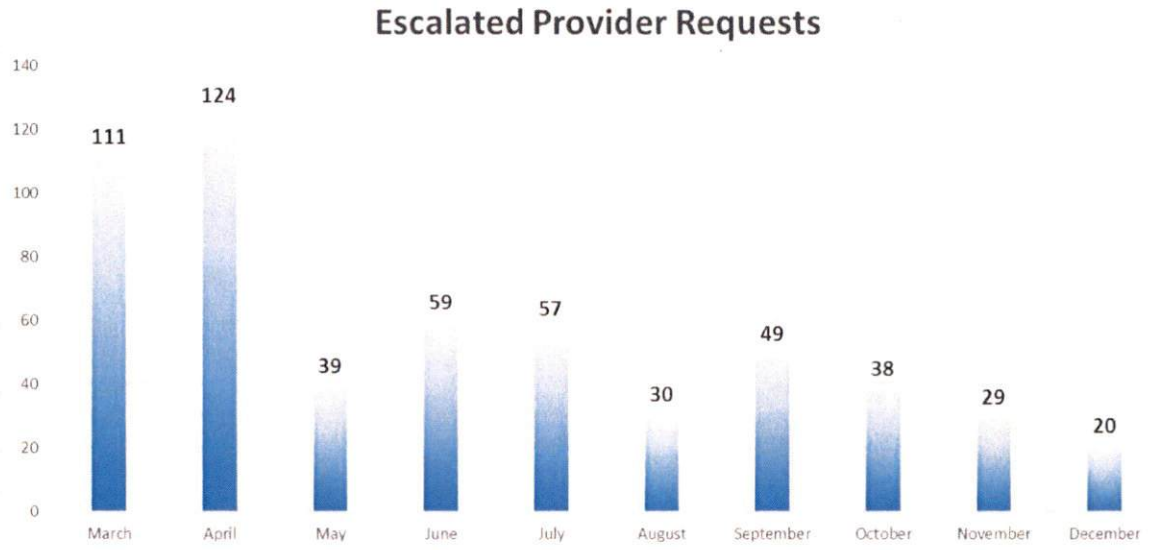


The Department understands a one-time payment of 80% of historical payments is not sufficient to sustain many providers experiencing distress. Therefore, the Department allows providers to request recurring interim payments. Upon request, these payments are automatically processed on a weekly basis until the provider requests or until the Department or DXC resolves billing issues. At this time, 85 providers are receiving recurring payments. The chart below shows the decline in new requests for recurring payments. Of the total amount of interim payments, 12% has been voluntarily paid back to the Department from providers.



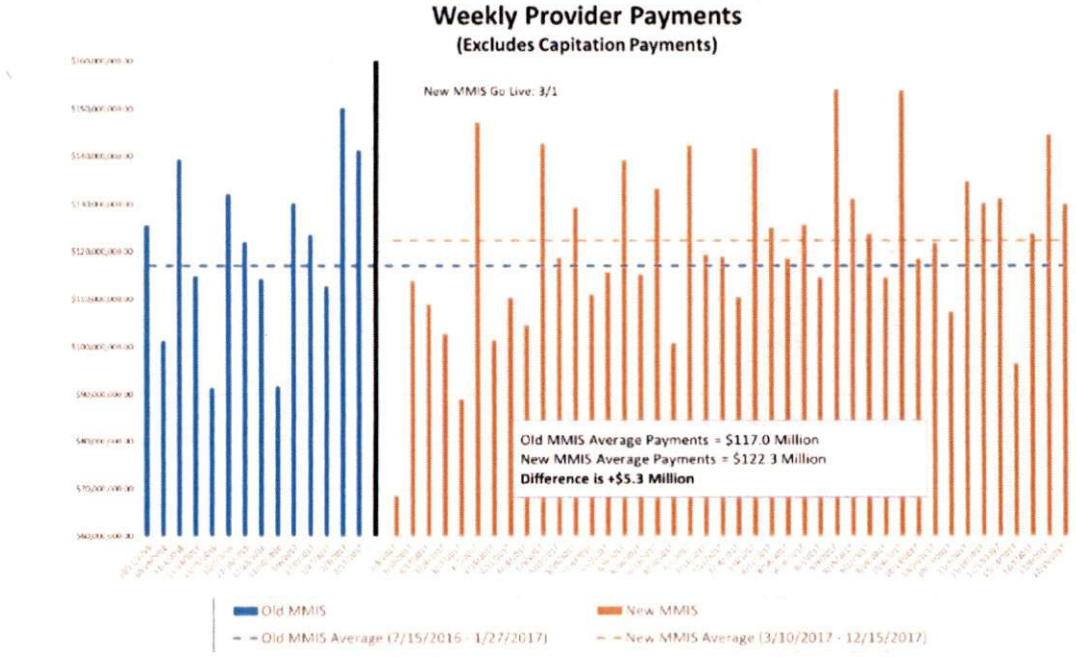
Trends in Escalated Provider Cases

Many of you have sent constituent complaints to the Department which have become part of our escalated provider process. When providers are sent through that process, they receive one-on-one assistance from DXC and/or the Department to resolve their issues. We have seen the number of new requests for this process go down, month by month.



Claims Payment Trends

The current average weekly payments exceed the weekly payments in the old MMIS by $5.3 Million. The weekly financial payment cycle to providers for Friday, December 15, 2017 was $130.0 Million compared to only $68.3 Million in the first payment cycle after the system was launched.



Based on systems that have been in production for several years, the Department expects that the Paid Claims Percentage should average between 75% - 80% in Normal Operations. The Department is approaching this range.

DXC Provider Services Call Data

The Department and DXC work together to compile common provider questions or concerns. These questions and concerns are what dictate the content of our Known Issues and Updates web page. We also send weekly update emails to providers about new identified issues or newly resolved issues (example from this week).

The DXC Provider Services Call Center does generate a report on the category of incoming calls, but the report does not go in great depth about the specific call reasons. The metrics we receive from DXC is based on the call queues. Below is a summary of the metrics we have related to contact reasons for 12/1- 12/11.

Claim Inquiry	3,164
Eligibility Inquiry	894
Other	783
Enrollment - Update	393
Enrollment - New Application	253
Prior Authorization Inquiry	180
Portal - Log on/ Password	122
Portal Assistance	87
Enrollment - Revalidation	76
Non-provider inquiry	73
Portal - Functionality	72
Claim Denial - Type of Bill	55
Claim Denial - Procedure Code	34
Claim Payment - Policy Change	34

Payment inquiry	33
General Billing Questions	29
Electronic Data Interchange (EDI) Inquiry	27
Benefits or Policy	14
Pharmacy	13
EFT Inquiry	13
Claim Denial - Policy change	8
Financial Refund/Recoupment/Stop Pay Reissue	8
Provider - Affiliation issue	6
Claim Payment - Rate issue	5
ERA Inquiry	3
EDI Report Retrieval	2
Administration Question/Concern	2
Provider - Portal access issue	2
Appeals-Instructions	2
Provider - Specialty missing	2
Appeals-Misc Inquiry	1

Implementation of the Ordering, Prescribing and Rendering (OPR) Provider Enrollment requirement

Effective January 1, 2018, the Department will be enforcing 42 CFR 455.410(b) which provides that Medicaid must require all ordering or referring physicians or other professionals providing services be enrolled as providers, and 42 CFR 455.440, which provides that Medicaid must require all claims for the payment of items and services that were ordered, referred, and prescribed to include the National Provider Identifier (NPI) of the ordering, referring or prescribing physician or other professional.

The Department will **not** pay for new prescriptions written on or after 01/01/2018 if the prescriber is not enrolled with Colorado Medicaid. Refills written prior to 01/01/2018 by unenrolled prescribers will pay until the prescription expires or until there are no remaining refills. Prior Authorizations requested by unenrolled prescribers will not be processed by the call center beginning 01/01/18.

If a prescriber does not wish to enroll with Colorado Medicaid they should begin referring their patients to a prescriber that is enrolled. Patients needing new prescriptions for their medications written on or after 01/01/18 must be written by an enrolled prescriber for Colorado Medicaid to pay for and process the claims.

