COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 3, 2011

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

Dear Senator Hodge:

The Department of Health Care Policy and Financing respectfully submits this response to the following Legislative Request for Information from the Joint Budget Committee regarding the Accountable Care Collaborative Program:

> **Department of Health Care Policy and Financing, Medical Services Premiums** – The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and any initial results that demonstrate savings for the pilot program. If data is not available to determine saving results, the Department shall note when such data is anticipated to be available.

This response provides a brief background on the program, shows client enrollment and provider participation data, discusses program costs and administrative fees, and discusses how the Department is measuring the success of the program.

Please note that the Joint Budget Committee requested that the Department submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, which is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

Please direct any further questions to Suzanne Brennan, Director of the Medical and CHP+ Program Administration Office, at suzanne.brennan@state.co.us or 303-866-5929.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Cc: Senator Mary Hodge, Vice-Chairman, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Senator Brandon Shaffer, President of the Senate
Senator John Morse, Senate Majority Leader
Senator Mike Kopp, Senate Minority Leader
Representative Frank McNulty, Speaker of the House
Representative Amy Stephens, House Majority Leader
Representative Sal Pace, House Minority Leader
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lorez Meinhold, Deputy Policy Director, Governor's Office
Henry Sobanet, Director, Office of State Planning and Budgeting
Erick Scheminske, Deputy Director, Office of State Planning and Budgeting
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library (6 copies)
State Library (4 copies)
Susan E. Birch, Executive Director
Suzanne Brennan, Medical and CHP+ Program Administration Office Director
John Bartholomew, Financial & Administrative Services Office Director
Antoinette Taranto, Client & Community Relations Office Director
Phil Kalin, Center for Improving Value in Health Care (CIVHC) Director
Carrie Cortiglio, Legislative Liaison
Joanne Zahora, Public Information Officer
HCPF Budget Library, HCPF Budget Division

Accountable Care Collaborative Project
Report to the Joint Budget Committee
November 1, 2011

The Joint Budget Committee (the Committee) requested the Department of Health Care Policy and Financing (the Department) submit a report to the Committee by November 1, 2011, providing information on the implementation of the Accountable Care Collaborative (ACC) project. The Committee requested that the Department provide the following information:

1. How many Medicaid clients are enrolled in the pilot program;
2. Current administrative fees and costs for the program, and any initial results that demonstrate savings for the pilot program; and
3. If data is not available to determine saving results, the Department shall note when such data is anticipated to be available.

This report will provide a brief background on the program, show client enrollment and provider participation data, discuss program costs and administrative fees, and discuss how the Department is measuring the success of the program.

Background

The State of Colorado implemented a new Medicaid program called the Accountable Care Collaborative (ACC) Program effective May 1, 2011. The program has been approximately three years in development, and the design pre-dates the drafting and passing of the Affordable Care Act. In Colorado, enrollment in managed care is voluntary; approximately 15% of Colorado Medicaid clients are enrolled in one of the managed care programs and the remaining 85% receive services through fee-for-service Medicaid. The ACC Program was designed to remedy the inefficiencies of the current structure, provide cost savings to the State and federal government and improve health outcomes for Medicaid clients. The Department's goal is that the program will serve as the primary Medicaid health care delivery system and be the platform for ongoing Medicaid reform initiatives, including expansion of care to adults without dependent children, integration of physical and mental health, adoption of the initiative for health homes for chronically ill clients, and payment reform.

The ACC Program is a hybrid model that adds the characteristics of an accountable care organization to the Primary Care Case Manager (PCCM) model. It is composed of seven regional accountable care organizations called Regional Care Collaborative Organizations (RCCOs). The RCCOs cover the entire state, which has been divided into seven regions. These organizations act as integrators and coordinators of care across disparate provider types, community resources, and state programs, including the statewide Medicaid Behavioral Health Organization capitation program. The RCCOs have created provider networks, which they support in a number of ways including consultation on practice redesign and identification of best practices. The seven RCCO contracts were awarded in December 2010 through a competitive procurement process. The seven RCCOs are:

Region 1. Rocky Mountain Health Plans
Region 2. Colorado Access

Region 3. Colorado Access
Region 4. Integrated Community Health Partners
Region 5. Colorado Access
Region 6. Colorado Community Health Alliance
Region 7. Community Health Partnership

Attachment A to this report provides a map of the seven regions, the counties within those regions served by the RCCOs, and the Medicaid population within each region.

