Colorado State Innovation Model

Application for Funding for Test Assistance

JULY 21, 2014

State of COLORADO

Abstract

The Colorado State Innovation Model touches nearly every aspect of our health system, setting the stage for a sweeping transformation that will help us accelerate our progress toward the Triple Aim of lower costs, better care and improved population health. It will also allow us to reach our goal of becoming the healthiest state.

Our vision is bold. Central to transforming the Colorado health system is the integration of behavioral health and primary care, a necessary step in our accelerated achievement of the Triple Aim. Our integration efforts will be supported by an improved public health infrastructure. In turn, behavioral health integration will improve population health by addressing behavioral factors that often impede the management of chronic health problems, especially obesity, smoking and diabetes. Improving access to behavioral health services and programs for most Coloradans is the cornerstone of the Colorado transformation effort.

Under our plan, we will offer truly integrated physical and behavioral health care. A broad range of public health programs will extend health care, including disease prevention, on a population-wide scale. Payment systems will evolve to ensure that our new model of care is sustainable for the long haul. Data will be used effectively and securely to support innovation. And Coloradans will be at the center, with the power and opportunity to make the best choices possible for their own health.

Our vision is attainable, particularly because we are building on important work that is already underway. And Coloradans know how to work together to accomplish big projects. Today, stakeholders throughout the state and from the full spectrum of the health community are on board to collaborate on our SIM proposal. Key partners include eight leading commercial payers and primary care providers covering the majority of the state population.

There is urgency in our work. While we have a strong, collaborative foundation, health costs continue to rise, patients receive fragmented care and key population metrics must be improved. SIM will allow Colorado to strengthen our efforts in primary and behavioral care and broaden our reach to most Coloradans.

The overarching goal of Colorado SIM is to improve the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of state residents by 2019. There is strong evidence that treating physical health, mental health and substance use disorders together will help us take aim at the ever-increasing burden of chronic disease. Our plan, called The Colorado Framework, creates a system of supports, both clinic-based and through expanded public health efforts, to spur integration.

But while integrated care is necessary, it is not sufficient to achieving the healthiest state possible. We recognize that health outcomes are strongly impacted by social, economic and environmental factors. Based on the social determinants of health model, the Colorado SIM proposal leverages the efforts of public health to support the clinical health transformation. We will focus on 12 core population health target areas.

Colorado seeks SIM funding of $86.9 million across four years. These resources will help us integrate physical and behavioral health care in more than 400 primary care practices and community mental health centers (CMHCs) with about 1,600 primary care providers; bring the majority of payers into shared risk and savings programs by 2019; expand information technology efforts, including telehealth; launch a robust evaluation program that measures both processes and outcomes; and finalize our statewide plan to improve population health.

We project total cost of care savings of $126.6 million over the course of the SIM program, with annual savings of $85 million thereafter to help sustain Colorado's model.

1. Plan for Improving Population Health: Colorado's SIM aims to improve population health through two primary vehicles – an improved public health system and a transformed health care delivery system with integrated primary care and behavioral health services – that will work together to create an effective and sustainable community-based system.

Colorado's SIM Goal: We will improve the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of the state's residents by 2019.

Establishing a strong and ongoing partnership between our public health, behavioral health and primary care sectors is crucial because health outcomes are strongly impacted by factors beyond the clinical setting, including social, economic and environmental influences. Based on the social determinants of health model, our plan leverages the work of public health to reinforce strides in our clinical health delivery system. Working together, the two systems will build a collaborative and outcomes oriented model of primary care and public health integration that helps us reach our SIM goal.

Colorado has a head start on developing our statewide plan to improve population health. Governor John Hickenlooper set the stage in 2013 for Colorado to become the healthiest state in the nation when he unveiled the administration's sweeping health agenda, "The State of Health." Led by the Colorado Department of Public Health and Environment (CDPHE), multiple state agencies and community partners have prioritized Colorado's 10 Winnable Battles – focus areas such as obesity, substance use and mental health, and oral health – in which Colorado can make population-level progress in a relatively short period of time. SIM will allow us to make greater strides toward these goals.

We also have sound leadership in place as we move forward. The state's 55 local public health agencies (LPHAs), already key players in Colorado's public health model, are helping to

prioritize local health needs, important in a state with wide regional and demographic variations in disease prevalence. They excel at collaborating with regional partners, leveraging shared strengths to achieve better population health.

Overarching leadership will be provided by the Governor's Office; CDPHE; the Colorado Department of Health Care Policy and Financing (HCPF), which administers Medicaid; Colorado Department of Human Services (CDHS), which oversees behavioral health and social services; the Department of Personnel Administration (DPA); and the Colorado Department of Regulatory Agencies (DORA), which oversees the regulation of insurance and professional licensing. (See the Operational Plan).

Connecting providers and patients to community resources that support physical and behavioral health needs, chronic disease management, and the social determinants of health is essential to Colorado's SIM plan. Colorado will develop its statewide plan for improving population health within this conceptual framework:

Population Health Transformation Collaboratives: Population Health Transformation Collaboratives will be comprised of community health leaders and will disseminate evidence-based strategies, assist with setting priorities and goals, support collaboration toward population health goals using established metrics, and distribute resources to local agencies. Collaboratives will work with our newly created Health Extension Service (See Section 2: Health Care Delivery System Transformation Plan) to strengthen work underway at the local level and will be defined around existing state divisions to maximize shared resources. There are a number of activities that will be undertaken by the collaboratives. For example, as more than 23 percent of Colorado's population is children, a Child Mental Health Coordinator will be tasked with developing targeted population health initiatives for prevention and early intervention of mental

health problems in very young children. Providers will also receive training in depression, obesity and other behavioral disorders. Evidence-based practices, such as Mental Health First Aid, will also be made available statewide. Targeted LPHAs will receive funding to increase access to covered preventive services, improve community prevention work, and create linkages between practices, community resources and public health.

***Population Metrics and Shared Data*:** Colorado proposes to track our progress in 12 core population health target areas, including tobacco use, obesity and diabetes. Our enhanced connectivity through Health Information Technology (HIT) and state Health Information Exchanges (HIEs), will build upon and expand the Comprehensive Primary Care initiative (CPCi) centralized data hub that integrates clinical and claims data, and use other sources of shared information. Our population health plan will outline in detail how Colorado will use these data to inform interventions by communities and to help providers translate population-level metrics into actionable patient care improvement efforts. We will work with the Center for Medicare & Medicaid Innovation's (CMMI's) national evaluator to ensure aligned metrics.

Table 1. Proposed SIM Population Health Measures

Target Area	SIM Clinical Measures	Colorado Winnable Battles	USPSTF A & B Recommendations	CDC Recommendations
Hypertension	Blood pressure		Blood pressure screening – A	Taking HTN medication
Obesity	Weight assessment and management	Obesity	Obesity screening (adults and children) – B	BMI (adult, youth) exercise, vegetable and fruit consumption, food desert
Tobacco	Tobacco use screening and intervention	Tobacco	Tobacco use counseling and intervention - A	Use and quit attempts, youth use
Prevention	Breast cancer and colorectal cancer screens; flu shots	Clean air, clean water, safe food	Breast cancer screening, colorectal	Colorectal screening, immunization rate

			screening – B,A	
Asthma	Identify, appropriate prescription			
Diabetes	HbA1c, blood pressure, LDL-Cholesterol		Gestational diabetes screening – B	Diabetes A1c, foot exam, eye exam
Ischemic Vascular Disease	Complete lipid panel and control		Aspirin for CVD prevention – A Cholesterol abnormalities – A, B	Cholesterol levels
Safety	Screening for fall risk	Injury prevention	Fall prevention in older adults, intimate partner violence – B	
Depression	PHQ-9 for adolescents and adults, maternal depression screening	Mental health and substance use	Depression screening (adults and adolescents) – B	
Anxiety	GAD-7	Mental health, substance use		
Substance Use	Audit	Mental health, substance use	Alcohol misuse – B	
Child Development	To be determined	Immunizations (disease prevention), oral health, unintended pregnancy	Dental caries prevention to age 5 – B	Immunization rate, low birth rate

Policy Advocacy: State and local public health agencies will jointly advance regulatory issues that improve population health and address regulatory barriers in areas such as obesity, behavioral health, tobacco access and pricing, food access, diabetes, and environmental safety and activity measures (See Section 4: Leveraging Regulatory Authority). We will continue existing partnerships that support alignment between private and public payment strategies and

public health initiatives, allowing for sustainability. We will create a timeline for expanding integration to include oral health and chronic disease self-management training.

Ongoing stakeholder engagement will be an important part of Colorado's success. Our population plan will detail our strategy to tap into a robust dialogue to allow for continual enhancements to meet our goals. (See Section 6: Stakeholder Engagement).

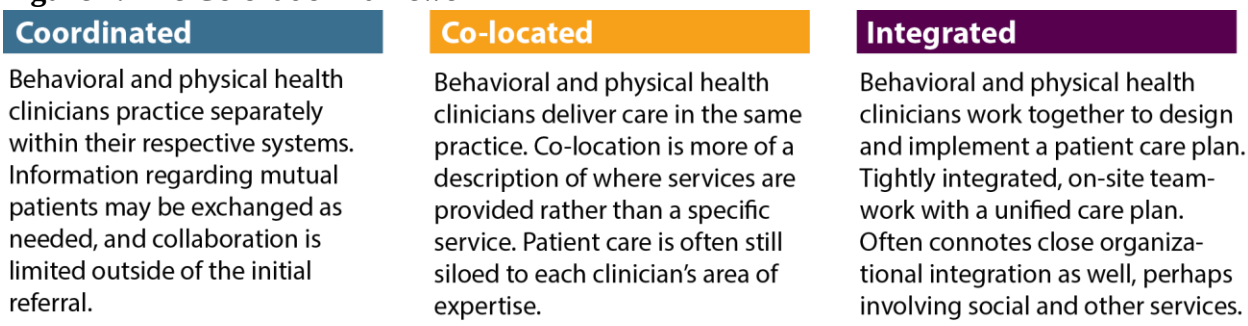
2. Health Care Delivery System Transformation Plan: Colorado's SIM aims for wide-scale practice transformation in order to reach our goal. We will assist more than 400 primary care practices and community mental health centers (CMHCs) statewide as they integrate physical health and behavioral health services. By the full build-out in 2019, we will engage approximately 1,600 primary care providers (PCPs) serving at least four million people, or approximately 80 percent of all Coloradans. This will encompass about one million Medicaid clients, approximately 90,000 Medicare clients, and about three million commercially-insured residents, including state employees.