Pharmacy staff members can identify prescriptions filled by an unenrolled prescriber with a current message that is sent back on the pharmacy claim that says, "On 1/01/18 claim denies- MD not enrolled, call DXC to enroll". Beginning 01/01/18 the message will read, "Prescriber not enrolled. Call DXC at 844-235-2387 to enroll".

The Department has been identifying and making direct calls to these providers since October 2016, has sent many faxes to pharmacies about the implementation and has been noticing pharmacies via the claim message referenced above.

As always, members with questions or concerns can contact the Department at (303) 866-2993 or use our Find a Provider tool to find a provider enrolled with Colorado Medicaid.

Co-payment Policy Updates

In accordance with state and federal law, 42 C.F.R. §§447.53, 447.56(f),(1),(2),(3), the Department has made updates to the Health First Colorado (Colorado's Medicaid Program) co-payment policies. These changes have been previously reflected in the Department's December Provider Bulletin and December Special Provider Bulletin. This message reiterates the policy updates and points you to a recorded a webinar that discusses the updates to Health First Colorado co-payment policies.

Co-Payment Increase for Health First Colorado Members Effective January 1, 2018

In accordance with SB17-267 and as stated in the Department's December Provider Bulletin and December Special Provider Bulletin, the Department plans to change the following co-payment policies effective January 1, 2018 for Health First Colorado Members:

Service	Dates of service on and prior to December 31, 2017	Dates of service on and after January 1, 2018
Outpatient hospital visit	$3	$4
Outpatient hospital non-emergent emergency room visit	$3	$6
Generic drug*	$1	$3
Brand name drug *	$3	$3

*Changes apply to all new and refill prescriptions.

The emergency status of an Emergency Department visit must be determined by the hospital/provider. The Colorado interChange will deduct a $6 co-payment amount from the UB-04 (837I) claim based on the presence of Revenue Code 0456 or Revenue Code 0459 on the claim for all co-pay eligible members.

The Department's Medical Services Board voted December 8, 2017 to adopt the Revision to the Medical Assistance Rule Concerning Client Co-Payment, Section 8.754 rule that supports the co-payment increase. For more information on the Medical Services Board, visit: CO.gov/hcpf/medical-services-board.

Resource

- *Providers can learn more about the co-payment increases by viewing our recorded webinar featuring the Department's Chief Medical Officer, Dr. Judy Zerzan.*

Co-Pay Limit for Health First Colorado Members

As previously stated in the Department's Provider Bulletins and December Special Provider Bulletin, all providers should be aware that members are liable for no more than 5% of their monthly household income towards co-payments per month.

Beginning in October 2017, Health First Colorado now notifies members by mail when their household has met its co-payment maximum for the month. The co-payment maximum is 5% of the household monthly income. The head of household will receive a letter showing the household has reached the monthly limit, and how the limit was calculated. Once a member has paid 5% of their monthly household income on co-pays in a month, no one in the household pays co-pays for the rest of that month. For more information, visit HealthFirstColorado.com/copay.

As with current practice, it is critical that providers verify a member's eligibility and co-payment amount at each visit. The Colorado interChange Provider Web Portal will reflect the member's current eligibility and the proper co-payment amount.

Resources

- *Verifying Member Eligibility & Co-payment Quick Guide is available on the Department's interChange Resource website that provides step-by-step instructions for providers on how to verify a member's eligibility and check a member's co-payment amount.*
- *Remittance Advice (RA) Quick Guide is available on the Department's interChange Resource website that provides step-by-step instructions for providers on how to read their remittance advice.*
- *Providers can learn more about the 5% co-payment maximum by viewing our recorded webinar featuring the Department's Chief Medical Officer, Dr. Judy Zerzan.*
- *The Quick Guides and the recorded webinar can be found at CO.gov/hcpf/interchange-resources.*

As always, provider questions should be directed to the DXC Technology Provider Call Center: 1-844-235-2387

CASE STUDY
SEPTEMBER 2017

Health Care Improvement in Pueblo, Colorado: Building on Common Ground

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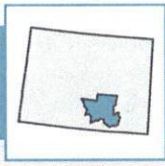
The high-desert region encompassing Pueblo in southeastern Colorado was one of only 14 out of 306 regions nationally to improve on a majority of performance measures tracked by the Commonwealth Fund's *Scorecard on Local Health System Performance, 2016 Edition*. Socioeconomic challenges and geographic isolation have fostered a sense of interdependence among local health care providers, who have leveraged the state's Medicaid expansion to enhance access to care while improving coordination. Providers have also joined with public health and social service agencies, businesses, educators, and nonprofits in creating the Pueblo Triple Aim Corporation, an improvement collaborative that uses data to define problems and create shared accountability for solving them. The group engaged the community in youth development programs as part of an effort that reduced the teen pregnancy rate by more than half. This and other collaborative efforts tap state policy to accomplish local priorities while seeking to build community pride.

KEY TAKEAWAYS

- **Pueblo's providers have leveraged Colorado's Medicaid expansion to enhance access to care while improving coordination.**
- **Local improvement collaboratives use data to define problems and promote shared accountability for solving them.**

PUEBLO PROFILE



HEALTH SYSTEM PERFORMANCE

Improved on
17 OF **32**
indicators tracked over time — second-most among all regions

HEALTH SYSTEM RANK

128 OF **306** regions in 2016 *vs.* **181** OF **306** regions in 2012

DEMOGRAPHICS (2014)

170,798 residents (including 161,875 in Pueblo County)

- **55%** white (vs. 62% nationally)
- **41%** Hispanic (vs. 17% nationally)
- **3%** other non-Hispanic (vs. 8% nationally)
- **2%** Black (vs. 12% nationally)

$44,623 median household income (vs. $58,489 nationally)

46% living on incomes below 200% of the federal poverty level (vs. 34% nationally)

Note: Race/ethnicity data may not sum to 100% because of rounding.
Data: D. C. Radley, D. McCarthy, and S. L. Hayes, *Rising to the Challenge: A Scorecard on Local Health System Performance, 2016 Edition* (The Commonwealth Fund, July 2016); and American Community Survey, 2014 1-year estimates, www.factfinder.census.gov. Unless otherwise noted, data on the Pueblo hospital referral region are derived from the *Scorecard*.