Primary Care Medical Providers (PCMPs) are another essential part of the ACC Program. These providers function as medical homes for Medicaid clients enrolled in the ACC Program. PCMPs contract with a RCCO to serve the members in that region, and receive administrative and operational support from the RCCO. To be eligible to become a PCMP, a provider must already be a provider under the Medicaid and CHP+ Medical Homes for Children Program, or be a physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

The third important part of the ACC Program is the Statewide Data and Analytics Contractor (SDAC), an organization that is responsible for building a repository of statewide Medicaid data and health care analytics. The SDAC is also responsible for sharing the data and analytics with the Department, the RCCOs and the PCMPs so that they may better understand the needs of members, manage their care, and track the success of the program. Treo Solutions was selected as the SDAC in January 2011 after a competitive procurement process.

The ACC Program provides an ideal platform on which the Department anticipates building in later phases to encompass initiatives such as the Affordable Care Act Section 2703 "medical homes for chronic illnesses" initiative and the Adults without Dependent Children initiative. The Department has already put into place the following features and infrastructure that it can leverage for such initiatives:

- An interdisciplinary team-oriented delivery system, with care management, care coordination, health promotion, and comprehensive transitional care.
- Mechanisms to accomplish two of the ACC Program's primary goals: reduced hospital re-admissions and emergency room visits.
- Health information technology that helps to improve service delivery and care coordination.
- Connections and referrals to community and social support services.
- Flexibility and support from the Centers for Medicare and Medicaid Services to develop creative payment methodologies.

Enrollment

The initial enrollment into this program was anticipated to be approximately 60,000 clients (40,000 adults and 20,000 children). An additional 63,000 clients are scheduled to be enrolled into the program by early 2012. Currently, there are approximately 55,000 Medicaid clients enrolled in the ACC program. Overall enrollments occurred at a slower rate than expected. A primary reason for the slower enrollments were delays in getting contracts executed with RCCOs

and PCMPs. Also contributing to the delay was the great care taken in collaborating with the RCCOs in determining the methodology for attributing clients to PCMPs so there would be no disruption of existing provider-client relationships.

At this time there are 128 PCMPs in the ACC Program. These PCMPs include safety net providers such as federally qualified health centers (FQHCs), Denver Health, Kaiser, and large clinics, as well as individual practitioners. Therefore, a single PCMP contract often represents multiple providers in multiple locations. There are a total of 2,947 individual practitioners/clinicians participating as PCMPs in the ACC Program.

The table below shows the number of clients enrolled, the number of participating PCMPs, and the number of participating Practitioner/Clinicians for each RCCO as of October 20, 2011.

RCCO	**Number of Clients Enrolled**	**Future Dated Enrollments as of November 1, 2011**	**Number of PCMPs**	**Number of Providers**
Region #1-Rocky Mountain Health Plan	6,645	1,198	14	126
Region #2-Colorado Access	5,488	607	14	631
Region #3-Colorado Access	7,985	2,820	29	889
Region #4-Integrated Community Health Partners	9,455	1,589	17	139
Region #5-Colorado Access	3,631	549	33	993
Region #6-Colorado Community Health Alliance	4,340	3,431	19	101
Region #7- Community Health Partnership	8,279	683	2	68
Total	45,823	10,877	128	2,947

The Department is pleased with the progress that has been made in client enrollments and provider participation after overcoming the obstacles that delayed the enrollment schedule. The time spent on solving these critical issues has made the program stronger, allowing the Department to move forward with outreach and expansion.

If the program has proven effective in saving costs and improving health outcomes, the Department anticipates that enrollment would be expanded to eventually encompass all of the Medicaid population. This expansion would begin in FY 2012-13.

Administrative Fees and Costs

The administrative costs for the program consist of the costs to pay the RCCOs, the PCMPs and the SDAC. RCCOs are paid a per member per month (PMPM) fee for each Medicaid member enrolled with that RCCO. The RCCO PMPM is different for each of the seven RCCOs because each one submitted a price during the competitive procurement. For FY 2011-12, each RCCO bid $13.00 PMPM. There are no incentive payments available during this year. For FY 2012-13, there were a range of bids; all RCCOs will receive between $11.00 and $12.00 PMPM. During FY 2012-13, RCCOs will be able to earn an incentive payment of up to $1.00 PMPM for reaching certain goals, such as reducing the number of emergency room visits.