Integrating behavioral health and primary care is the logical evolution of comprehensive primary care and a critical step in defragmenting health care. Evidence suggests integrated care improves individual care, results in better population health and contains costs. Most importantly, integrated care reduces the state's chronic disease burden.

Our health care delivery system transformation plan, called "The Colorado Framework" and outlined in our State Health Innovation Plan, leverages a strong foundation of federal, state and private sector investments in primary care transformation and integrated care (see Section 9: Alignment with State and Federal Innovation). We will knit various important initiatives into long-term, comprehensive innovation.

The Colorado Framework envisions three stages of integrated primary care and behavioral health (see Figure 1):

Figure 1. The Colorado Framework



Our goal is to help as many practices as possible move to the "Integrated" stage by the end of the grant period. Outcomes measures, as shown in the SIM Minimum Dataset (see Section 7: Quality Measure Alignment), will track our progress for both adult and pediatric populations.

Our transformation plan is ambitious and far-reaching. To make it manageable and ensure its success, we will use a phased approach to recruit practices. This will allow for intense support, enabling us to share lessons learned and to conduct meaningful, rapid-cycle evaluation. The initial cohort will be roughly 100 practices that have met key integration milestones, are prepared to adopt reformed payment models, and have demonstrated Stage One Meaningful Use (MU) Electronic Health Record (EHR) capabilities.

These pioneering practices will include CPCi participants; participants in grant-funded integrated care pilots as well as partnerships between federally qualified health centers (FQHCs) and CMHCs; and practices that have made significant progress toward comprehensive primary care models, which include many pediatric practices. We will seek diversity in types, sizes, and populations served. We will work with both individual practices and large health care delivery systems.

We also recognize that the need for integration is not unique to primary care practices. Bidirectional approaches that bring primary care into behavioral health settings for those with severe and persistent mental illness are a priority. We will also spur integration in long-term services and supports (LTSS), schools and jails.

Colorado Health Neighborhoods, Centura Health's provider network of more than 2,500 physicians statewide, will play a key role in the model test, starting in the first cohort. Across three years, 75 Centura Health practices caring for about one million people will participate. Colorado Health Neighborhoods will tap behavioral health services statewide through a participation agreement a statewide network of behavioral health providers.

Selection criteria for subsequent cohorts will be refined to reflect lessons learned and to ensure the longest reach possible. Practices will commit to at least three years of practice transformation facilitation, workforce training, collaborative learning sessions with other practices, ongoing evaluation, and strengthening of their community health networks. Practices will receive tailored transformation assistance based on a baseline Practice Readiness Assessment and ongoing technical assistance. Transformation support can include infrastructure investment, coaching, workforce training for primary care providers, and salary offsets for behavioral health providers (BHPs). Participating practices may be eligible to apply for assistance through the Health Transformation Investment Fund.

Colorado will also engage practice facilitators, approximately one for every 12 practices to provide clinic-level technical assistance. They will help practices achieve the core competencies of comprehensive primary care and integrated care, using the practice milestones defined by the CPCi, with additional milestones relating to behavioral health integration aligned with the Agency for Healthcare Research and Quality's *Lexicon for Behavioral Health and*

Primary Care Integration, which is aligned with SAMSHA/HRSA's Six Levels of Behavioral Health Integration.

Community health efforts will be guided by our Population Health Transformation Collaboratives with Health Extension Agents liaising with practice facilitators, CO-REC IT agents (See Section 5: HIT), Local Public Health Agencies, Early Childhood Mental Health Specialists (See Section 1: Plan for Improving Population Health) and other supports as identified by the community. Health Extension Agents key activities include:

- Engaging with practice and organizational leaders, educating them about SIM;
- Conducting a readiness assessment with practice leaders, then link practices to needed resources;
- Connecting practices with technical support for data linkage, extraction and management (See Section 5: HIT), as well as MU Stage 1 Attestation in concert with the Regional Extension Centers (REC);
- Providing practice transformation resources, including facilitation, learning collaboratives, online modules, conference calls, and cross-practice learning networks;
- Working with the behavioral health community to help practices determine the integration strategy that works best for them as a starting point;
- Connecting BHPs with training resources in the integrated clinical model;
- Providing business consultation resources to help plan for integrated delivery systems and outcomes-based payment systems;
- Helping to establish patient advisory groups and assist with patient engagement efforts;

The competencies will include data-driven quality improvement and practice transformation; team-based care with all practice members, including integrated BHPs, working

at the top of licensure; coordination of care across all providers and care settings; identification of high-risk patients for care management; systematic monitoring and adjustment of treatment plans; and engaging patients in their own care and in the overall practice transformation.

Each practice will develop a team-based workforce plan, including an HIT technical plan that considers the physical and behavioral health needs of its patient population. The plan will include strategies to engage primary care and specialist clinicians, non-medical staff, and BHPs. Linkages to community resources, with coordinated referrals to public health and community agencies may also feature in the plans. Practice facilitators will help with workforce planning, training and recruitment. A Health Transformation Investment Fund will provide early incentives to both payers and providers as they make the necessary changes toward integrating behavioral health and primary care, both financially and clinically.

Finally, we have planned for the sustainability of this important work beyond the SIM funding period. Colorado proposes to use one-third of actuarially projected savings to support ongoing activities related to the project. We also anticipate that changes in payment models will become permanent and ongoing after the grant period.

We believe that these efforts will create a tipping point for integrating Colorado's health delivery system, achieving a critical mass that will make innovation inevitable. By focusing on whole person care within both the behavioral health and primary care settings, Colorado will achieve the Triple Aim of better care, better population health and lower per capita costs.

3. Payment Delivery Model: Payment reform must go hand in hand with health care delivery redesign in order to bring about lasting and sustainable change. As Colorado's practices progress toward integration, so too will payment.

Our goal is that by 2019, the fourth year of the SIM grant, payers serving a majority of Coloradans will reimburse practices for integrated physical health and behavioral health services in shared risk and savings programs. Further, a significant number of integrated practices will receive a global or capitated payment for comprehensive primary care.

Colorado offers fertile ground for innovative payment reform. For example, Medicaid offers a fee for service (FFS) payment with an enhanced per member per month (PMPM) payment for primary care practices acting as a medical home. Seventy-three practices and eight payers participate in the CPCi, a multi-payer pilot that pays for coordinated care. Recent legislation (HB 12-1281) has opened new frontiers of payment initiatives. One such pilot which coordinates behavioral health and physical health through a complete transfer of risk and budget accountability to community partners, is underway in western Colorado. More tests are planned in 2015. Furthermore, the state has committed to integrating primary care across the behavioral health system, as demonstrated in the latest Behavioral Health Organization (BHO) RFP, where organizations were specifically asked to articulate their plans for integration, including care coordination and supportive services just to name a few. Colorado's BHOs already have experience in coordinating with medical health providers and helping individuals to get medical treatment and arrange for supportive services, and the lessons they have learned will inform Colorado's SIM work.

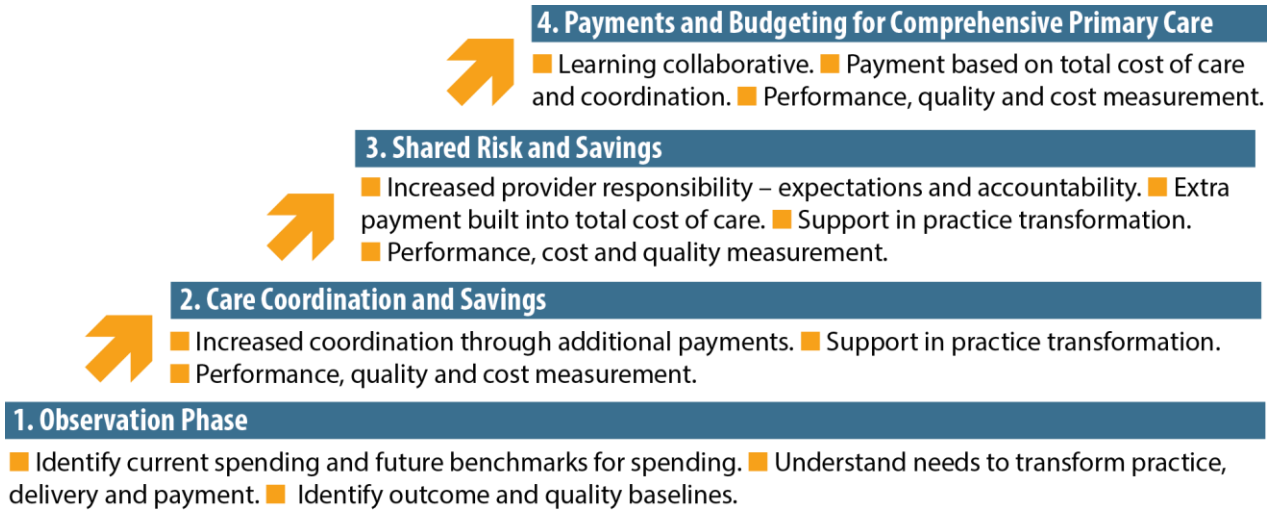
SIM funding will allow Colorado to scale our efforts and reach more Coloradans, providing infrastructure, operations and administration that will last beyond the four years of funding.

Payers in today's market have a high degree of interest in supporting and paying for integrated care. The challenge is maturing behavioral health and primary care settings so that

they can administer, receive and monitor payments that progress beyond FFS. Payers have revealed their willingness to adopt alternative payment methods when practices are able and willing to accept non-FFS payments. SIM funding will ready the market for this advancement.

Our trajectory of payment reform parallels practice readiness, beginning with an observation phase and progressing through payments and budgeting for comprehensive primary care and behavioral health.

Figure 2. Payment Steps Toward Integrating Behavioral Health and Primary Care



The cornerstone of this payment reform glide path is the readiness and ability of primary care practices to move from a FFS environment. As the practices evolve, payers will begin to employ alternative payment methodologies and move to shared risk models.

Critical to our success will be to continue regular and open discussions with all of Colorado's payers. Building upon CPCi, Year One will be focused on finalizing specific payer commitments and agreeing to details of the care coordination, shared savings, shared risk and sub-capitated plans. We also will work on aligning administration of the current FFS physical health system with the currently capitated behavioral health system in Medicaid. We acknowledge the work and challenges ahead and have built a trusted stakeholder community that will deliver on this goal.

