November 1, 2014

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

Dear Representative Duran:

Enclosed please find the Department's response to the Joint Budget Committee's Request for Information #4 regarding the Accountable Care Collaborative.

Legislative Request for Information #4 states:

Department of Health Care Policy and Financing, Medical Services Premiums - The Department is requested to submit a report by November 1, 2014, 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 program, the current administrative fees and costs for the program, and performance results with an emphasis on the fiscal impact.

Attached is the Accountable Care Collaborative annual report which provides information regarding program enrollment, expenditure, and performance in FY 2013-14.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at zach.lynkiewicz@state.co.us or 303-854-9882.

Sincerely,

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

SEB/mdj

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Executive Summary

Many factors contribute to health: personal health behaviors, access to medical care, good provider-patient communication, a connected health system and access to resources to meet basic needs. The Accountable Care Collaborative (ACC), now serving nearly 60% of Medicaid clients, reduced health care expenditures for the state while making progress on all of these fronts in FY 2013–2014.

In its third year, the ACC continued to make changes to the way health care is delivered and paid for—incremental changes that add up to big results like fewer emergency room visits, a decrease in unnecessary use of expensive services like imaging, and better access to primary care and behavioral health care. Equally important, the ACC has helped providers make the connection between the care they provide and the outcomes that result, and has strengthened the health system infrastructure across Colorado. The Department of Health Care Policy and Financing is pleased to submit this annual report on the ACC to the Joint Budget Committee. It includes an update on:

- The number of Medicaid clients enrolled in the ACC
- Current administrative fees and costs associated with the program
- Performance results that demonstrate savings for the program

The report also includes some of the most promising and exciting highlights of the ACC's success, and new plans to create more savings, better health outcomes, and a stronger health care system in the coming year.

Enrollment

As of June 2014, there were **609,051** members enrolled in the ACC (nearly 60% of all Colorado Medicaid clients). Enrollment includes 328,958 non-disabled children, 242,468 non-disabled adults, and 37,625 individuals with a disability. This is a 73% increase in membership since June 2013.

Administrative Fees and Costs for the Program

For FY 2013–14, total administrative costs for the ACC were **$69,102,976**. This amount covers payments made to RCCOs, PCMPs, and the SDAC:

- $52,683,152 for payments to Regional Care Collaborative Organizations (RCCOs), of which $1,899,306 was paid as an incentive for improvements on Key Performance Indicators (KPIs)
- $13,052,324 for payments to Primary Care Medical Providers (PCMPs), of which $1,295,028 was paid as an incentive for improvements on KPIs
- $3,367,500 for services purchased from the Statewide Data and Analytics Contractor (SDAC)

During FY 2013–14, the ACC generated savings that exceeded all administrative costs. In FY 2013–14, the ACC achieved gross savings in medical costs between **$98,433,017** and **$102,100,305**, with net savings totaling **$29,330,495** to **$32,997,329** after accounting for administrative expenses.

Program Performance Highlights

- **Reduction in emergency room (ER) visits**: Children and adults who were enrolled in the ACC for more than six months had a lower rate of ER visits than children and adults who were not enrolled, or had been in the ACC for less than six months.
- **Reduction in high cost imaging**: Consistently lower utilization of these services for all members who have been enrolled in the ACC for six months or longer as compared to those not enrolled and those enrolled for less than six month. Performance on this metric has been so strong for the Program that the Department will no longer include it as a pay-for-performance metric.
- **Reduction in 30 day, all-cause hospital readmissions**: Hospital readmissions rates were lower for all children and adults who had been in the ACC for six months or longer,
- **Switch from ER visits to professional visits for children with disabilities**: Since 2012 there has been a 6% increase in the rate of professional visits for children with disabilities and a 7% decrease in emergency room visits.
- **Health care delivery system transformation**: Regional Care Collaborative Organizations across the state have improved communication, referrals and relationships among both medical and non-medical providers. In some areas, they have even taken steps towards integrating physical and behavioral health care.

In FY 2014–15, the ACC will continue to build on its success by developing regional health care infrastructure, creating new ways to deliver integrated health care, and using new payment strategies that drive incremental but lasting system change.