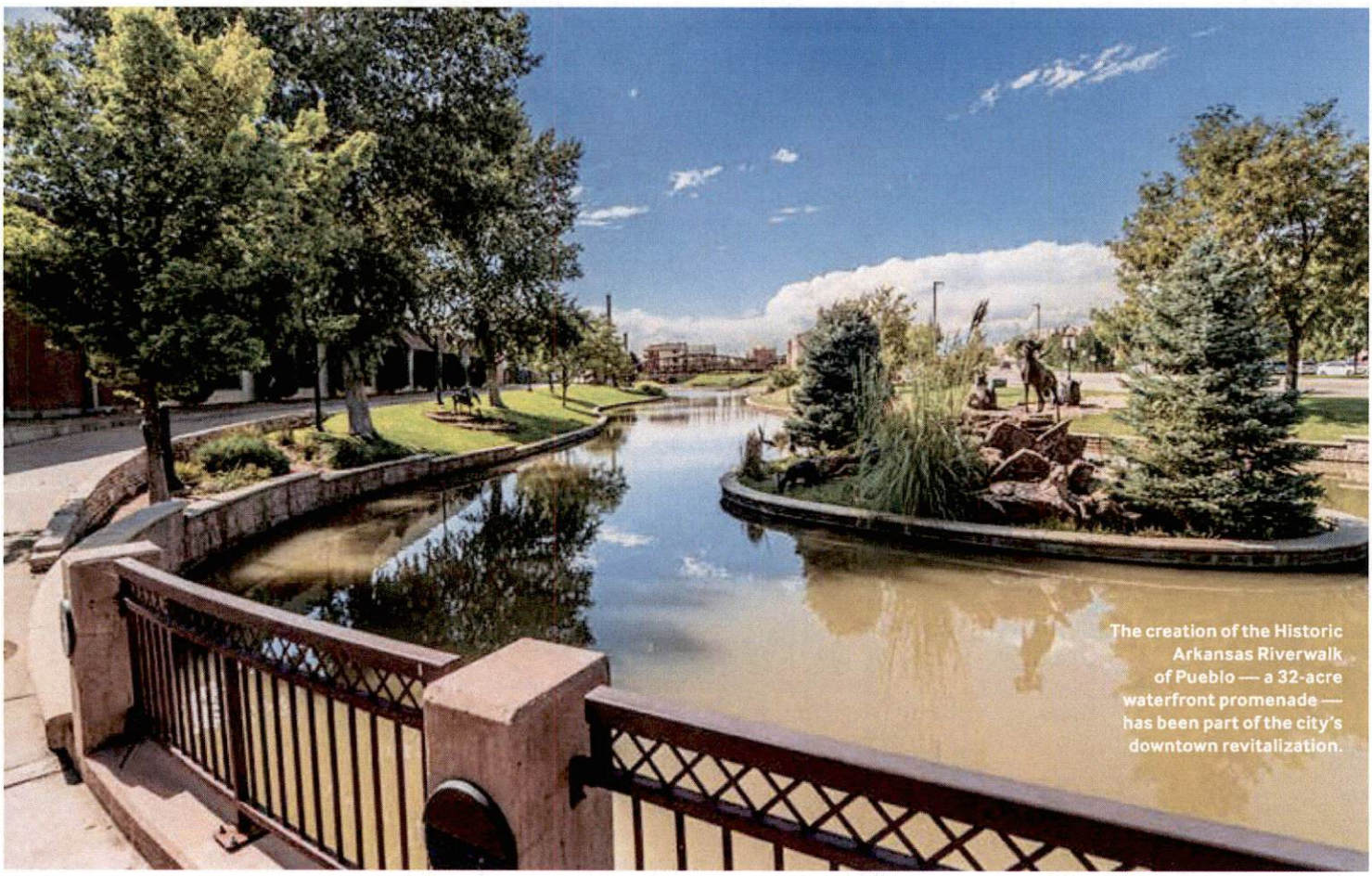
The Commonwealth Fund

BACKGROUND

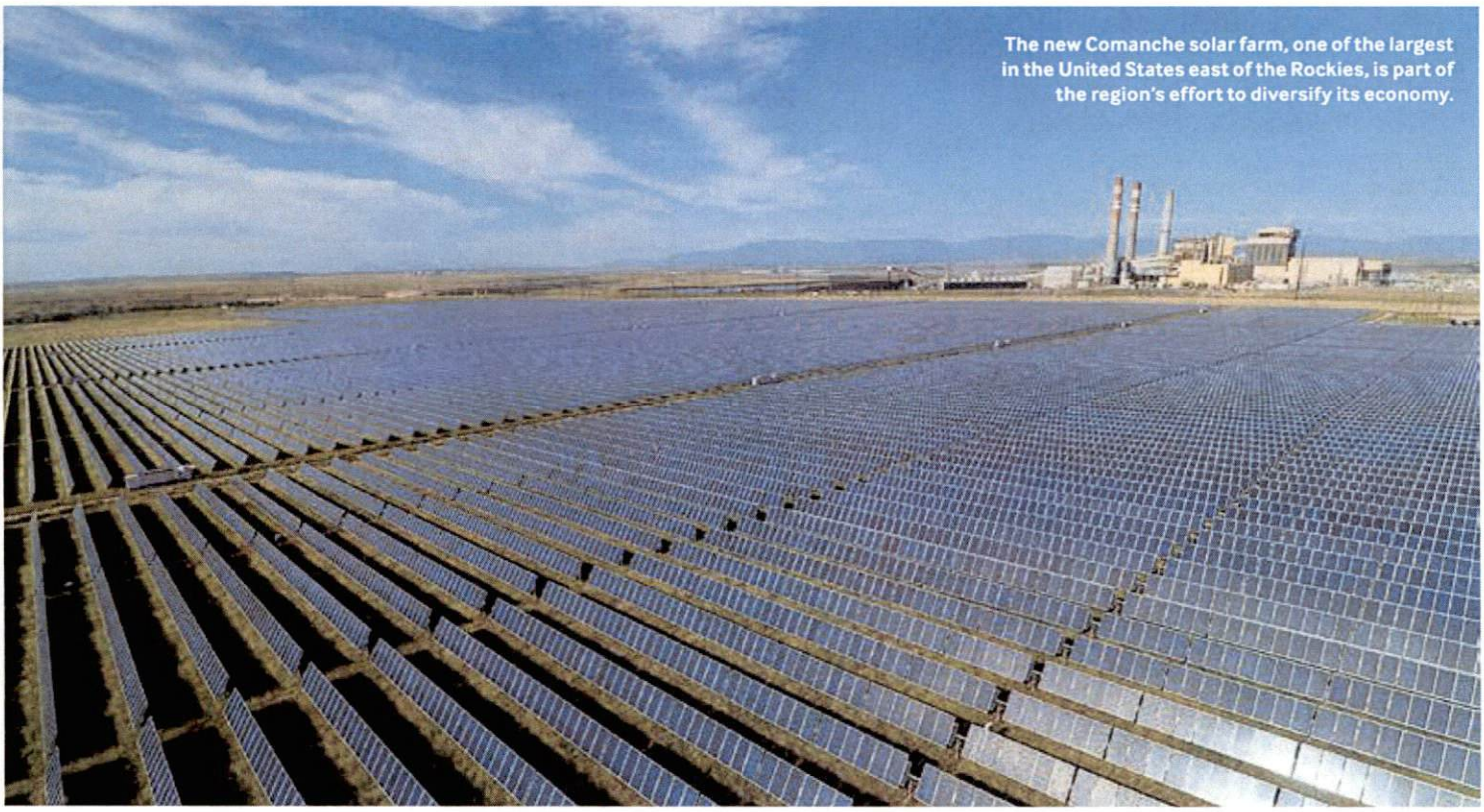
The high-desert city of Pueblo, home to over 108,000 residents in southeastern Colorado, is a world apart from the buzzing economy that lines the Denver-to-Boulder corridor just a few hours north. Once known as the "Pittsburgh of the West," the region evolved around the steel industry, with the largest mill owned by John D. Rockefeller. It suffered through many boom-and-bust cycles in the 19th and 20th centuries, but the collapse of the steel market in 1982 and the recent recession were the worst blows, shuttering all but one of the mills and draining away thousands of jobs. For the past several decades, many of the region's residents have lived in generational poverty; nearly half (46%) subsist on incomes that are less than twice the federal poverty level.

Hispanics make up a large portion of the population (41%). One of four adults smoke and nearly a third are obese, both risk factors for diabetes, which is twice as prevalent among adults in Pueblo County as in Colorado (13.6% vs. 6.8%).[1] Many residents suffer from disabilities, whether from the complications of disease, injuries from steel jobs, or self-harm due to substance abuse.[2] Community leaders say that while Colorado's legalization of marijuana has added jobs, it has also strained social services by attracting homeless and drug-seeking populations to the region, where the cost of living is lower than in other parts of the state.

This case study is part of a series exploring the factors that may contribute to improved regional health system performance. It describes how Pueblo's health care provider organizations have joined forces with government agencies including the public health and fire departments, as well as business leaders, social service agencies, philanthropists, and educators to address the community's health and social problems. Deliberate efforts to use data to define the problems and secure engagement from diverse leaders seem to have helped cut the teen pregnancy rate by half and curbed unnecessary hospital use, for example.



The creation of the Historic Arkansas Riverwalk of Pueblo — a 32-acre waterfront promenade — has been part of the city's downtown revitalization.



The new Comanche solar farm, one of the largest in the United States east of the Rockies, is part of the region's effort to diversify its economy.

"There is a nucleus of people here who are exceptionally devoted to collaboration," says Rev. Linda Stetter, director of mission and spiritual care for St. Mary–Corwin Medical Center, one of two hospitals in Pueblo. "I don't think I've lived in another community where the collaboration is this intentional." Such collaborative efforts build on providers' commitment to health care quality improvement, first pursued in the 1980s at Parkview Medical Center, and subsequently taken up by other local institutions.[3]

It's also notable that Pueblo's economy has improved somewhat in recent years; its steelmaking equipment has been repurposed to recycle scrap metal and build wind turbines, and a large solar farm opened there in 2014. This recovery may have played a role in the improvements tracked in the *Scorecard*.