4. Leveraging Regulatory Authority: Colorado supports a policy and regulatory framework that buttresses the integration of comprehensive primary care and behavioral health services and strengthens public health, smoothing the way for innovation and for reaching our SIM goal of improved population health. The four core areas of "The State of Health," Colorado's health care agenda, illustrate this commitment:

Promoting Prevention and Wellness: Innovating how we deliver health care in Colorado presents an opportunity for LPHAs and other community-based organizations to provide population-based services with the long-term potential for reimbursement. CDPHE is analyzing its statutory authority to act as a pass-through or aggregator organization for reimbursements that are aligned with our payment reform models to support community-based local public health efforts.

Improving mental health and reducing substance use disorder – including tobacco, alcohol, marijuana, prescription drugs, and illicit substances – is a top priority. Colorado will

work to eliminate limits on the ability of local jurisdictions to regulate tobacco sales and prices. We will build on recent successes with our Colorado Plan to Reduce Prescription Drug Abuse and a regulatory structure for legalized adult-use marijuana that focuses investments in treatment, enforcement, education and research.

We are developing a State Plan Amendment (SPA) to expand the role of public health in the lives of over one million Medicaid clients. In addition, we have launched two pilots to integrate core public health functions into our Regional Care Collaborative Organizations (RCCOs). LPHAs and other community partners are providing enrollment support, referrals to clinical and community services, and chronic disease management.

Expanding Coverage, Access and Capacity: Our state insurance marketplace and Medicaid expansion jointly expanded coverage to 305,741 Coloradans during 2014 open enrollment. A number of efforts are underway to ensure that all Coloradans, including the newly insured, have access to affordable, quality coverage.

Colorado is one of seven states selected by the National Governors Association to implement a health workforce development plan that will create a centralize data and analytics hub, use data to drive statewide workforce planning that is responsive to local needs and build on Colorado's nationally recognized loan repayment program to expand recruiting and retraining efforts. The Governor's Office will work with the Colorado Department of Higher Education, the Community College System, and key health professions' educators to ensure that team-based, integrated care delivery is a training priority.

Colorado is also committed to developing policy and regulatory supports for all providers who can help leverage our primary care workforce. A Governor-appointed, inter-professional task force is currently examining whether existing requirements for advance practice nurses'

prescriptive authority are overly burdensome. Colorado is developing standard, consensus-based criteria for community health workers and patient navigators that will support both professionals and training programs.

A health cost study conducted in spring 2014 will inform the work of the legislatively created Colorado Commission on Affordable Health Care, a bipartisan initiative to help reduce health care costs while improving quality and access.

Improving Health System Integration and Quality: We have streamlined or eliminated many regulations affecting behavioral health services. We will pursue additional contracting, regulatory or legislative changes as they are identified. Colorado Medicaid will recognize CMHCs and other providers delivering qualified primary care services as Patient-Centered Medical Homes. Colorado will work with stakeholders to develop and apply for an SPA to create Section 2703 health homes and will incentivize contractual and financial alignment between Colorado's RCCOs and BHOs.

Colorado's Division of Insurance has regulatory authority over Qualified Health Plans and works with our marketplace to ensure regulatory functions are non-duplicative. As a result, reforms and innovations reach all of our individual and small group markets. We acknowledge that some new care delivery and payment models – particularly those involving risk-sharing at the provider or community level – pose a challenge to traditional insurance regulatory models. We commit to evaluating regulatory alternatives that enable innovation while ensuring consumer protection.

Enhancing Value and Strengthening Sustainability: Colorado will build on our high rates of EHR and HIE adoption to expand the role of HIT across three key domains that support integrated care through better infrastructure and analytic capacity: state IT systems, clinical and

claims systems, and patient engagement tools. The following are completed efforts. (See Section 5: HIT for efforts that are underway or planned.)

- State level, standards-based interoperability requirements.
- State-driven support and funding for HIT and HIE adoption, including appropriate exchange of behavioral health information to improve care.
- Leveraging HIT infrastructure for uses within and beyond the health system, including Colorado's state marketplace, eligibility services, provider directories, prescription drug monitoring, health condition registries, and other social services and public health programs.

5. HIT: Colorado, already a leader in heath IT innovation, plans to expand our infrastructure to support practice transformation, improve population health, develop shared care planning resources, expand telehealth and coordinate public health services. We will build on existing work to realize the creation of a fully integrated electronic health care system with statewide reach, a key component of reaching our SIM goal.

Colorado received federal, state and community funding to build and strengthen local HIT infrastructure and test innovations. We won a CPCi grant to foster collaboration between public and private payers and successfully implemented our health insurance exchange. Our innovation plan will extend these investments to the majority of Coloradans. Through our HIT plan, we will:

- Provide technical assistance at the community and practice level to improve quality of data capture and extraction;
- Consolidate clinical quality data reporting to create a centralized hub with user interfaces, benchmarking, and dashboards allowing real-time monitoring of population metrics at the community, practice and patient level;

• Connect the clinical data hub to the CPCi administrative data hub for aggregated clinical and cost data information; and

• Support telehealth infrastructure and delivery expansion strategies, including a Telehealth Resource Center (TRC).

A centralized data repository will aggregate clinical information (building upon the CPCi solution), provide consolidated reporting for providers to public and commercial payers and give population and practice benchmarking information to providers and payers. The Governor's Office will continue to work with existing data governing authorities on safe and appropriate data sharing practices by supporting policies, operational practices, technical safe guards, and educational resources. The hub will create a platform for shared care planning resources and a non-condition specific repository for state population health evaluation. It will leverage the existing Master Patient Index (MPI), provider directories and other tools. Building on clinical information, the phased approach will link to administrative claims information via the Colorado All-Payer Claims Database (APCD) and other sources as needed, providing a central aggregated clinical and cost data hub. The following work will support our plan:

Governance: Overseen by the Governor's Office, the state SIM office will provide planning and oversight and will manage HIT contracts for tasks, such as the provision of technical assistance to practices, done at the regional level. The state SIM office also will manage the contract for a centralized data hub with the State Designated Entity (SDE). The SDE will work through Colorado's two HIEs, Quality Health Network (QHN) and Colorado Regional Health Information Organization (CORHIO) and other HIT partners. To address conflicts over data ownership, the SDE's HIE Policy Committee has a stakeholder process, as well as a scalable,

flexible policy model. We will incorporate new data owners into data governance policies and use agreements.

Policy: Colorado has worked to align state health policy, including creation of the APCD, which is aggregating claims between 2009 and 2012 by more than three million patients. A policy is in process to include payers in the governance and sustainability of HIE. The SIM office will advance new policies to disseminate up-to-date federal IT standards, evaluate and promote the use of telehealth, share information, and support the central data hub. In the planning stage are policies removing real and perceived barriers to exchange through clear privacy and security policies; requiring HIT tools to adhere to federally endorsed standards; and ending policies that inhibit telehealth. Colorado aligned the sharing of mental health data with HIPAA in 2011, enabling organizations to share such data through the state's HIE networks, with the exclusion of 42CFR Part 2 data.

HIT Infrastructure: Colorado's two HIEs have developed products for hospitals and ambulatory providers. They supply reporting to public health agencies and allow providers to access clinical data, alerts, direct secure messaging, longitudinal patient histories and transitions of care solutions.

TABLE 2. Current Rate of HIT Adoption.

Measure	Percentage
Providers meeting MU in EHR incentive programs	92% hospitals, 48.3% professionals, 72% registered
Unique patients in the HIE	72.5%
Providers using the HIE	28.4%
Users of HIE	58.4%
Long-term post-acute care facilities connected to HIE	50%
Acute care hospitals with over 100 beds connected to HIE	93%

Colorado will implement its technology plan in phases, building first on the work of advanced clinical practices to establish a data quality, sharing and reporting infrastructure. We

will improve data quality at the point of care with the SIM measure set, scaling to a comprehensive clinical data set. Through the creation of user interface and reporting tools, public health entities will be able to uncover issues at a state level.

Colorado's SIM technology plan will leverage planned HIT architecture expansion for uses within and beyond the health care system, connecting health data across the Medicaid enterprise and state systems. HCPF plans to leverage 90-10 Federal Financial Participation (FFP) funding to re-use data from the HIE network and services with the new MMIS system (Colorado InterChange). Additional activities connecting the network with eligibility and enrollment systems (CBMS/PEAK) and human service systems are being discussed and planned.

Technical Assistance: The practice transformation teams and health extension agents will provide technical assistance to ensure that data is driving improved clinical outcomes. Technical assistance will be targeted to behavioral health practices and non-MU Incentive-eligible practices to leverage Colorado's Medicaid expansion funding. By supporting effective use of HIT tools in the clinical workflow, we will make improvements beyond SIM, attesting to MU, connecting to the HIE network and improving data integration across public and private resources.

Telehealth Infrastructure and Delivery Expansion: The Colorado Telehealth Network (CTN) will leverage the Healthcare Connect Fund to reach underserved urban and rural health care facilities. The state will leverage CTN's 195-site network to increase and expedite access to care across physical and mental health providers. The SIM HIT plan supports expansion for an additional 300 telehealth sites for rural and underserved communities. These sites are separate from the 400 practices targeted for behavioral health integration, although there may be some overlap. A telehealth planning grant will develop an implementation and evaluation plan aimed at incorporating telehealth tools into medical settings.

6. Stakeholder Engagement:

Colorado's plan to engage a wide array of SIM stakeholders builds on a rich history of collaboration in our state. Under the leadership of Governor John Hickenlooper, we are framing our SIM outreach strategy to maximize the involvement, insight and expertise of statewide partners to reach our health care transformation goal**.**

Stakeholder engagement will be the cornerstone of our success, and our outreach efforts will ensure participation of a wide array of individuals and organizations. A detailed committee structure will serve as the foundation of our strategic engagement plan.

SIM Oversight Board: This highly visible board will be comprised of Colorado's health leaders and visionaries, who will heighten awareness and provide momentum around Colorado's SIM initiative. The group will be further charged with ensuring that the linkage between primary care and population health is a primary focus of SIM implementation. It will monitor Colorado's progress on all aspects of the model. Members will include representatives from behavioral health representatives, patients, payers, providers and technology experts. The board will meet regularly to provide direction to the SIM project director and staff, to ensure coordination among state agencies, and to keep the project on target to meet its milestones, which are detailed in the operational plan.