The PCMPs all receive a $4.00 PMPM fee during FY 2011-12, and a $3.00 PMPM fee during FY 2012-13. Like the RCCOs, the PCMPs are able to earn up to $1.00 PMPM in incentive payments during FY 2012-13 for reaching certain utilization targets. Although the initial incentive measures are all focused on utilization, future incentive measures will include both utilization and outcome measures.

The SDAC, received $750,000 for work done in FY 2010-11 and will receive no more than $3 million for FY 2011-12 and future years. The SDAC contract is scaled up or down based on the number and complexity of reports and data analytics the contractor does.

Cost Savings

Utilization measures as indicators of cost savings

At this early stage in program implementation, it is difficult to determine cost savings attributable to the ACC Program. To determine cost savings requires the Department to compare actual claims costs of ACC Program members to the actual claims costs of fee-for-service clients who are not in the ACC Program. This requires the availability of relevant claims data, which is only available once providers submit claims and the Department processes them. This process typically takes between 90-120 days. For example, to analyze the full costs of claims incurred prior to June 30, the Department is not typically able to perform valid analysis until at least September 30.

Because claims data will not be initially available, the Department is using three utilization measures as indicators of cost savings: emergency room visits, hospital re-admissions, and outpatient radiology utilization. The SDAC is able to track progress on these indicators by RCCO, by PCMP, and by client. Equally important, the SDAC is able to "risk-adjust" both utilization and cost data. This means that the SDAC's analysis will take into consideration how ill a population is when it analyzes the progress a PCMP or RCCO is making in utilization and cost. The SDAC is able to take into consideration that one RCCO may start with a higher cost population than another RCCO. Each client will have a risk score, which will allow the SDAC to provide data on risk from the client level (for care management purposes) on up to the regional or program level (for strategic resource allocation and evaluation purposes). The SDAC groups clients into these major clinical risk groups:

1. Healthy & Non-Users
2. Pregnancy & Deliveries

3. Significant Acute
4. Minor Chronic
5. Dominant or Moderate Chronic
6. Malignancies & Catastrophic

The SDAC makes the claims data and its analyses available to the Department, the RCCOs, and PCMPs on a user-friendly web portal that makes it easy to pull meaningful information from the data.

The Department anticipates that it will be able to update the Joint Budget Committee on these utilization measures during its scheduled hearing in December 2011.

Future cost savings reports
The SDAC will create comparative analytical reports that will compare those clients in the ACC Program against the initial baseline period, as well as against a similar "control group" of Medicaid clients not enrolled in the ACC Program. This will give the Department a better sense of the program's cost savings. The Department anticipates that a preliminary savings report for FY 2011-12 will be available by June 2012, with the final report complete by November 2012.

In these analyses, the Joint Budget Committee can expect to see these costs expressed in two ways that is typical of health care cost analyses: (1) health care costs as PMPM costs, and (2) health care utilization rates, admissions, patient days, and visits expressed in units of per 1,000 members, per-year (PKPY).

The data that will be used by the Department and the RCCOs to manage the medical cost and utilization of their clients can also be used by the Department to evaluate the overall effectiveness of the ACC Program. The dashboards will provide transparent monthly reporting of multiple performance measures that can be viewed at the Program level, the RCCO level and the PCMP level, including:

1. Key performance indicators identified by the Department for the ACC Program:
   a. All cause re-admissions
   b. ER visits per 1,000
   c. High cost radiology (CT/MRI/X-Ray)
2. Total cost of care PMPM (in aggregate and by major category of service)
3. Utilization statistics PKPY
4. Potentially preventable events (re-admissions, procedures, etc. that might have been prevented).

Measuring performance will be both an ongoing endeavor and a part of the year-end evaluation of the ACC Program. Going forward, these statistics can be prepared for each subsequent reporting period, and a comparison can be created to track the change over time from the initial baseline period. Upon completion of FY 2011-12, comparative analytical reports will be created which will compare the results of those clients in the ACC Program over time against this baseline period, as well as against a similar "control group" of Medicaid clients not enrolled in the ACC Program.