HEALTH SYSTEM PERFORMANCE IN PUEBLO

The Pueblo hospital referral region (HRR), a regional market for health care, includes the city and surrounding Pueblo County as well as parts of adjacent counties.[4] On the Commonwealth Fund's *Scorecard on Local Health System Performance, 2016 Edition*, the region stands out for achieving significant improvements on a majority (17 of 32) of measures for which trend data exist. It was one of only 14 regions among 306 studied by the *Scorecard* to achieve this distinction — a finding even more notable given the region's high poverty rate, since higher income usually correlates with better health and health care. The *Scorecard* found wide variation among HRRs on indicators of health care access, quality, avoidable hospital use, costs, and outcomes.

DELIVERY SYSTEM: SPIRIT OF "CO-OPETITION"

Because of Pueblo's relatively small size and geographic isolation, health care services tend to be concentrated within a few institutions, including two nonprofit hospitals: the independent Parkview Medical Center and St. Mary–Corwin Medical Center, part of the Centura network of faith-based hospitals. Together with Pueblo Community Health Center, a federally qualified health center (FQHC), and Health Solutions, a community mental health center, they are Pueblo's safety net. At Parkview, for example, about 80 percent of admitted patients are covered by Medicare or Medicaid or are uninsured.

Pueblo, Colorado, Hospital Referral Region Local Scorecard Performance

Ranking Summary (of 306 Local Areas)

	Quintile		Rank	
	2012*	2016	2012*	2016
OVERALL	**3**	**3**	**181**	**128**
Access & Affordability	4	4	193	191
Prevention & Treatment	5	2	270	115
Avoidable Hospital Use & Cost	1	1	45	56
Healthy Lives	3	3	182	177

Change in Performance[a]

	Pueblo		Average of HRRs in the U.S.	
	Count	Percent	Count	Percent
Indicators with trends	32		33	
Area rate improved	17	53%	11	33%
Area rate worsened	5	16%	3	9%
Little or no change in area rate	10	31%	19	58%

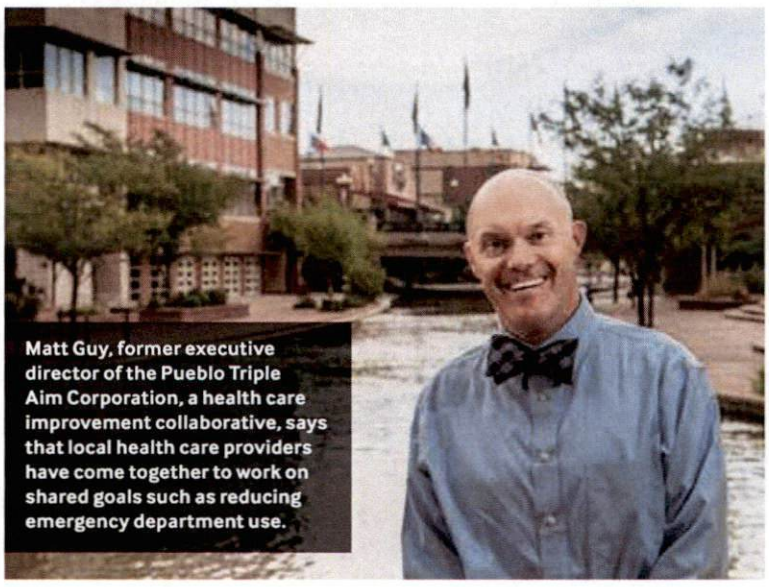
* Rankings from the 2012 edition of the *Scorecard* have been revised to match methodology and measure definitions used in the 2016 edition.
[a] Improved or worsened denotes a change of at least one-half (0.5) of a standard deviation (a statistical measure of variation) larger than the indicator's distribution among all HRRs over the two time points. Little or no change denotes no change in rate or a change of less than one-half of a standard deviation. For complete results, visit the Health System Data Center.

Data: D. C. Radley, D. McCarthy, and S. L. Hayes, *Rising to the Challenge: A Scorecard on Local Health System Performance, 2016 Edition* (The Commonwealth Fund, July 2016).

High demand for services, coupled with lean reimbursement and workforce shortages, foster interdependence among Pueblo's health care organizations. A spirit of "co-opetition" — a willingness to work together to pursue common interests, while competing for patient loyalty — is evident in the two hospitals' practice of sharing medical specialists, who are scarce resources in this region. Both have made a commitment not to divert patients from their emergency departments, since there is nowhere else for patients to go. Such efforts are enabled by routine meetings of the CEOs and an open-door policy among leaders at both institutions to discuss community concerns. "Both hospitals have a significant role to play to address the large community health burden in Pueblo," says Matt Guy, former executive director of the Pueblo Triple Aim Corporation, a health care improvement collaborative, and now president of the consulting firm Accelerated Transformation Associates.

Expanding Access to Care

Local providers have worked to enroll people in health coverage, building on Colorado's efforts to expand Medicaid. These began in 2010 with the institution of a hospital provider fee that draws additional federal matching funds to expand coverage to more low-income children and adults and enhance reimbursement to providers, thereby reducing uncompensated care.[5] This has helped Pueblo's safety-net hospitals expand access to care, while also rewarding them for improving quality. In 2014, Colorado further expanded Medicaid to more low-income adults through the Affordable Care Act.

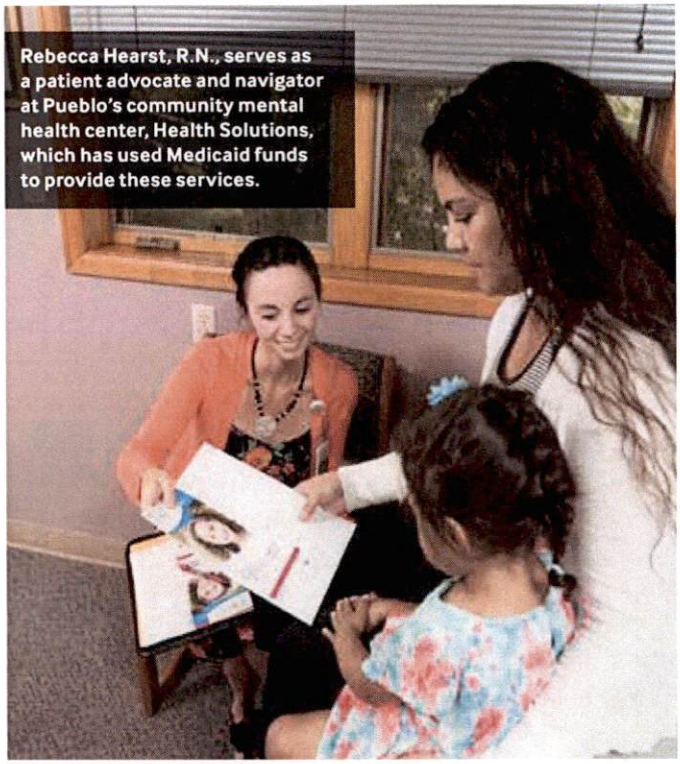


Matt Guy, former executive director of the Pueblo Triple Aim Corporation, a health care improvement collaborative, says that local health care providers have come together to work on shared goals such as reducing emergency department use.