A **Large Advisory Committee** will meet twice a year with a broad, diverse membership of more than 150 people from more than 90 organizations. It functions as a communications vehicle, engaging its members in ambassadorship and program knowledge and engendering a solid understanding of their roles and responsibilities as participants in the SIM. Representation in this committee includes patients, behavioral health providers, payers, advocates, foundations and many others.

A **Patient Committee** will ensure that the voices of patients and consumers are not only heard but that the systems of care that SIM builds are focused on the needs of individuals. Patient-centered, integrated care must first and foremost serve the needs of patients. A key focus of the committee will be that systems – both financial and clinical – are designed in ways that allow for consumer engagement and full participation.

A **Provider Committee** will examine various models of integration and determine how, when and why primary care practices can and will integrate care. A chief goal of the committee will be to ensure that the transformation expected at the practice level – from cultural changes, to HIT to financial changes – be well articulated and well supported. The committee will also examine how to scale best practices to all willing practices in Colorado. This committee will also work in partnership with the payer and population health committees to support critical linkages and collaborative efforts that will accelerate the Triple Aim.

A **Payer Committee** will examine how payment changes can provide incentives for care integration to achieve the Triple Aim. This committee will actively explore how the state will migrate from FFS models to shared savings and ultimately risk based models of integrated care. It will work closely with the provider committee to ensure that practices demonstrate appropriate readiness to assume non-FFS based models.

A **Population Health Committee** will align SIM with the state's overall health improvement plans and explore ways to leverage LPHAs to help achieve the SIM goals. The committee also will address how SIM can help specific populations, including American Indian tribes and the homeless. A cornerstone of the Colorado SIM is the critical linkages between primary care practices and community based population health services. This committee will focus on how to strengthen these linkages in communities throughout the state.

Strategically, our stakeholder engagement will work on two levels – targeted when needed and more broadly expansive when appropriate.

Actively involved stakeholders who have participated in various committees include companies representing the majority of Colorado's insurance market, United Healthcare, Rocky Mountain Health Plans, Kaiser Permanente, CIGNA, Anthem and Aetna; representatives of major providers, including the Colorado Hospital Association, Denver Health, and Centura Health; the state's insurance marketplace, Connect for Health Colorado; and foundations and nonprofits, including the Colorado Health Foundation, The Colorado Trust, the Caring for Colorado Foundation, and the Colorado Consumer Health Initiative. For a full listing of stakeholder organizations and other information disseminated through our project to date, please see www.coloradosim.org.

Colorado's SIM application benefits from a history of meaningful stakeholder involvement in health care transformation under the past three governors, including Governor John Hickenlooper. Former Governor Bill Owens, a Republican, helped to create the Blue Ribbon Commission on Health Care Reform in 2006. His successor, former Governor Bill Ritter, a Democrat, embraced the commission and worked closely with its members. The group brought together health care consumers, providers, payers, and policymakers to recommend a comprehensive set of reforms, many of which have been enacted into law. Its focus on affordable care, improved access and better health outcomes served as an early precursor to the Triple Aim and the Affordable Care Act.

7. Quality Measure Alignment:

Measuring and evaluating what is being done, to whom, how effectively, and at what cost, will be central to our plan to transform health care in Colorado. We have restricted our

proposed candidate measures to those that are most aligned with where practices are and what payers have committed to in Colorado.

Understanding the diversity of constituents who will provide and use the data, we have selected measures for their ability to serve multiple purposes. This will limit the reporting burden on frontline practices and maximize the impact. That said, Colorado remains open to further refinement of our proposed measures.

Because Colorado's clinical and population-level interventions intend to affect behavioral and physical health outcomes, measures need to include both health components. We started by listing the clinical quality measures currently being used in the field, then created a spreadsheet to reveal which measures would best show the impact of the SIM interventions on quality. From this group, we identified measures with multi-payer support.

CPCi has provided a solid foundation on which to build clinical measures for SIM, which allows us to further leverage and expand our CPCi efforts and commitments. The majority of our clinical and quality measures start with the basic CPC measure set. However, since our focus is around behavioral health and primary care, we have added three measures.

TABLE 2. Proposed CPC+ Measures

Basic CPC Conditions	Measure	Citations
Hypertension*	Blood pressure	NQF 0018
Obesity*	Weight assessment and management	NQF 0024
Tobacco*	Screening and intervention	NQF 0028
Prevention*	Breast cancer screening, colorectal cancer screening, influenza immunization	NQF 0031, NQF 0034, NQF 0041
Asthma*	Identification and appropriate prescription	NQF 0036
Diabetes*	HbA1c, Blood Pressure, LDL- Cholesterol	NQF 0059, NQF 0061, NQF 0064
Ischemic Vascular Disease*	Complete lipid panel and control	NQF 0075
Safety *	Screening for fall risk	NQF 0101

Depression*	PHQ-9 for adolescents and adults, maternal depression screening	NQF 0418, NQF 1401
CPC+ Conditions	**Measure**	**Citations**
Anxiety*	GAD-7	SHAPE
Substance Use*	Audit	SHAPE
Child Development*	To be determined	

* These conditions also affect children and can be addressed in pediatric care settings. While current CPCi measures primarily focus on adults, during the first year we will confirm which pediatric measures will be used for certain of these conditions.

The 73 practices participating in the multi-payer CPC initiative in Colorado, along with the participating payers, have already initiated these measures. Our proposal leverages the multipayer buy-in to begin measuring the impact of behavioral health integration with three additional measures of behavioral health – depression, anxiety, and substance use. These behavioral health measures are included because of the prevalence of these conditions in primary care specifically and in Colorado generally.

Colorado will cooperate with other states and CMMI evaluators to optimize and potentially streamline measurement across the CMMI portfolio. Beginning in January 2015, a group of pediatric mental health leaders, health plans, HCPF and consumers will be convened to work on finalizing the pediatric mental health measures. SIM leadership, in partnership with stakeholders, will be responsible for finalizing the measure set.

Alignment with Medicaid: A recently-launched interagency initiative, the Colorado Opportunity Project, is a partnership between CDPHE, Colorado Department of Education, HCPF and CDHS to align measures that target social emotional development in early childhood in order to alleviate poverty. Medicaid pays for annual developmental screens up to age 5, reimburses for annual depression screenings for individuals 11 and older, and reimburses for tobacco cessation programs. It also monitors performance on control of BP, HbA1c, and depression screening. The state is exploring how to feed this information to practices more quickly and more often.

Reducing the reporting burden on practices is a major driving factor behind our proposed measurement plan. By focusing on a limited number of measures, we can provide support across programs and add value to clinicians.

8. Monitoring and Evaluation Plan:

Colorado will develop and implement a self-monitoring plan in conjunction with an internal evaluation that incorporates a formative component, an outcome/impact component with a return on investment (ROI) analysis, and a rapid-cycle component that will inform ongoing model adjustments.

The specific plan will be developed with CMMI to align with the national evaluation, provide required data, and minimize duplicative efforts and stakeholder burden. We will select an independent organization to finalize the design and conduct the activities. This will enhance our in-state evaluation expertise and ensure evaluation efforts continue after model funding has ended.

The self-monitoring plan and evaluation will assess our progress in achieving the overall project goal of increasing access to comprehensive primary care, including integrated behavioral health, that improves our population's health and experiences with care while containing, if not lowering, costs through value-based payment models for integrated primary care.

We will focus on measuring population health, both overall and for key population subgroups; transformation of the health care delivery system, including quality of care and alternative payment models; and the costs of care, including per-capita total health care spending statewide, across regions and among population subgroups. Some measures will be calculated monthly or quarterly while others will be determined annually. Specific measures will be selected with CMMI, the CMMI evaluator, and our stakeholders.

We also will identify selected measures for our rapid-cycle evaluation to guide continuous quality improvement, identify unanticipated challenges and detect unintended consequences. In addition, the Population Health Transformation Collaboratives will provide a Community Scorecard demonstrating progress toward Triple Aim.

The RE-AIM framework (Reach Effectiveness-Adoption, Implementation, Maintenance) will guide the development and implementation of our self-monitoring plan and internal evaluation. We will use a mixed-methods approach developed in collaboration with CMS and its evaluator guided by the RE-AIM framework in all three evaluation components (formative, impact, rapid-cycle) to examine the overall impact of our model, the effectiveness of policy and regulatory levers, and determine what program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes. A mixed-methods approach will allow us to examine the overall impact of our model, the effectiveness of policy and regulatory levers, and those program characteristics, implementation approaches or adaptations, and contextual factors associated with better outcomes. This is a high-level description of our proposed approach:

The formative component will apply quantitative and qualitative methods to evaluate the reach element of the framework and provide critical contextual information on the adoption, implementation and maintenance elements.

We will examine reach among different groups of stakeholders, including patients, providers, payers, and purchasers.

For example, we will use multiple approaches to measure the percentage of patients with access to integrated primary care and behavioral health in the patient's medical home. These approaches could include supplementing existing population surveys such as Behavioral Risk

Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBSS) with questions on access to behavioral health for statewide measures and/or aggregating the number of patients in practices with integrated behavioral health services for estimates of reach statewide and for county-based regions. We will track the integration of behavioral health and the proportion of patient panels under alternative payment methods at baseline and throughout the project. We will measure whether integration of behavioral health in primary care affects contracting and purchasing decisions and use of value-based payment models.

To develop a deeper understanding we will also collect information through site visits, focus groups, and key informant interviews with stakeholders representing the same groups surveyed, as well as state and local government agencies, tribal communities, consumer and patient advocacy groups, and public health organizations.

Additional information to inform our formative evaluation will be gathered from model documents, including practice transformation facilitator notes. Qualitative methods will allow us to understand how the model was implemented in practices and communities, explain what may have contributed to variation in reach, effectiveness, and maintenance, and describe stakeholder engagement.

We will use a prospective, quasi-experimental design for our impact evaluation. We expect that the phased roll-out of practices will provide in-state comparison groups for difference-in-differences and interrupted time series designs to help control for as many confounding factors as possible.

Outcome measures will encompass all three focus areas. Population health measures obtained from surveys and surveillance data will include prevalence of, and disparities in,

tobacco use, diabetes, and obesity. Delivery system transformation outcome measures will include patient care experiences and provider and staff satisfaction obtained from surveys such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Quality of care measures will be developed from HIE data, claims data and payer quality reporting systems. Cost of care and utilization measures will be developed from the APCD and other claims databases, applying methods to assess total cost of care and other cost and utilization measures.