1. Introduction

The Accountable Care Collaborative (ACC) is designed to transform Colorado Medicaid from a system that relies on fee-for-service payment for episodic care into a system that encourages and rewards integrated, person-centered care that leads to good health outcomes for Colorado's Medicaid clients and lower costs for the State.

This annual report on the ACC is submitted by the Department of Health Care Policy and Financing (the Department) in response to a request from the Joint Budget Committee for the following information:

- Number of Medicaid clients enrolled in the ACC
- Current administrative fees and costs associated with the program
- Performance results that demonstrate savings for the program

The ACC is central to the Department's mission to increase access to health care and improve health outcomes while showing careful stewardship of financial resources. This mission is aligned with the Triple Aim created by the Institute for Healthcare Improvement and adopted by the Centers for Medicare and Medicaid Services: improve the patient experience of care, improve the health of populations, and reduce the cost of health care.

These are ambitious goals that require innovation throughout the system, and the ACC is making changes on all fronts: engaging clients to be active in their own care, supporting providers, improving access to primary care, connecting the fragmented pieces of the health care system, and helping clients obtain non-medical services that have a dramatic impact on health. Because of its thoughtful and steady approach to health system transformation, the ACC has achieved cost savings while working within the current system to change the way health care is delivered.

1.1. Design of the ACC

The Department implemented the ACC program in May 2011 with one practice and roughly 500 people in a few counties. The program has grown to statewide enrollment of 609,051members, as of June 2014. There are about 450 practices, statewide, functioning as Primary Care Medical Providers (PCMPs) within the program, accounting for over 2,500 rendering practitioners.

The ACC pays for medical services on a fee-for-service basis, but has introduced new payments tied to increased value and health outcomes. The program is designed to provide a client-centered, whole-person approach to care. It connects and leverages medical and non-medical resources to minimize barriers to access and ensure the delivery of timely, appropriate, quality care to all its members—leading to better health outcomes at lower costs.

The four primary goals of the ACC are to:

- Ensure access to a focal point of care or medical home for all ACC members;

- Coordinate medical and non-medical care and services;
- Improve member and provider experiences in the Colorado Medicaid system; and
- Provide the necessary data to support these goals, analyze progress, and move the program forward.

There are three core components of the ACC program:
- Seven Regional Care Collaborative Organizations, each accountable for the program in a different part of the state;
- Primary Care Medical Providers who function as medical homes for ACC members;
- The Statewide Data Analytics Contractor, which provides the Department, RCCOs and PCMPs with actionable data at the population and client level.

Regional Care Collaborative Organizations (RCCOs)

The purpose of the RCCOs is to meet health and financial outcome targets in their region while ensuring appropriate care coordination and a medical home for every member. RCCOs work at the local level to support ACC members and providers. The RCCOs' main responsibilities are the following:
- **Medical management and care coordination**: ensuring that every client in their region receives coordinated, comprehensive, person-centered care, and other non-medical supports as needed to overcome barriers to getting appropriate care
- **Provider network development**: developing a formal contracted network of primary care providers, and an informal community network of medical and non-medical services
- **Provider support:** supporting primary care medical providers in providing efficient, high quality care by providing clinical tools, client materials, administrative support, and practice redesign
- **Accountability and reporting**: reporting to the state on the region's progress, and meeting programmatic and Departmental goals

Primary Care Medical Providers (PCMP)

One of the ACC's goals is to link every member to a primary care medical provider (PCMP) as his or her central point of care. The PCMPs function as medical homes, a model that promotes comprehensive, coordinated, team-based, client-centered care that leads to a positive client experience and better health outcomes. PCMPs are responsible for ensuring timely access to primary care for ACC members, but may provide care coordination directly, or work with RCCOs to give the best possible support to members. The following are the responsibilities of PCMPs:
- **Medical home**: be the focal point of care for members
- **Primary care**: provide the majority of their members' primary and preventive care

- **Connection to other services**: assess members' medical and non-medical needs, and help them access services they need to improve their overall health and well-being and attain their health goals

Statewide Data Analytics Contractor (SDAC)

The Statewide Data and Analytics Contractor provides the Department, RCCOs, and PCMPs with actionable data at both the population level and the client level. Population level data is used to evaluate and improve performance of RCCO and PCMP, and the program overall. Client level data is used to support care management activities, and can help RCCOs and PCMPs identify clients with many needs. Data is provided via an online portal with secure access monitored by the RCCOs and the Department.