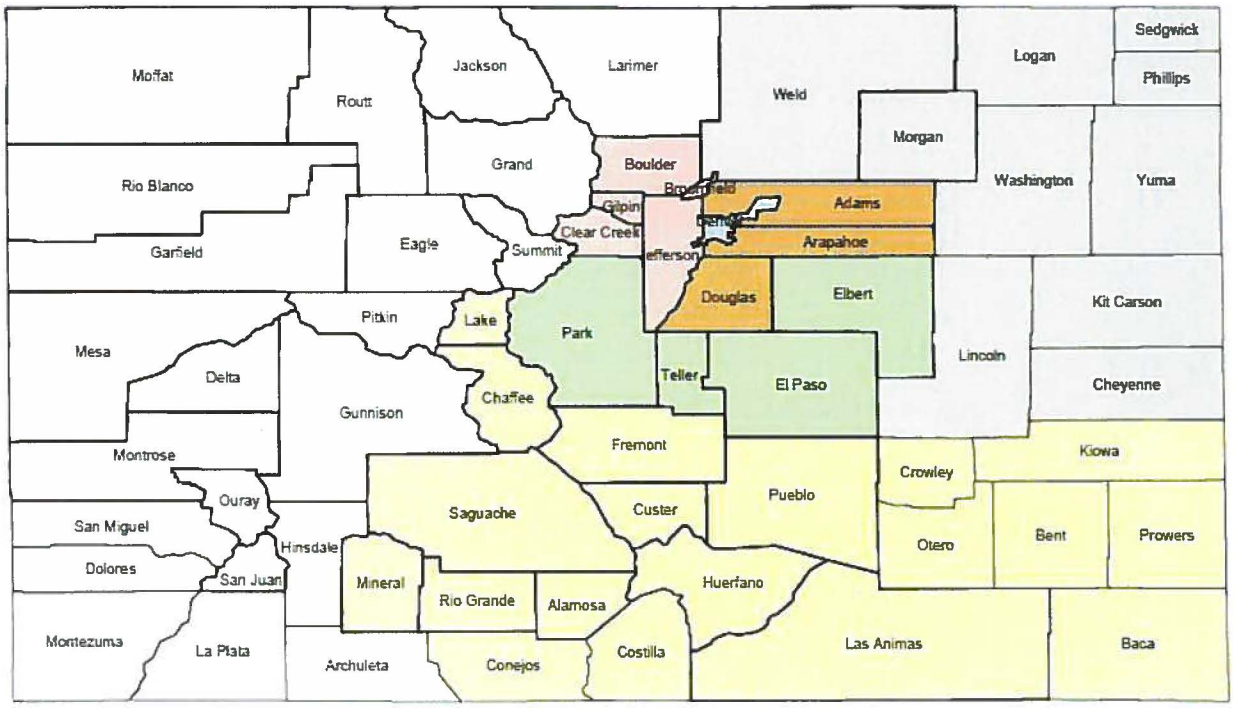
Conclusion

The Department looks forward to continued operation of the ACC Program and reporting on its success. The program has been established as the foundation for present and future Medicaid reform efforts, and has been planned with great care and an eye toward building a health care delivery system that is sustainable, flexible, and collaborative. It is based on each client having a medical home that draws on both medical and non-medical resources in the local community. It reflects the best application of data and best practices available at the practitioner level.

The Department intends that future years' cost savings will be used to reduce overall Medicaid program costs and to implement gain-sharing incentives for the RCCOs and PCMPs.[1] This will build into the program a mechanism to further reduce costs and promote better outcomes.

[1] The Department has included information about gainsharing in its November 1, 2011 Budget Request R-5, "Medicaid Fee-for-Service Reform".

Attachment A: Regional Care Collaborative Organization Map



	Region1: Rocky Mountain Health Plans
	Region 2: Colorado Access
	Region 3: Colorado Access
	Region 4: Integrated Community Health Partners
	Region 5: Colorado Access
	Region 6: Colorado Community Health Alliance
	Region7: Community Care of Colorado

Department of Health Care Policy and Financing
November 2011