A key component of our outcome/impact evaluation will be an ROI analysis for various groups that measures programmatic costs combined with changes in cost and utilization of care. The programmatic cost analyses will obtain startup and ongoing costs from multiple perspectives, including providers, private payers, government payers, purchasers and other government agencies. Combining the programmatic cost information with the changes in cost and utilization of care derived from our data analysis will allow us to examine the business case and sustainability of the model from the perspectives of providers, private payers, purchasers, and federal and state government.

Rapid-cycle evaluation results will be reported quarterly to promote continuous program improvement. We will apply the concepts of community-based participatory research to ensure that these findings are actionable and inform real-time decisions.

9. Alignment with State and Federal Innovation: Colorado's SIM builds on, and aligns with, numerous CMMI, Department of Health and Human Services (HHS) and state initiatives that support high-performing primary care and integrated behavioral health. SIM funding will enable practices engaged in these initiatives to add new services, or to extend programs beyond their current grant funding, without duplicating or supplanting current funding. Projects include:

- CMS State Financial Alignment Model to integrate care for Medicare-Medicaid beneficiaries within a managed FFS model (awarded July 2014);
- The Accountable Care Collaborative;
- CMMI Comprehensive Primary Care Initiative;
- CMMI Advanced Primary Care Practice Demonstration;
- Five CMMI Health Care Innovation Challenge projects for behavioral health integration;
- Two SAMHSA/HRSA funded integrated care initiatives;
- Medicaid global payment pilot for integrated care;
- Numerous private grant-funded and payer-specific integrated care initiatives.

Federally supported initiatives that align with Colorado SIM's population health improvement focus include the CMMI Community-based Care Transitions Program and CDC-funded programs in chronic disease management, tobacco prevention, health screenings, immunization and sexually transmitted infections.

Programs like the full federal match through 2016 to expand Medicaid eligibility, the TEFT grant for community-based long-term services and supports, and the Colorado Regional Extension Centers will support the expansion of HIT/HIE into all care settings, encourage evidence-based medicine and give technical support through te integration process.

Budget Narrative: Colorado requests $86,928,657 in SIM funding over the four years of the grant. Our proposal has several major components, including integrating behavioral health and primary care, strengthening linkages with public health, reforming the payment system, and improving health information technology supports. Together, these initiatives will accelerate our progress toward the Triple Aim goals of better care, improved population health and lower per capita costs. A summary of total cost by percentage can be seen in Table 1, followed by detailed descriptions of budgets.

Table 1. Summary of Total Budget by Initiative

Initiative	Percentage of Total Budget
Administrative	7.80%
CDPHE	7.13%
Office of Behavioral Health	1.62%
Stakeholder Engagement	0.20%
External Evaluation	7.70%
Transformation Fund	8.63%
Population Health	3.41%
Practice Transformation	30.66%
Bi-Directional Health Homes	8.41%
Health Information Technology (HIT)	24.46%
Total	**100.00%**

Personnel: Colorado proposes a model with an administrative office overseeing the statewide health transformation. Estimated personnel costs for this office are $4,102,663 for the SIM funding period. Staff functions are described below. (Note: HCPF Grants staff is external to the SIM infrastructure but will provide support for it, particularly around coordinating with HCPF Budget, Accounting, Procurement and HR staff; monitoring compliance with federal award terms and conditions; and maintaining required reporting schedule. Other HCPF staff will be providing infrastructure support as needed.)

Table 2. SIM Personnel: Position Title, Grade, and Description

Position Title	Grade	Position Description
SIM Director	GP VI	Manage SIM team, oversee implementation and execution of all grant activities, regularly report to advisory board on progress and issues
2 Administrative Assistants	PA II	Assist director and team, including material preparation, communications, operations, and related grant activities
Internal Evaluator	SA II	Conduct regular internal evaluations to ensure that deliverables are on track; liaison with CMMI and external evaluator
SIM Finance Manager/Accountant	SA II	Develop financial reports and analyses necessary for financial management and reporting
SIM Budget Analyst	BA II	Track grant budget, ensure appropriate expenditures and handling of funds
Operations Director	GP IV	Manage implementation and execution of grant initiatives both internally and externally
Regional Manager 1	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 2	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 3	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 4	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 5	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 6	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Regional Manager 7	GP III	Manage regional grant initiatives, contracts, and stakeholders, with regular communication with other regional managers and SIM director
Grants Staff	GP II	Assist with grant compliance and deliverables

Senior Contract Manager	GP V	Oversee implementation and performance management of grant related contracts
Senior Policy Advisor for Health, Governor's Office	GP IV	Oversee use of policy levers and implementation, advise on health policy matters, and act as health liaison between Governor's Office and SIM team
HIT Implementation Coordinator, Governor's Office	GP IV	Oversee implementation of all grant HIT initiatives and deliverables and act as HIT liaison between Governor's Office and SIM team
Communications Director	GP IV	Manage internal and external communications including meetings and conferences; create communications materials in conjunction with policy staff
Policy Manager	GP III	Advise on all matters related to state, federal, and grant policy and regulatory requirements and grant initiatives
Stakeholder Outreach Coordinator	GP III	Facilitate stakeholder engagement; create stakeholder facing communications materials

Fringe: Colorado's estimate of fringe benefits costs is based on the assumption of 21 personnel and their distribution across the grant years. Fringe benefits for personnel include 20.44 percent fringe for retirement and federal and state income taxes plus $4,421.04 for health, life and dental insurance. This estimate is $1,209,953 for the duration of SIM funding.

Travel: Colorado's estimate of travel costs is based on assumed lodging, mileage, transportation, and per diem costs assuming current travel reimbursement amounts. For out-of-state conferences, it is assumed that the costs per traveler, per conference, would be $213 per diem, $15 for incidentals, $500 for airfare, $50 for transportation, and $600 for lodging. Costs are assuming a three-day conference. For local travel, it is assumed that the costs per traveler, per trip, would be 50 cents per mile, 750 miles traveled, $130 per diem, $400 for lodging, and $10 for incidentals. Costs are assuming a two-day trip for regional conferences and meetings. Total estimated costs for the duration of the SIM funding period are $137,448.

Equipment: N/A. No single item over $5,000.

Supplies: Colorado's estimate of supply costs is based on the assumption of 21 personnel, including general office supplies cost of $500 per person, per year. Office supply costs will be ongoing operational expense of $9,500 per year. Also included are costs for computers, telephones and Office Suite software. Telephones have associated ongoing operational costs. Computers, desk phones and software will be a one-time cost. Total estimated supplies costs for the SIM funding period is $178,563.

Contractual Overall: Colorado assumes numerous contracts are necessary to reach the objectives of the SIM funding opportunity. Many of these contracts would be managed through the proposed SIM office. Based on the specific needs identified in the proposal, Colorado will contract with Milliman for actuarial services. We would contract for data from several entities, including the Center for Improving Value in Health Care (CIVHC) for the Colorado All Payer Claims Database (APCD). Colorado anticipates that many of the remaining contracts will be procured through the state's request for proposal and competitive bidding process. Total estimated contract costs for the duration of the SIM funding period are $80,889,763. Detailed cost information for major contracts can be found below.

Contractual – Administrative: Colorado plans to contract with a website services vendor to build and maintain the SIM website. Based on experience with similar services, Colorado estimates that costs associated with the website will be approximately $10,000 per grant year. Colorado will also hire a legal contractor to ensure SIM program design and implementation strategies are compliant with state and federal law. Based on experience with similar services, Colorado estimates that costs associated with a legal contractor will be approximately $50,000 per grant year. Funding is also requested for a contractor to assist with region development.

Costs are estimated at $500,000 during first year of the grant. Total estimated administrative contract costs are $740,000.

Contractual - Colorado Department of Public Health and Environment (CDPHE): CDPHE will require funds to support initiatives and infrastructure related to population health. These funds will cover personnel who will be tasked with overseeing the establishment of a state certification program for community health workers and patient navigators, development of key population measures, mechanisms for data sharing and governance, and public health staff involved in the project. Other functions of CDPHE that require funding include developing targeted initiatives around mental health, sub-contracts and grants to local public health agencies (LPHAs), providers, and media vendors, as well as logistics and training support. Colorado estimates that costs for contracting with CDPHE will total $6,195,117 across the grant period.

Contractual - Office of Behavioral Health (OBH): OBH, an office housed within the Colorado Department of Human Services, will provide expertise and support regarding the integration of behavioral health prevention into the public health system and fidelity to behavioral health evidence based practices, in collaboration with its existing network of substance use prevention providers and partners, among others. Colorado estimates that costs for contracting with the OBH will total $1,406,826. This funding will be utilized to hire 2 FTE including fringe benefits and operating expenses to provide technical assistance regarding the integration of behavioral health prevention into the public health system through intensive collaborations and integrated behavioral health and physical health prevention education programs and to assist in modeling for a continuum of quality care. The funding will also support the integration of behavioral health agencies into the OBH data system and to provide interoperability between systems.

Contractual - Stakeholder Engagement: To ensure strong stakeholder engagement, Colorado proposes hosting annual practice transformation conferences or symposiums and regular stakeholder meetings. The annual conferences would engage providers and project contributors and increase collaboration, address challenges in the integration process and share lessons learned, and help to build morale. Conference costs requiring funding would include space rental, speaker fees, materials, and travel assistance. Meetings would include the steering committee, large advisory committee provider track, payer track, patient track, and public health track. Meeting costs that require funding include space rental and materials. Colorado estimates that costs for contracting for stakeholder engagement activities will total $169,568 across the grant period.

Contractual - External Evaluation: Colorado is requesting funding for a comprehensive external evaluation program focuses on key aspects of the state's SIM efforts, including population health, delivery system transformation, quality of care, and cost of care. Colorado will contract with an evaluation team that will partner with public health and health information organizations for support with practice and patient sampling, surveying, interviewing, engagement, and data gathering. Administrative costs will include office equipment and supplies, transcription, printing, travel for the evaluation team and institutional review board and federal-wide assurance costs.

Colorado also proposes contracting with actuarial firm Milliman for actuarial assessments and analysis. Milliman will combine data from the APCD, Medicaid and Medicare, and other sources to create a complete data set and compare the data to baseline estimates including per member per month cost and savings, as well as other measures identified in the

financial plan and related to return on investment of the state's SIM efforts. See Table 3 for estimated costs.