The SDAC tracks performance metrics called Key Performance Indicators (KPIs). KPIs are used to determine incentive payments for RCCOs and PCMPs. KPIs are changed as the priorities and needs of the program evolve. The SDAC tracks these and other measures so the Department, RCCOs and PCMPs can monitor progress, and remain accountable for achieving program goals.

The SDAC originally used only Medicaid paid claims data, but has since added more data sources to increase the amount of information available for care coordination. The SDAC has added Medicare paid claims, most recent nursing facility and home health service data, and Behavioral Health Organizations (BHOs) information to inform care coordination for members of the ACC: Medicare-Medicaid Program. The ACC: Medicare-Medicaid Program is a special program to better coordinate care for ACC clients who are fully eligible for both Medicare and Medicaid benefits. Additionally, the Department is working with the Statewide Designated Entity for Health Information Exchange to find a way to include information on hospital admissions, discharges, and transfers in near real-time.

1.2. In This Report

This report has five major sections:

- Enrollment in the ACC
- Fiscal impact, including both costs and savings
- Program performance with a focus on key performance indicators
- Program performance, with a focus on the client and provider experience
- Health care delivery system transformation through the ACC

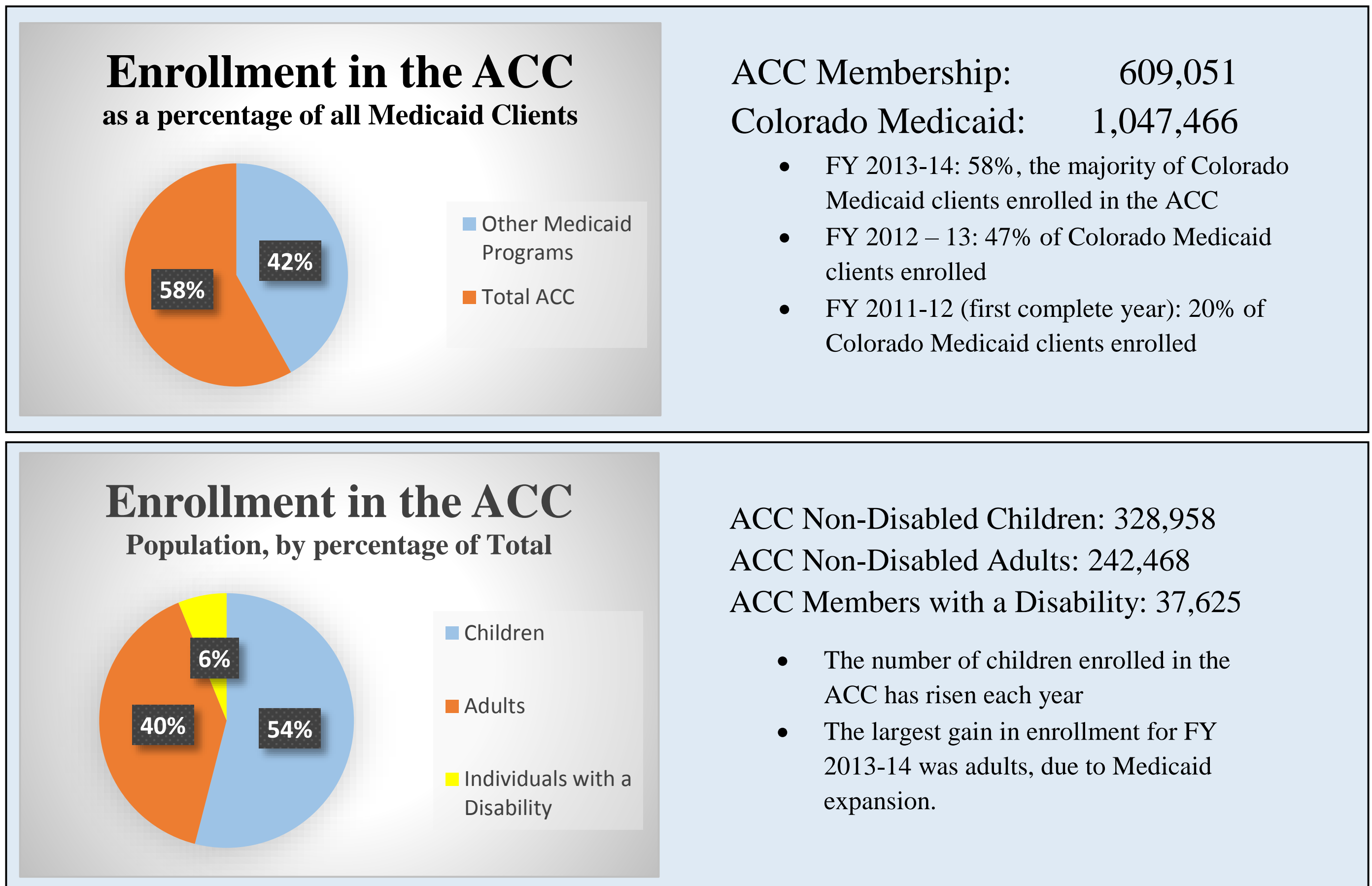
2. Enrollment in the ACC

2.1. Enrollment Numbers

As of June 2014, there were 609,051 members enrolled in the ACC. This is about 58% of all individuals enrolled in Colorado Medicaid.

These numbers represent a 73% increase in membership since June 2013, when there were 352,236 members. Much of this growth is due to the expansion of Medicaid eligibility, implemented on January 1, 2014, as part of the Affordable Care Act. This expansion made Medicaid coverage available to all adults with household incomes at or below 133% of the Federal Poverty Level.

Figure 1: **Enrollment in the ACC (June 2014)**



2.2. Enrollment Methodology

Participation in the ACC is optional. The Department enrolls all new Medicaid clients who are eligible to participate in the ACC, giving clients the ability to opt out within 90 days of their initial

notice of enrollment. This process is called "passive enrollment." Only 3% of clients passively enrolled in the ACC choose to opt out of the program.