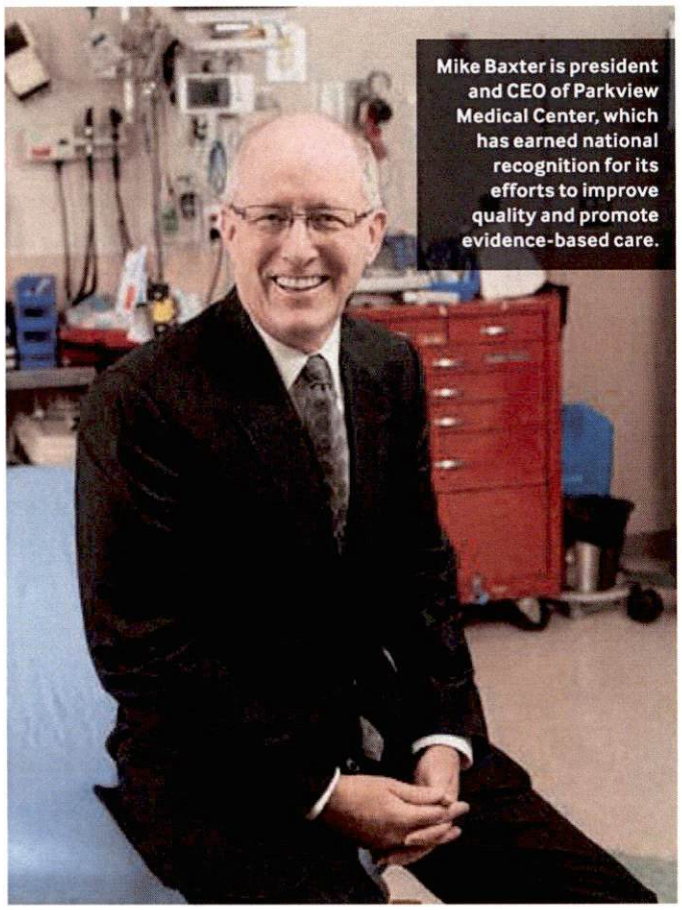
While the *Scorecard* did not detect a substantial drop in the region's uninsured working-age adult population from 2012 to 2014, the rate fell to 10 percent in 2015 — better than state (12%) and national (13%) rates.[6] The *Scorecard* found improvements from 2011–12 to 2013–14 on two related indicators: an increase in the share of adults with a usual source of care (from 77% to 81%), as well as a steep decline in the share of at-risk adults who went without a physician visit in the past two years (from 21% to 13%) — in both cases besting state and national rates. Parkview may have contributed to this improvement by providing Pueblo County's urgent care and emergency facilities with lists of local primary care physicians, information on school-based clinics, and health department resources to share with patients.

Health care providers have also expanded primary care capacity. In 2012, Parkview established an internal medicine residency program, which retained over half its graduates in its first two years. (This program complements a longstanding family medicine residency at St. Mary–Corwin.) The hospital also opened another primary care clinic and "leased" one of its staff endocrinologists to the FQHC for a few days each month, enabling easier access to this in-demand service. During the period the *Scorecard* measured, many of the practices affiliated with St. Mary–Corwin established themselves as patient-centered medical homes, part of an initiative to make after-hours care more available and chronic disease management and preventive services more accessible.[7]

Medicaid expansion also helped the FQHC hire more nurse practitioners and physician assistants to work on care teams in an expanded facility, thereby eliminating a waiting list for accepting new patients. Today the community health center is able to provide same- or next-day appointments for urgent issues and schedule most routine visits in less than 21 days, though it still faces capacity challenges given its difficulty in hiring primary care providers.[8] Since 2009, it has operated five school-based clinics in a partnership with Parkview Medical Center that provide primary care, vaccinations, birth control, sports fitness exams, prescriptions, and referrals for specialty care.



Rebecca Hearst, R.N., serves as a patient advocate and navigator at Pueblo's community mental health center, Health Solutions, which has used Medicaid funds to provide these services.



Mike Baxter is president and CEO of Parkview Medical Center, which has earned national recognition for its efforts to improve quality and promote evidence-based care.

Improving the Quality of Care

Pueblo's most notable gains were on measures assessing the delivery of preventive care and evidence-based treatment. Improvements on 10 of 12 indicators vaulted the region from the fifth to the second quintile of performance on this domain. This progress suggests that quality improvement has become embedded in the local health care culture. This may be attributable, in part, to deliberate steps taken by Parkview Medical Center, which retains the largest market share in the region, to reduce variation and promote evidence-based care.[9] Leaders say Parkview's commitment to quality improvement — and national recognitions it received as a result — spurred others to improve. "Several thousand people visited to see what the hospital was doing," says Michael Pugh, who served as CEO in the 1990s.

During the years tracked by the *Scorecard,* Parkview set goals to reduce patient harm and improve clinical quality and service, reporting progress monthly to all staff and its board.[10] Among other efforts, staff members began checking on patients every hour and making bedside shift changes to promote clear and continuous communication among providers and between patients and providers.

With incentives from public and private insurers to improve the quality of care, Pueblo Community Health Center has achieved its goal of performing above the national median among FQHCs for nine of 15 indicators tracked by the federal government. Through Colorado Medicaid's Accountable Care Collaborative, created in 2010 to improve care while expanding coverage, the FQHC receives per member per month funding (in addition to fee-for-service reimbursement) to coordinate care for its 20,000 Medicaid patients. It uses a web-based system and claims data to identify gaps in care — for example missed postpartum appointments or well-child checks — and to work with frequent emergency department or hospital users to offer chronic care management and other support.[11] In 2011, the FQHC received recognition

Parkview Medical Center Fiscal Year 2017 Quality and Service Goals

PILLAR	GOAL BY June 30, 2017	Operating Measure	Year-to-Date Actual*
QUALITY	**REDUCE PATIENT HARM**		
	Central Line–Associated Bloodstream Infections (CLABSIs)	Reduce total number of CLABSIs 20% or more from 10 to fewer than 8	Goal is being met
	Reduce Catheter-Associated Urinary Tract Infections (CAUTIs)	Reduce total number of CAUTIs 14% or more from 20 to fewer than 17	Goal is being met
	IMPROVE CLINICAL OUTCOMES		
	Reduce Readmission Rate	Reduce overall readmission rate 10% or more from 11.1 to 10.0 or less	Goal is not being met
	Reduce Sepsis Mortality Rate	Reduce sepsis mortality rate from 11.1% to 10%	Goal is being met
	Achieve Hand Hygiene Compliance	Increase hand hygiene compliance based on internal surveillance to 94% or higher	Goal is not being met
SERVICE	Increase Overall Service Score	Overall HCAHPS from 75.3 to 76.3 or higher HCAHPS data (Note: 2-month lag)	Goal is being met
	Improve Physician Communication Score	HCAHPS score from 75.45 to 79.45 or higher HCAHPS data (note: 2-month lag)	Goal is being met
	Improve Hospital Cleanliness Score	HCAHPS score from 79.7 to 80.7 or higher HCAHPS data (note: 2-month lag)	Goal is being met

Notes: Goals not shown for people (employees), growth, and finance. HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems.

* Actual as of Sept. 2016.

Data: Parkview Medical Center.

as a medical home by the Accreditation Association of Ambulatory Health Care for its efforts to expand access and improve the quality of care.

Collaborative efforts to promote preventive care and to improve care coordination across settings have also been launched. Pueblo's public health department partners with the residency programs at Parkview and St. Mary–Corwin to promote colorectal cancer screenings through a chart review and tracking system, which led to an increase in the number of adults screened.[12] Case managers at the FQHC coordinate care for high-risk obstetric patients by scheduling appointments for them at St. Mary–Corwin's high-risk obstetrics clinic, making sure they attend, and helping them adhere to recommended treatment.

Since 2001, the FQHC has been the first point of contact for hospitals when they discharge patients who do not have an identified source of primary care. In recent years, Parkview added a dedicated team to contact patients after discharge to ensure they understand their treatment plan and have a follow-up appointment scheduled. In 2015, the Southeastern Colorado Transitions of Care Consortium (launched by the Pueblo Triple Aim Corporation) brought together Pueblo's urban and regional hospitals, community mental health center, and the FQHC, physician groups, insurers, and the Medicaid Regional Care Collaborative Organization to align and improve their care coordination efforts.