Table 3. External Evaluation

Item	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grand Total
Evaluation Team	$526,356	$865,566	$887,352	$873,160	$3,152,434
Administration	$69,500	$56,000	$51,500	$50,550	$227,550
Actuary Analysis	$750,000	$750,000	$750,000	$750,000	$3,000,000
Indirect Costs (10%)	$52,636	$86,557	$88,735	$87,316	$315,244
Total	**$1,398,492**	**$1,758,123**	**$1,777,587**	**$1,761,026**	**$6,695,228**

Contractual - Transformation Fund: A health transformation fund will provide financial support for payers and providers as they move to alternative payment models that foster integrated care. These incentives will help to support long-term changes in reimbursement among payers. Entities interested in receiving these funds will apply through a competitive process to the SIM office. Colorado estimates that transformation fund award amounts will total $7,500,000 across the SIM funding period.

Contractual - Population Health: The Population Health Transformation Collaboratives will be allocated to a local entity that assume responsibility for resource allocation and strategic planning for a region. The state will award grants in the third year of the project. Colorado estimates costs will total $2,960,000 across years 3 and 4 of the SIM funding period.

Contractual - Practice Transformation and Bi-Directional Health Homes: A large component of Colorado's proposal centers on delivery system and primary care practice transformation. Funding is requested to support the Health Extension Service and practice transformation efforts aimed at integrating behavioral health and primary care. The budget assumes that the health information technology (HIT) and health information exchange (HIE) portion of the project

would be responsible for supporting data capacity, including reporting the quality measure set and providing practices and transformation teams with monthly reports of measures and other basic analytics. The roles of regional coordinators, extension agents, and HIT clinical systems advisors and their related expenses will be contracted with regional/local organizations instead of direct employees of the extension service

Colorado's request includes funding for the implementation of bi-directional health homes in which physical health care will be provided in the same setting as behavioral health care. Community mental health centers (CMHCs) are not usually staffed or equipped to provide the types of services offered in a physical health setting, and the implementation of bi-directional health homes and the associated personnel and equipment will allow patients to receive basic physical services on-site along with behavioral health services. Each health home will have a team who will champion practice transformation. Health home staff may include a nurse care manager, a care coordinator, a peer support/health coach, and an administrative/data assistant. See Table 4 for estimated costs.

Table 4. Practice Transformation and Bi-Directional Health Homes

Item	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grand Total
Personnel Costs	$368,687	$542,929	$531,829	$547,783	$1,991,228
Administration	$116,400	$458,000	$458,000	$408,000	$1,440,400
Patient Engagement Training	$50,000	$30,000	$20,000	$10,000	$110,000
Practice Facilitator Training	$80,000	$0	$0	$0	$80,000
Speakers for Collaboratives and Webinars; Content Experts for E-learning Modules	$40,000	$40,000	$40,000	$20,000	$140,000
Web and E-learning Development	$100,000	$20,000	$20,000	$10,000	$150,000
Health Transformation	$50,000	$50,000	$50,000	$25,000	$175,000

Consultation					
Business Consultation	$30,000	$30,000	$30,000	$30,000	$120,000
Practice Facilitation	$0	$1,650,000	$3,750,000	$5,200,000	$10,600,000
Extension Agents	$559,028	$1,677,000	$1,727,310	$1,779,129	$5,742,467
Extension Agents Administrative Costs	$110,000	$160,000	$160,000	$130,000	$560,000
HIT/Clinical Systems Advisors	$400,000	$1,600,000	$1,648,000	$1,697,440	$5,345,440
Indirect Costs	$36,869	$54,293	$53,183	$54,778	$199,123
Subtotal	*$1,940,984*	*$6,312,222*	*$8,488,322*	*$9,912,130*	*$26,653,658*
Bi-Directional Health Homes					
Personnel and Fringe Benefits	$1,039,320	$1,234,517	$1,271,552	$1,309,701	$4,855,094
Administration and Start-Up	$283,400	$10,400	$10,400	$10,400	$314,600
Service Costs	$429,280	$604,003	$569,560	$534,088	$2,136,931
Subtotal	*$1,752,000*	*$1,848,920*	*$1,851,516*	*$1,854,189*	*$7,306,625*
Grand total	**$3,692,984**	**$8,161,142**	**$10,339,838**	**$11,766,319**	**$33,960,283**

Contractual - Health Information Technology (HIT): Colorado's proposed expansion of telehealth will increase and expedite access to integrated care. Funding will support start-up and operational costs of a central Telehealth Resource Center (TRC) with regional centers and the development of a strategy and implementation plan for the TRC to administer telehealth policy, regulatory, technical assistance, training, usage analysis, and evaluation. See Table 5 for further cost detail.

Table 5. Estimated Telehealth Expansion Costs

Item	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grand Total
Personnel	$168,000	$168,000	$168,000	$168,000	$672,000
Travel	$35,024	$35,024	$35,024	$29,512	$134,584
Supplies	$5,000	$5,000	$5,000	$5,000	$20,000
Contract Costs	$260,000	$180,960	$180,960	$161,200	$783,120
Telehealth Planning Grant	$120,800	$120,800	$20,800	$20,800	$283,200

Broadband Expansion	$250,000	$300,000	$300,000	$275,000	$1,125,000
Program Design Deployment Support and Maintenance	$387,000	$541,200	$541,200	$284,600	$1,754,000
Total	**$1,225,824**	**$1,350,984**	**$1,250,984**	**$944,112**	**$4,771,904**

The funding request includes creating an analytic platform that will provide clear and meaningful performance measures, communicate performance to stakeholders, and provide actionable detail. Data will come from a number of sources, including the statewide APCD as well as other claims and non-claims datasets. The APCD is a secure database that will include claims data from commercial health plans as well as Medicare and Medicaid. Colorado will evaluate and track both provider and state level performance as well as create dashboards to share data across providers. See Table 6 for cost detail.

Table 6. Estimated Data Integration Costs

Item	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grand Total
Personnel Support	$80,486	$82,900	$85,387	$87,949	$336,722
Query Design and Infrastructure	$300,000	$80,000	$80,000	$80,000	$540,000
Patient and Practice Identification and Validation	$500,000	$520,000	$420,000	$370,000	$1,810,000
Licensing Reports	$150,000	$150,000	$150,000	$150,000	$600,000
Analytics Integration	$50,000	$50,000	$50,000	$50,000	$200,000
Total	**$1,080,486**	**$882,900**	**$785,387**	**$737,949**	**$3,486,722**

Funding is also requested for the portion of Colorado's proposed health information technology (HIT) solution that would incorporate extensive data infrastructure, including infrastructure for data warehousing and reporting, a data quality program and tools, data acquisition, and the HIT program management and administration. See Table 7 for further detail.

Table 7. Estimated Health Information Technology Costs

Item	Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4	Grand Total
User Interface and Reports					
Data analysts	$120,000	$120,000	$60,000	$60,000	$360,000
Reports analysts/developers	$135,000	$135,000	$67,500	$67,500	$405,000
Subtotal	*$255,000*	*$255,000*	*$127,500*	*$127,500*	*$765,000*
Data Warehouse and Reporting Infrastructure					
Data warehouse and reports setup	$202,500	$0	$0	$0	$202,500
Data warehouse and reports	$112,500	$287,033	$337,500	$375,000	$1,112,033
Database administration	$162,452	$108,301	$108,301	$108,301	$487,355
Network administration	$37,500	$19,254	$19,254	$19,254	$95,262
Interface management	$75,000	$42,117	$42,117	$42,117	$201,351
Architecture setup	$75,000	$0	$0	$0	$75,000
MPI	$112,500	$150,000	$150,000	$150,000	$562,500
Interfaces setup	$68,190	$0	$0	$0	$68,190
Distribution tools configuration	$97,500	$37,500	$37,500	$37,500	$210,000
Subtotal	*$943,142*	*$644,205*	*$694,672*	*$732,172*	*$3,014,191*
Data Quality Program and Tools					
Data processing	$6,942	$46,283	$46,283	$46,283	$145,791
Data quality assurance and support	$8,909	$30,373	$30,373	$30,373	$100,028
Terminology integration engine	$375,000	$257,438	$257,438	$257,438	$1,147,314
Clinical data quality	$112,500	$300,000	$300,000	$300,000	$1,012,500
Subtotal	*$503,351*	*$634,094*	*$634,094*	*$634,094*	*$2,405,633*
Setup Data and Acquisition Infrastructure					
Interface analysts	$112,500	$112,500	$150,000	$187,500	$562,500
Interface engines	$75,000	$69,300	$69,300	$69,300	$282,900
Practice data extracts	$150,000	$375,000	$750,000	$1,125,000	$2,400,000
Subtotal	*$337,500*	*$556,800*	*$969,300*	*$1,381,800*	*$3,245,400*
Practice Assessment Tools					
Interface analysts	$120,000	$60,000	$30,000	$30,000	$240,000
Clinical business analysts	$180,000	$90,000	$45,000	$45,000	$360,000
Data analysts	$120,000	$60,000	$30,000	$30,000	$240,000
Practice assessment tool	$225,000	$37,500	$37,500	$37,500	$337,500

Meetings travel	$37,500	$37,500	$37,500	$37,500	$150,000
Subtotal	*$682,500*	*$285,000*	*$180,000*	*$180,000*	*$1,327,500*
HIT Program Management and Administration					
Account executive	$74,588	$150,000	$150,000	$150,000	$524,588
Project management	$104,079	$192,564	$192,564	$192,564	$681,771
Help desk and technical support	$62,156	$91,434	$91,434	$91,434	$336,458
Training and functional support	$46,244	$91,434	$91,434	$91,434	$320,546
Accounting/contract management	$0	$30,000	$30,000	$30,000	$90,000
Help desk and training software	$37,500	$18,750	$18,750	$18,750	$93,750
Legal and contractual	$112,500	$28,926	$28,926	$28,926	$199,278
Subtotal	*$437,067*	*$603,108*	*$603,108*	*$603,108*	*$2,246,391*
Grand Total	**$3,158,560**	**$2,978,207**	**$3,208,674**	**$3,658,674**	**$13,004,115**

Indirect: All administrative costs (direct and indirect) will be charged to the Federal SIM award by implementing the Public Assistance Cost Allocation Plan (PACAP). In accordance with Subpart E of 45 CFR Part 95, Colorado has a PACAP approved for the Colorado Department of Health Care Policy and Financing (HCPF) by CMS on August 30, 2010. HCPF's PACAP involves a double step-down method to allocate identified indirect costs to all programs operated by HCPF. Additional funding received by HCPF in the form of grants will receive a quarterly allocation of indirect costs, per the plan, based on expenditures and personnel. As specified in the FOA, Colorado assumes an indirect cost rate of 10 percent of the total personnel budget and requests this amount to be included in the grant budget. A copy of HCPF's approved PACAP may be furnished upon request. Colorado estimates that indirect costs will total $410,266 across the SIM funding period.

OPERATIONAL PLAN

Colorado will develop a long-term governance structure to execute on the grant deliverables and funding distribution through the Governor's Office. SIM activities will be overseen by a group comprising directors of key state agencies, including HCPF, CDHS, and CDPHE, as well as representatives of payers, providers, patients and public health.

SIM staff will be responsible for coordinating all relevant stakeholders, managing contracts and overseeing all grant-related activities with CMMI. (See organizational chart below.) Key activities related to HIT will be overseen by Colorado's Health Information Technology Coordinator and practice transformation will be managed through contracts with community organizations in Health Extension Regions. These regions will build upon collaborative work under way in many parts of the state and will include local public health agencies as critical partners.

The Colorado SIM office will provide oversight of project-related deliverables with contracted vendors as well as work that is undertaken at the regional level. This will be done by deploying regionally focused coordinators who will ensure that all activities within a particular region are being executed seamlessly and effectively.

SIM OFFICE *Goal: Oversee, coordinate and ensure success of all SIM project deliverables*	**2015**				**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Establish Colorado SIM office in Governor's Office through executive order	x															
Hire SIM staff (see organizational chart, page 8)	x															
Advance alternative payment models among payers according to project goals (see Section 3: Payment Delivery Model)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop communications plan		x														
Bi-annual SIM conference		x		x		x		x		x		x		x		x
CMMI coordination and reporting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
STAKEHOLDER ENGAGEMENT *Goal: Ensure the active engagement of all stakeholders, including but not limited to payers, providers and key contractors*	**2015**				**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Establish composition of Advisory Committee	x		x		x		x		x		x		x		x	

and twice-yearly meeting schedule																
Invite participation in stakeholder committees: providers, payers, patients, public health and specific populations	x															
Develop scope of work, roles and responsibilities for stakeholder committees	x															
Regular meetings with stakeholder committees		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
POPULATION HEALTH ***Goal: To develop and execute on a plan for improving population health with Governor's Office, key state agencies and stakeholders***	**2015**				**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Develop Colorado's Plan for Improving Population Health	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Engage in consensus-based process for creating collaboratives with HCPF, DHS and stakeholders	x	x	x	x												
Develop MOUs/contracts between SIM office and regional collaboratives				x												
Hire and deploy child mental health coordinators to develop prevention and early intervention program for children's mental health			x													
Expand reach of evidence-based programs through media contract and scholarships			x													
Hire and deploy two health system specialists to work with payers on standardization of USPSTF A and B recommendations as covered benefits			x													
Hire and deploy manager to lead patient navigation certification work			x	x	x	x	x	x	x	x	x	x	x	x	x	x
Contract with five LPHAs to increase access to					x	x	x	x	x	x	x	x	x	x	x	x

preventive services based on demonstrated need																
Implement community education and health promotion program grants					x	x	x	x	x	x	x	x	x	x	x	x
Report, share and provide technical assistance for using data to support population health statewide					x	x	x	x	x	x	x	x	x	x	x	x
Multi-stakeholder Extension Advisory Group meetings every other month	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Collaborate with public and population health group, perform environmental scan and hold community forums to gather concepts for structuring the extension service	x	x	x	x												
Solicit letters of interest from community organizations to house regional extension offices				x												
Achieve consensus on how to select lead agency for extension in each region and selection process for health extension agents				x												
Define the roles and responsibilities of extension agents; develop job description; hire				x												
Develop training program for extension agents that includes experts from states with programs			x	x												
Develop structure for maintaining a continuous learning network among extension agents; begin monthly meetings or conference calls			x	x												
Identify tools and resources needed to support extension agents			x	x												

HEALTH INFORMATION TECHNOLOGY *Goal: Develop a seamless IT infrastructure and data hub that supports the needs of communities in direct clinical care and population health*	**2015**				**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Establish SIM HIT program management and administration oversight	x															
Outreach – practice transformation technical assistance (planning): Convene stakeholders, prioritize foreseeable uses cases for clinical data. Develop project plan, curriculum, timeline, communication/outreach plan, schedule, budget	x	x														
Telehealth and broadband (Phase 1 planning)	x															
Implement Telehealth Resource Centers aligned with regional structure		x														
Technology assistance tools (planning): Establish first iteration of HIT and practice transformation tools		x														
Outreach – technical assistance to implement robust practice transformation/reengineering					x (first 100)				x (next 150)				x (next 150)			
Technology assistance tools (implementation)				x												
Data quality program and tools	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Set up data acquisition infrastructure				x												
Develop central clinical data hub and reporting infrastructure (planning)		x	x	x												
Implement/execute central hub, reports				x												

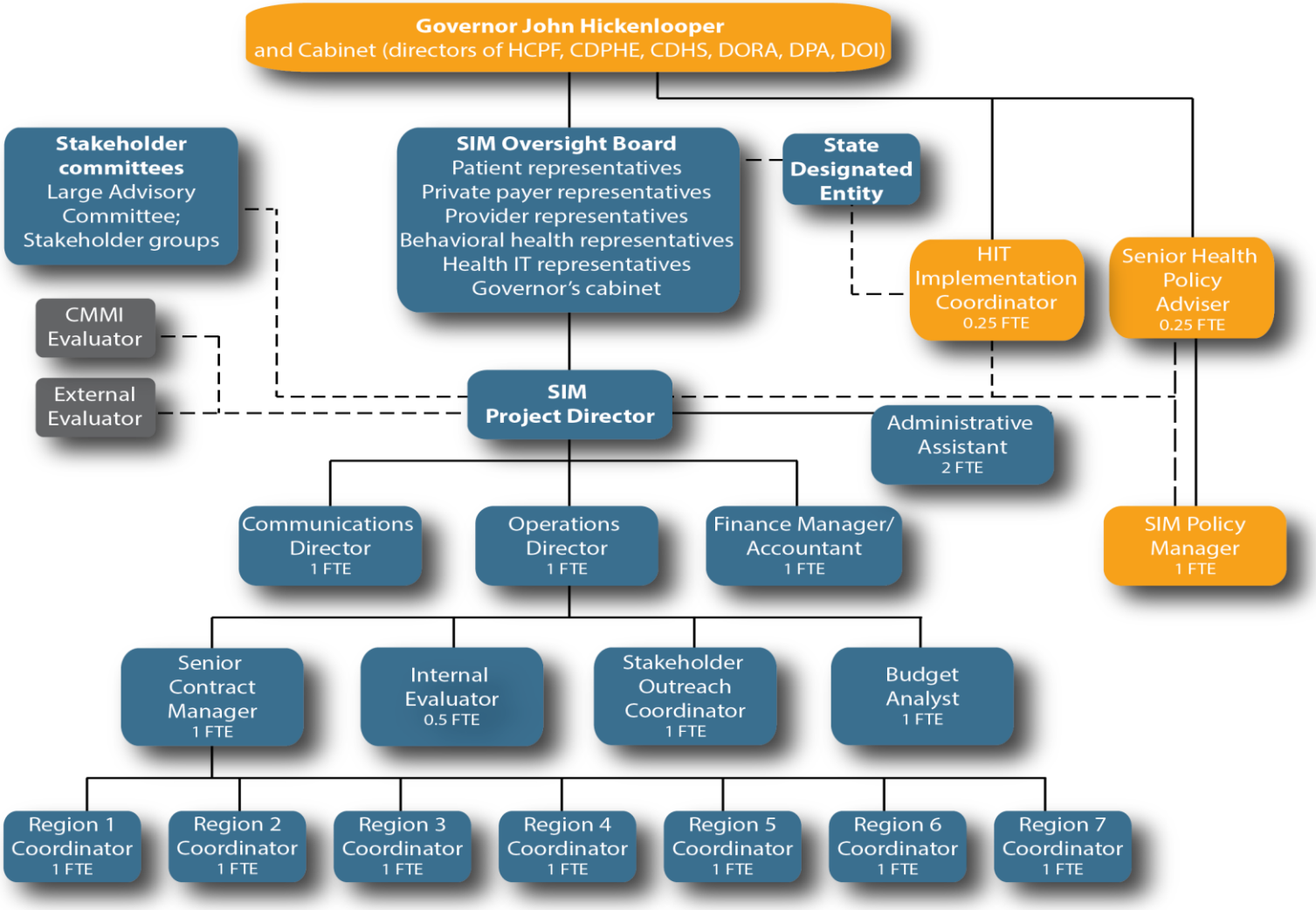
Administrative and cost data connection to APCD (Planning, including analysis plan and strategy)	x	x	x	x												
Administrative and cost data connection to APCD, other data sources (implementation). Provide medical claims, pharmacy claims, membership enrollment claims, provider claims					x (first 100)				x (next 150				x (next 150)			
Implement telehealth planning grant				x												
Telehealth and broadband (implementation). Expand telehealth network access to infrastructure								x (first 100)				x (next 100)				x (next 100)
PRACTICE TRANSFORMATION ***Goal: Provide intensive support to practices to integrate behavioral health and primary care***	**2015**				**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Convene practice facilitation partners, monthly meetings for 18 months, then every other month	x	x	x	x	x	x		x		x		x		x		x
Develop and finalize logic model for intervention that addresses SIM aims, payment models, and data capacity plans	x	x														
Agree on milestones/benchmarks for practices and practice transformation (with evaluation team, SIM management team, others)		x														
Identify "tool kits" needed to support delivery of interventions by practice transformation teams		x														
Assemble all tools, resources, and materials available among partners and in public domain		x														
Identify gaps and resources that need to be created to support interventions			x													
Plan and develop e-learning materials for		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

asynchronous training for practice transformation and primary care and behavioral workforce development and retraining																
Finalize practice assessment tools for HIT team to build online assessment			x													
Collaboration with HIT/HIE leads to assure facilitator and clinical system advisor interventions are consistent with capacity for data collection, aggregation, analytics and reporting back to practices and communities	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
First cohort practices assessed and enrolled				x												
Contracting with practice transformation partners for facilitation and clinical systems advising				x				x				x				
Training for key on-ground personnel in regions (clinical systems advisors, facilitators)				x	x	x	x	x	x	x	x	x	x	x	x	x
Practice recruitment communication		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CMHC readiness assessment, RFP and coordination with SIM office	x	x	x	x												
Behavioral health and primary care integration at four CMHC pilot sites per year for three years					x	x	x	x	x	x	x	x	x	x	x	x
CBHC communication with SIM Office, evaluation and practice transformation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
EVALUATION	**2015**				**2016**				**2017**				**2018**			
Goal: Develop both process and outcomes measures to track progress toward the Triple Aim	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Select external evaluation contractor			x													
Self-monitoring and evaluation report design				x												

Coordination with CMS Evaluator	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Primary data collection, including data for the process/formative evaluation and site visits, collection and coding of key informant interviews and focus group information	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Claims data fulfillment and delivery to evaluation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Actuarial data analysis and coordination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Monthly meetings with evaluation team to plan and conduct continuous, rapid cycle learning	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Data analysis and management	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Figure 1. Colorado SIM Office Organizational Chart

The Colorado Department of Health Care Policy & Financing will serve as Colorado's designated fiscal agent and will provide the administrative structure to support implementation.