Pueblo's fire department has joined the consortium, prompted by a growing number of 911 calls, which increased from 2,000 in 2008 to 21,000 in 2015. Some came from residents who would repeatedly fall in their homes; others came from people who simply needed a way to access the health system.[13] This resulted in the 2016 launch a pilot program called Directing Others to Service, or DOTS, in which fire department staff and providers connect frequent users of the emergency response system with medical homes or other sources of help. Fire department staff also visit frequent 911 callers to identify needs — such as a grab bar in their bathroom or an eyeglass prescription — that could be addressed to head off future emergencies.[14]

Quality-of-Care Performance for Pueblo Community Health Center and Ranking Compared with Federally Qualified Health Centers Nationally

	2013	2014	2015	Adjusted Quartile Ranking	
Quality of Care Measures				**2014**	**2015**
Perinatal Health					
Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	75.6%	79.2%	81.1%	2	2
Low Birth Weight	9.5%	10.1%	9.0%	4	3
Preventive Health Screening & Services					
Cervical Cancer Screening	48.4%	68.0%	64.1%	1	2
Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents	6.0%	18.1%	63.6%	4	2
Adult Weight Screening and Follow-Up	27.4%	84.6%	90.0%	1	1
Adults Screened for Tobacco Use and Receiving Cessation Intervention	—	73.9%	80.9%	3	3
Colorectal Cancer Screening	24.1%	36.4%	42.1%	2	2
Childhood Immunization	85.8%	89.1%	80.2%	1	2
Depression Screening	—	5.9%	18.2%	4	4
Dental Sealants	—	—	30.0%	—	3
Chronic Disease Management					
Asthma Treatment (Appropriate Treatment Plan)	50.5%	100.0%	94.0%	1	2
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease)	52.6%	66.4%	92.4%	4	1
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	20.6%	51.5%	80.0%	4	3
Blood Pressure Control (Hypertensive Patients with Blood Pressure < 140/90)	66.6%	65.2%	69.0%	2	2
Uncontrolled Diabetes (Diabetic Patients with HbA1c > 9%)	38.4%	33.4%	32.0%	—	3
HIV Linkage to Care	—	100.0%	100.0%	—	—

Note: Quartile ranking is out of Health Resources and Services Administration (HRSA)-funded health centers nationwide; 1st or 2nd quartile of performance is above the national median.

Data: HRSA Health Center Program, Pueblo Community Health Center 2015 Profile.

COLLABORATING REGIONALLY TO COORDINATE CARE FOR MEDICAID PATIENTS

Colorado in 2010 created a Medicaid Accountable Care Collaborative (ACC) to promote care coordination and efficiency while expanding coverage for Medicaid beneficiaries.[a] The ACC comprises seven regional care collaborative organizations (RCCOs) selected by the state, which pays them a fee of up to $12 per member per month (PMPM) to oversee medical management, provider network development and support, and performance reporting. RCCOs contract with primary care providers, who receive $3 PMPM from the state (on top of fee-for-service reimbursement) for participating in care coordination and quality improvement activities. Both may also earn financial incentives for meeting performance targets.

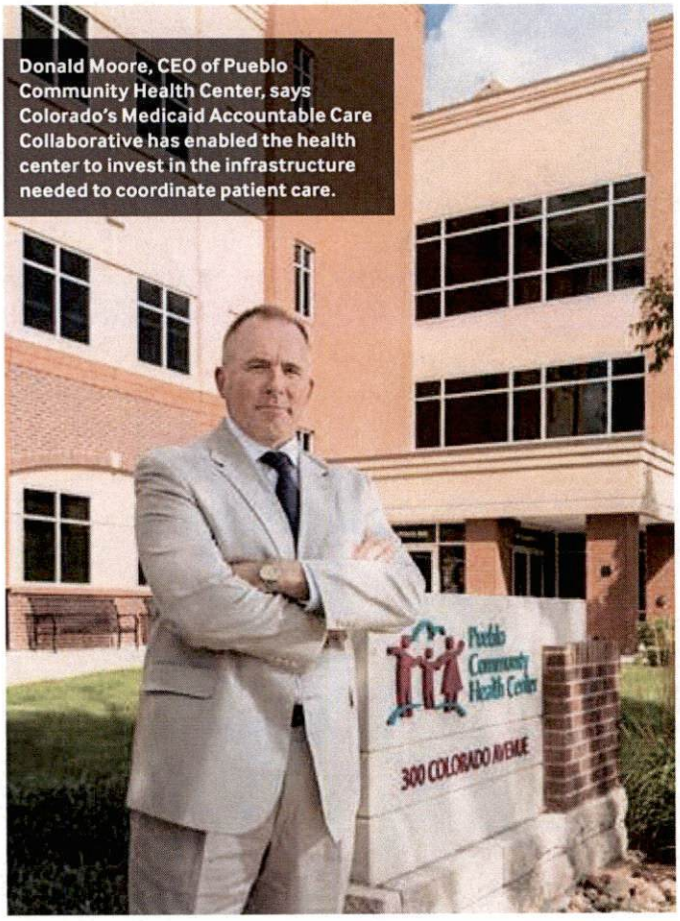
Integrated Community Health Partnership, LLC, is the RCCO serving Pueblo and 18 other counties in southeastern Colorado. Its members include a behavioral health organization and four community mental health centers as well as a consortium of three FQHCs.[b] The RCCO passes a portion of its fee to the FQHCs to coordinate care for their Medicaid patients and to the community mental health centers (Health Solutions in Pueblo) to coordinate care for other Medicaid beneficiaries. For example, Health Solutions hired 10 registered nurses to serve as patient advocates and navigators primarily on behalf of dually eligible Medicare and Medicaid clients. They spend time in providers' practices and connect clients to resources to meet their medical and nonmedical needs.

To date, the most beneficial aspect of the RCCO has been to bring the partners together to identify what is and isn't working in their communities, according to Chris Senz, CEO of Integrated Community Health Partnership. The program has enabled FQHCs such as the Pueblo Community Health Center to create a care coordination infrastructure that was not possible under traditional fee-for-service reimbursement, according to Donald Moore, its CEO. The ACC program saved an estimated $37 million statewide in fiscal 2014–15, according to the state of Colorado.[c]

[a] D. Rodin and S. Silow-Carroll, *Medicaid Payment and Delivery Reform in Colorado: ACOs at the Regional Level* (The Commonwealth Fund, March 2013).

[b] The consortium is known as the Colorado Community Managed Care Network.

[c] Colorado Department of Health Care Policy and Financing, Legislative Request for Information, Nov. 1, 2015; J. Lloyd, R. Houston, and T. McGinnis, *Medicaid Accountable Care Organization Programs: State Profiles* (Center for Health Care Strategies, Oct. 2015); National Academy for State Health Policy, Colorado ACO.



Donald Moore, CEO of Pueblo Community Health Center, says Colorado's Medicaid Accountable Care Collaborative has enabled the health center to invest in the infrastructure needed to coordinate patient care.

Addressing Social Determinants

Pueblo's health care providers have also moved to address the social determinants of poor health, including poor nutrition. In response to evidence that 17 percent of Pueblo residents lacked access to healthy food, St. Mary–Corwin in 2013 launched a farm stand in its own neighborhood, which is considered both a food desert because of its lack of healthy food options and a food swamp because of its abundance of cheap, low-nutrition options.[15] The hospitals' physicians are able to write prescriptions for high-risk patients, including those who are obese and/or diabetic, to receive free fruit and vegetables there.[16] Parkview has also sought to promote better nutrition by sending nurses to worksites and public venues to offer dietary advice and free diabetes screenings. Such work is reinforced by the public health department's efforts to help local food retailers purchase freezers or make other changes necessary to sell healthier products, and successful lobbying of Walmart to open a store in one of Pueblo's poorest neighborhoods.

St. Mary–Corwin has also partnered with the city to enforce code violations against landlords for problems that impact health, like mold and bug infestations. And Stetter has led an effort to educate Pueblo's religious leaders about health issues and enlist them in supporting members of their congregations.

COLLECTIVE ACTION ACROSS SECTORS

Several leaders note that Pueblo has a history of collaborative efforts, most notably the One Community Pueblo initiative, begun in 2008, involving health providers, educators, law enforcement officials, and judges in supporting healthy child and youth development, in part by promoting access to mental and physical health services. The effort involves collecting extensive data and reporting it on a public dashboard.[17]

Rev. Linda Stetter, director of mission and spiritual care for St. Mary–Corwin Medical Center, at the hospital's farm stand. St. Mary–Corwin physicians can write prescriptions for patients to receive free fruit and vegetables.