Colorado State Innovation Model: *The Road Ahead*

Our goal:

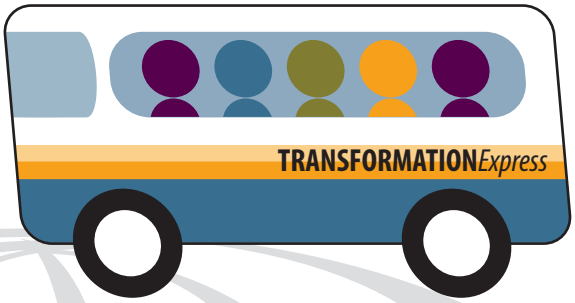
We will improve the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of the state's residents by 2019.

Our fragmentation problem

Like a gridlocked highway, our health care system is inefficient and expensive. We often treat patients one condition at a time when evidence shows that caring for the whole person – body and mind – leads to better health.

Our transformation solution

We will get everyone on the bus to provide access to integrated behavioral and primary care to 80 percent of Coloradans. We will form a strong partnership between public health and health care that coordinates clinical, public health, technology and community resources. Federal SIM funding will support our efforts.



Our plan of action

Patients
Will have to work less to get more out of their health care. They will experience seamless care delivery addressing both physical and behavioral needs.

Providers
Will work side-by-side to treat patients physical and behavioral health needs. We will provide ongoing support to providers to smooth this transition.

Policymakers
Will ensure that rules and laws support the transition, and that evidence is evaluated to make sure our reforms are working.

Public health
Will partner with health care providers to leverage care and expertise throughout the community and improve population health.

Health IT
Will help provide interconnected medical records and support telehealth for more seamless medical care.

Payers
Will move toward payment models based on quality and value of care, rather than fee-for-service.

Our reach

We will help transform care for 80 percent of Coloradans all across the state, no matter where they live.

1400 Wewatta Street
Suite 300
Denver, CO 80202-5549
USA

Tel +1 303 299 9400
Fax +1 303 299 9018

milliman.com

ACTUARIAL CERTIFICATION

I, Stephen P. Melek, am a consulting actuary with Milliman, and a member of the American Academy of Actuaries. I meet the Academy qualification standards for rendering actuarial opinions with respect to the development of the State Implementation Model (SIM) financial plans. I am rendering this opinion on behalf of the management of the Colorado SIM management team. This opinion applies to the financial plan that has been developed for the State of Colorado SIM proposal.

I certify that the data, assumptions, and projected savings outlined in the financial plan are consistent and reasonable. The financial plan has been reviewed in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and the financial plan complies with the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. Numerous local, state, and federal regulations apply to the applicant's business and operations. My opinion covers only the actuarial assumptions and application requirements for the financial plan. I have considered the following Actuarial Standards of Practice: ASOP #5, 23, 25 and 41.

In forming this opinion, I have relied upon detailed Medicaid claim and membership data provided by Colorado Healthcare Policy and Financing (HCPF), Commercial data provided in the Truven MarketScan data, and Medicare data provided in the CMS 5% sample files. I have also relied upon input from the SIM management team regarding projected impacts on healthcare costs by beneficiary type and service category, and on results published in the medical literature from similar integrated medical-behavioral programs.

Stephen P. Melek, FSA, MAAA — 7/15/2014 Date

Financial Analysis

We partnered with Milliman, a national leader in health insurance actuarial analysis, to complete the financial plan, cost savings analysis and projected return on investment.

The starting point for the development of the financial plan was actual historical incurred per member per month (PMPM) health care costs by beneficiary type and health care service category, separately for commercial (private) insured members, Medicare, and Medicaid eligibles. Detailed incurred claim cost and membership data were developed for calendar years 2010 through 2012. We used detailed historical commercial claim and membership data from carriers in Colorado, combined with detailed historical data obtained from the Truven MarketScan databases for commercial insured lives in Colorado. We used detailed historical Medicare claim and membership data from carriers in Colorado, combined with detailed historical experience data obtained from the CMS Medicare 5 percent sample files for Medicare eligibles. We used detailed historical Medicaid claim and membership data from Colorado Health Care Policy and Financing (HCPF) to develop our Medicaid experience for Colorado. We used detailed membership eligibility and claims data to separate the experience into different population categories (Medicaid adults, children, duals, and disableds/elderly; Medicare duals and fee-for-service; and commercially insured lives).

Additionally, because of the nature of the proposed SIM initiative, we further subdivided the commercial and Medicare experience data into four population cohorts, based on the medical and behavioral conditions of the eligible members as determined through analyses of their historical claims data, where the data were detailed enough:

1. Members with comorbid chronic medical and behavioral conditions
2. Members with behavioral conditions but no comorbid chronic medical condition

3. Members with chronic medical conditions but no comorbid behavioral conditions

4. Members with neither chronic medical conditions nor behavioral conditions

We did not have sufficient diagnostic claim detail to develop these separate member cohorts of results for the Medicaid population, so we used aggregate results by eligibility category. We developed these various member cohorts of experience because we believe that our integrated care program will impact the health care costs of these various cohorts of eligible members differently, and we wanted our projections to be as representative as possible of the projected impact of the program on the various populations and their health care costs during the course of the SIM testing period. For example, we expect the largest health care savings will be obtained from the program's impact on members with comorbid chronic medical and behavioral conditions, while the smallest impact will be on members with neither condition. Table 1 below shows the most recent experience year's (2012 baseline) total PMPM health care costs to the payers for each of these four member cohorts and for each of the eligibility categories included in our financial projection model, across all service categories combined, where we developed such detailed cohort experience.

Table 1: Baseline PMPM Costs by Population Cohort and Eligibility Category

Eligibility Category	Cohort 1	Cohort 2	Cohort 3	Cohort 4	All Cohorts Combined
Commercial	$1,155.08	$399.28	$704.02	$183.78	$358.94
Medicare ages <65	$729.82	$291.76	$731.89	$144.24	$329.60
Medicare ages 65+	$1,349.64	$577.81	$660.50	$147.98	$389.39

We used these 2012 calendar year PMPM costs for each cohort as our starting baseline costs for the Commercial and Medicare populations, and aggregate PMPM costs for the

Medicaid population by eligibility category, and developed annual utilization trends (ranging from -3 percent to 3 percent) and unit cost trends (also ranging from -2 percent to 3 percent) by service category and beneficiary type to project the ramp up year (CY2015) and the three model test years' (CY2016-18) PMPM costs for the Financial Plan.

The membership populations underlying our PMPM claim cost development represent a subset of the Colorado state totals for each eligibility type. We used publicly available data sources to balance our membership to Colorado state totals by eligibility type, including U.S. Census data, State Health Facts by the Kaiser Foundation, estimates of potential new covered lives through Medicaid expansion, etc. This represents 100 percent of the estimated Colorado insured population in 2012. We then applied population growth estimates for each eligibility type to project total eligible lives through the three-year SIM testing period. We then assumed a ramp-up period for PCP participation of 100 practices in test year one, 250 in test year two, and 400 in test year three, with each practice averaging four physicians, and each physician having an average panel size of 1,900 members.

We then developed assumptions for the expected impact of our program by health care service category, separately for each eligibility category. We developed separate assumptions for the impact of our behavioral health integration initiative on utilization levels (some service categories were projected to have decreases in utilization, while others have increases) and also on average unit costs. The program will increase the utilization of primary medical and behavioral health care services and improve clinical and financial outcomes for the insured members accessing these services. It is also expected to reduce hospital costs and increase patient adherence to treatment for their medical and behavioral conditions. For example, we assumed test year one savings (from a combination of utilization and unit cost impacts) in

inpatient hospital and emergency room costs of 0 percent to 4 percent, and an increase in spending in professional services and prescription drugs in test year one of 0.5 percent to 1 percent. Test years two and three had additional savings (or increased spending) that were more moderate compared to test year one. These savings were developed based on other program results in the medical literature, including the IMPACT, Pathways, Missouri Medicaid CMHC health homes, and MDDP programs. Table 2 summarizes the health care savings projected by member eligibility category for the three SIM test years.

Table 2: Projected Savings by Eligibility Category and Model Test Year

Eligibility Category	Test Year 1	Test Year 2	Test Year 3	Total of 3 Test Years
Medicaid Adults	$963,834	$2,088,966	$3,002,199	$6,054,999
Medicaid Child	$168,399	$345,675	$465,190	$979,264
Medicaid Duals	$3,108	$6,397	$9,146	$18,651
Medicaid Disabled and Elderly (no Duals)	$1,421,965	$3,830,011	$6,349,721	$11,601,697
Commercial	$9,625,219	$21,695,446	$32,968,248	$64,288,913
Medicare Duals	$1,635,964	$4,827,877	$8,372,237	$14,836,079
Medicare FFS	$3,450,298	$9,444,493	$15,913,460	$28,808,250
All Eligible Coloradans	$17,268,787	$42,238,866	$67,080,200	$126,587,853

The total requested budget for the Colorado SIM proposal is $86.9 million. When combined with the total projected savings as shown in Table 2 of $126.6 million, we project a ROI of 1.46 for this innovation model for the three year test period. For the year after the test period, we project annual savings of $85.0 million, a portion of which will be used to sustain the program after the federally funded project period.