ENGAGING FAITH COMMUNITIES, TRYING COMPLEMENTARY APPROACHES

When Rev. Linda Stetter came to Pueblo to become the director of mission and spiritual care for St. Mary–Corwin Medical Center in 2013, she started church-hopping on Sundays. Thus far she's visited more than 90 of the city's 125 churches. Having worked in communities with strong interfaith associations, Stetter knew that religious leaders could serve as community partners for hospitals such as hers — offering pastoral care to sick members of their congregations or speaking to congregants about good nutrition and other healthy behaviors. She began offering quarterly symposia to clergy on such topics and now receives requests from them to be educated about issues like autism that are of concern to their congregants.

Stetter hopes to try the Memphis Model in Pueblo, an approach developed at Methodist Le Bonheur Healthcare in Memphis, Tenn. Through the hospital's Congregational Health Network, members of some 500 Memphis churches, many African American, have agreed to help chronically ill congregants, in part by checking up on them after hospitalizations. "They are cared for like neighbors used to care for neighbors," says Stetter. Methodist Le Bonheur has reported that over a three-year period patients served through this network had shorter hospital stays, longer intervals between hospitalizations, and significantly lower mortality rates.[a]

Stetter also helps direct St. Mary–Corwin's use of complementary therapies such as acupuncture and mindfulness in the intensive care unit, emergency department, and elsewhere to help those dealing with addiction, pain, and stress. Such approaches have been especially needed to help the hospital's pain management clinic treat a population of opioid-dependent patients. In 2007 two local doctors were forced to close their practices over alleged overprescribing, and Pueblo has received negative publicity as the highest drug-prescribing city in Colorado.[b] The hospital's commitment to complementary therapies — including the services of a harpist — is an effort "to help people cope with their chronic illnesses and their mental conditions beyond the hospital walls," says Stetter.

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[a] A. Halperin, "It Really Does Take a Village: How Memphis Is Fixing Healthcare," *Salon*, Sept. 3, 2013.

[b] L. Sword, "Pain Specialist Plans Doctors' Class," *The Pueblo Chieftain*, Oct. 9, 2013.

In 2010, Pueblo's two hospitals conducted their first community health needs assessments, a requirement for nonprofit institutions under the Affordable Care Act, and the public health department created a new community health improvement plan. These analyses cast into stark relief the breadth and depth of Pueblo's health problems and prompted leaders to move beyond ad hoc efforts to take collective action. After hearing about the Institute for Healthcare Improvement's Triple Aim — for improved care, improved population health, and reduced per capita costs — leaders founded the Pueblo Triple Aim Corporation, a nonprofit with a dedicated staff and infrastructure.[18] Leaders from the business community, social services, philanthropy, economic development, and education, as well as Latino and other community groups, have joined.

The group uses a data dashboard to track key population health indicators for Pueblo County residents, compare Pueblo's performance with other counties, and set goals for improvement.[19] At this stage, some targets — such as a reduction in the premature death rate — appear to be largely aspirational, while others — such as reducing the rate of preventable hospitalizations — may be influenced in part by initiatives such as the care transitions consortium described above.

To guide their work, members worked with the ReThink Health initiative, a nonprofit promoting regional health improvement, to model the long-term effects of various health policies on Pueblo residents' lives, health care costs, quality of care, equity, and productivity.[20] This exercise helped convince employers facing rising health costs and overburdened safety-net providers that making long-term and even modest investments in better health could yield significant financial returns. "The big thing that became evident through the modeling was that to have impact they would have to move upstream and look at those social determinants of health," says Randy Evetts, senior program officer for the David and Lucile Packard Foundation, which financed the development of the dashboard and supports a number of causes in Pueblo, the birthplace of David Packard, Hewlett-Packard's cofounder. The Pueblo Triple Aim Corporation has leveraged grants from a number of foundations to fund its work.[21]

Pueblo Triple Aim Corporation: Triple Aim Metrics

Indicator	Baseline rate*	Recent rate**	Target rate
POPULATION HEALTH			
Years of Potential Life Lost (before age 75; rate per 100,000, age-adjusted)	8,435	8,552	7,940
Percent of Residents Reporting Fair to Poor Health	16%	18%	13%
PATIENT EXPERIENCE			
Clinical Care: Access and Quality (composite rank among 60 Colorado counties)	13	12	10
Percent of Residents with No Insurance	14%	15%	13%
COST OF CARE			
Population Health and Resource Use (illness burden score compared to statewide average)	1.25	1.34	1
Preventable Hospital Stays (rate per 1,000 Medicare enrollees)	68	35	33

* Baseline rate represents the 2010 reporting year.

** Recent rate represents the 2016 reporting year, except for Population Health and Resource Use (illness burden score compared to statewide average), which represents the 2012 reporting year.

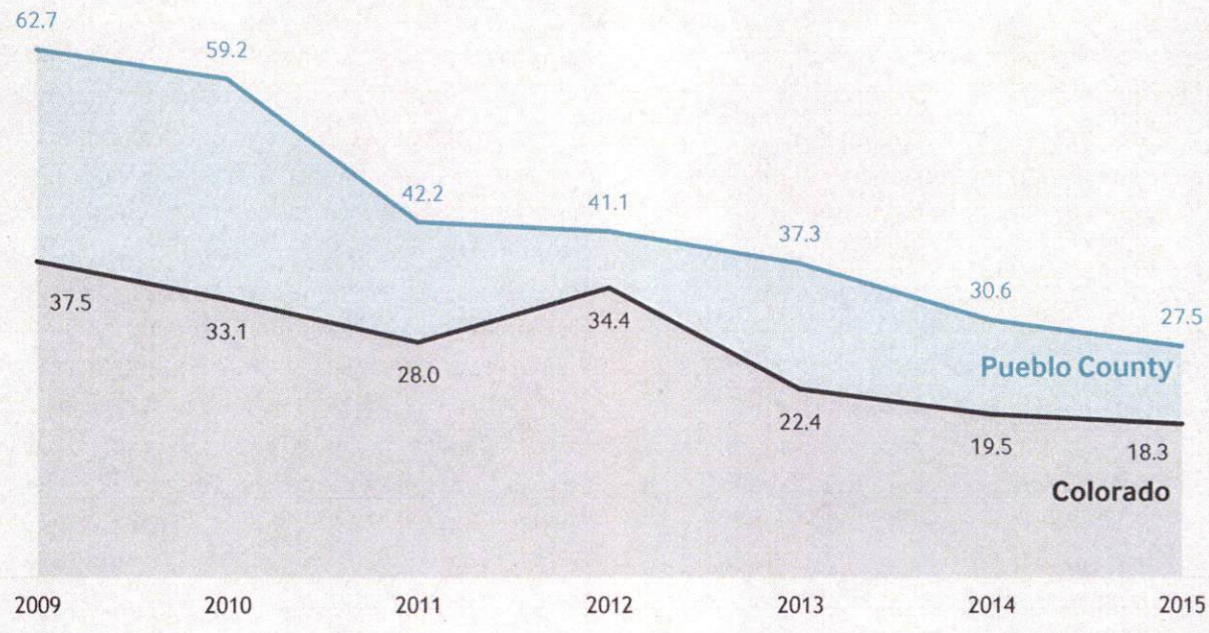
Data: *Triple Aim Measures* (Pueblo Triple Aim Corporation, n.d.).

The group's initial effort, led by the public health department, sought to reduce teen pregnancy rates, which for years were among the highest in the state. Past efforts to address the issue had splintered, in part over disagreements about whether to promote contraception or abstinence-only approaches (many in the community identify as Catholic or evangelical Christian).[22] Cognizant of this history, the Triple Aim group recast the issue as not just preventing pregnancies but promoting positive youth development — including mentoring initiatives, efforts to educate teens about their career options, and a sexual health educational campaign.[23]

The community's effort to reduce teen pregnancy gained momentum from Colorado's groundbreaking policy to make long-acting reversible contraception (LARC) free to low-income teenagers and women through family planning centers, which led to a 50 percent drop in the state's teen pregnancy rate from 2009 to 2015.[24] Pueblo County more than halved its rate during this time, representing a much larger decline in absolute terms (a reduction of 35.2 per 1,000 in Pueblo vs. 19.2 per 1,000 for the state). The local public health department helped promote use of LARC, in part by talking to providers. "We found that teens were very scared and reluctant to even come in to a clinic and talk about their sexual health," says Sylvia Proud, director of Pueblo City-County Health Department. "We have done a lot with how to talk to teens, how to make clinics more teen-friendly environments."

Members of the Pueblo Triple Aim Corporation are also working to increase healthy behaviors and reduce obesity. Pueblo was the first Colorado city to ban smoking in public spaces; the group is now working with the housing authority to make low-income housing units smoke free. The organization also participates in national learning collaboratives on health improvement.[25]

Teen Pregnancy Rate per 1,000 Ages 15–19: Pueblo County vs. Colorado State



Data: Pueblo City-County Health Department, based on vital statistics data collected and reported by the Colorado Department of Public Health and Environment.

The public health department has played a leading role in reducing teen pregnancies. From left to right: Public Health Director Sylvia Proud, Program Manager Zak VanOoyen, Public Health Nurse Desiree Wolfe, and Nurse Practitioner Janet Pippenger.

LESSONS

Cross-sector coalitions can help communities build the will needed to take collective action.

The Pueblo region has worked to create a positive identity in the face of long-standing social problems that can wear down the spirit of volunteerism over time. Improvement efforts have gained traction in recent years as community leaders have found common ground, helped to a great extent by coalitions such as the Pueblo Triple Aim Corporation.[26] Cross-sector efforts have built on one another to develop leaders' capacity for public–private collaboration, nurtured by financial support from foundations, local charities, and an insurer. To make progress in a collaborative way, community leaders need to cultivate a sense of "patient urgency," says Guy, by slowly building trusting relationships while immediately taking incremental steps toward achieving agreed-upon goals for improvement.

Supportive state policies lay the groundwork for local improvement.

Pueblo has benefitted from supportive state policy, most notably Colorado's health care reforms that expanded Medicaid before and after enactment of the Affordable Care Act, as well as the creation of the Medicaid Accountable Care Collaborative and policies such as support for the use of long-acting reversible contraceptives. But the grassroots efforts led by Pueblo's community leaders have ensured there is fertile ground for localizing state policy to serve the priorities of this independent region, which can be wary of receiving dictates from state government. "There is a very fierce Pueblo culture of, 'We are going to do it our way,'" says Guy. "We will take your help, but this is our community, and we are going to do it our way."

NOTES

1 Colorado Department of Public Health and the Environment, *Visual Information System for Identifying Opportunities and Needs, Data by County, Diabetes—Adults, 2013–2015*.

2 J. Puzzanghera, "Low Pay? Disabilities? Video Games? Researchers Seek Answers," *The Pueblo Chieftain,* Dec. 3, 2016.

3 B. J. Ivey, "Improving Quality at Parkview," *Journal for Healthcare Quality,* Sept./Oct. 1992 14(5):56–62.

4 The Pueblo hospital referral region also includes parts of Crowley, Custer, El Paso, Fremont, Huerfano, Las Animas, and Otero counties.

5 The Colorado hospital provider fee was enacted in 2009 following recommendations of a bipartisan Blue Ribbon Commission on Health Care Reform. Enabling legislation prohibits hospitals from shifting the fee to clients or insurers. Since enactment of the fee, reimbursement to hospitals for care provided to Medicaid patients has increased from 54% to 75% of costs statewide, while the amount of bad debt and charity care decreased by 58% from 2013 to 2015, according to the state's Hospital Provider Fee Oversight and Advisory Board; see *Colorado Health Care Affordability Act Annual Report*, Jan. 15, 2017.

6 Commonwealth Fund analysis of data from the U.S. Census Bureau, 2015 1-Year American Community Survey Public Use Micro Sample (ACS PUMS); also see S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, and S. Beutel, *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015* (The Commonwealth Fund, Dec. 2016).

7 *Colorado Health Neighborhoods* (Centura Health, n.d.).

8 The federal government has designated Pueblo Community Health Center as a health professional shortage facility (https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx), and about half of Pueblo County as a medically underserved area (https://www.colorado.gov/pacific/sites/default/files/PCO_HPSA-mua-mup-map.pdf).

9 Use of concurrent review of medical records while patients are still hospitalized enabled timely delivery of education and reminders to staff at the point of care, leading to top performance on measures of care processes for pneumonia and heart in failure in 2007 and 2008. See A. Lashbrook, *Parkview Medical Center: Underscoring the Importance of Communication in Pneumonia Care* (The Commonwealth Fund, Dec. 2009).

10 Parkview was recently noted as one of 49 hospitals nationwide to achieve the lowest rates of hospitalwide readmissions from July 2014 through June 2015; see H. Punke, "49 Hospitals With the Lowest Readmission Rates," *Becker's Infection Control and Clinical Quality,* Dec. 28, 2016.

11 Pueblo Community Health Center is also eligible for quality bonuses from Kaiser Permanente for meeting targets for its Medicare Advantage patients, as well as from other private insurers.

12 The project resulted in the creation of a toolkit for statewide use and paved the way for related collaboration, such as an effort to increase the referral of tobacco users to cessation resources.

13 K. Galer, "Pueblo Fire Launches New Program to Help Decrease Record Number of Calls for Service," KKTV 11 News, Feb. 12, 2016.

14 *Pueblo County DOTS Program* (n.d.).

15 See U.S. Department of Agriculture, *Food Access Research Atlas and County Business Patterns 2012* (USDA, n.d.).

16 The food purchases are funded by local medical practices, accountable care organizations, and a grant from the hospital's foundation. The local food bank also will begin donating food this year.

[17] See One Community Pueblo dashboard (n.d.).

[18] B. Milstein, "ReThinking Health in Pueblo, Colorado: A Stewardship Strategy to Advance the Triple Aim," *Improving Population Health Blog,* Aug. 21, 2012; and K. Mitchell, *Pueblo County Triple Aim: Tips for Population Health Success* (Institute for Healthcare Improvement, Jan. 13, 2016).

[19] See *Triple Aim Measures* (Pueblo Triple Aim Corporation, n.d.).

[20] ReThink Health is an initiative of the Fannie E. Rippel Foundation. For background on the ReThink Health Dynamics model, see: https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/.

[21] Major grants have included $709,000 from the Colorado Health Foundation and $565,000 from Kaiser Permanente, which opened medical offices in Pueblo in 2009 to serve its new Medicare Advantage and commercially insured members. The grant from Kaiser helps support efforts to reduce avoidable readmissions and emergency department use and promote community health. Pueblo Triple Aim Corporation also has a $25,000 contract with Colorado's Medicaid agency to further develop community data in conjunction with the Medicaid Regional Collaborative Care Organization.

[22] In the 1990s the community lost a $1 million grant from the Colorado Trust because members of the collaboration formed to use the funds couldn't agree on the best way to address teen pregnancy.

[23] See *The Pueblo County Teen Pregnancy Research Project Final Report* (John Snow, Inc., n.d.).

[24] Data provided by the Pueblo City-County Health Department, based on vital statistics collected and reported by the Colorado Department of Public Health and Environment. The Long-Acting Reversible Contraception Program, originally funded anonymously by the Susan Thompson Buffet Foundation, gained state funding in 2016; see S. Tavernise, "Colorado's Effort Against Teenage Pregnancies Is a Startling Success," *New York Times,* July 5, 2015.

[25] Pueblo is one of 24 communities participating in the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative led by the Institute for Healthcare Improvement with funding from the Robert Wood Johnson Foundation, and is one of 50 communities participating in the Invest Health initiative sponsored by the Robert Wood Johnson Foundation and the Reinvestment Fund to promote cross-sector collaboration at the neighborhood level.

[26] J. Kania and M. Kramer, "Collective Impact," *Stanford Social Science Review,* Winter 2011.

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