In FY 2013-14, Medicaid clients not actively enrolled in the ACC include clients who

- Were institutionalized; or
- Were full benefit Medicaid and Medicare enrollees.

Clients who were already members of the ACC when they were institutionalized or became eligible for Medicare could continue their ACC membership, if they chose. Also, Medicaid clients who became eligible while living in Denver County were passively enrolled in the Denver Health Medical Plan, but could opt out of Denver Health Medical Plan and into the ACC (or regular fee-for-service Medicaid) within 90 days of initial notice of eligibility.

3. Fiscal Impact

The ACC is a managed fee-for-service (FFS) program. This means that providers are paid for each medical service they deliver, but PCMPs and RCCOs also have financial incentives to provide the right care that leads to good health outcomes. The state invests in the ACC's administrative costs to realize a savings in medical service costs.

3.1. Program Costs

For FY 2013-14, total administrative costs for the ACC were **$69,102,976**. This amount covers payments made to RCCOs, payments made to PCMPs, and payments made to the SDAC.

RCCO Payments

RCCOs receive a per-member-per-month (PMPM) payment for its care coordination, provider support, network development, and reporting responsibilities. The RCCO PMPM rate for FY 2013–14 did not change from FY 2012–13.[1]

RCCOs are also eligible to receive incentive payments for improvement on Key Performance Indicators, or KPIs. In FY 2013–14, RCCOs were paid a total of **$52,683,152**, including **$50,783,846** in PMPM payments and **$1,899,306** in incentive payments. This represents 77% of total ACC administrative costs.

[1] The RCCOs do not all receive the same PMPM. There is a range between $8.93 and $9.50)

PCMP Payments

PCMPs receive PMPM payments for the extra commitment associated with providing medical home services to members. Like the RCCOs, PCMPs are also eligible to receive incentive payments for reaching performance targets on KPIs.

During FY 2013-14, PCMPs were paid a total of **$13,052,324**, which includes **$11,757,296** in PMPM payments and **$1,295,028** in incentive payments. Payments to PCMPs represent 19% of all ACC administrative costs.

SDAC Payments

The SDAC receives payment for its services in providing timely, actionable data to the RCCOs, PCMPs and the Department. For FY 2013–14, the SDAC was paid the contracted rate of **$3,367,500**.

3.2. Program Savings

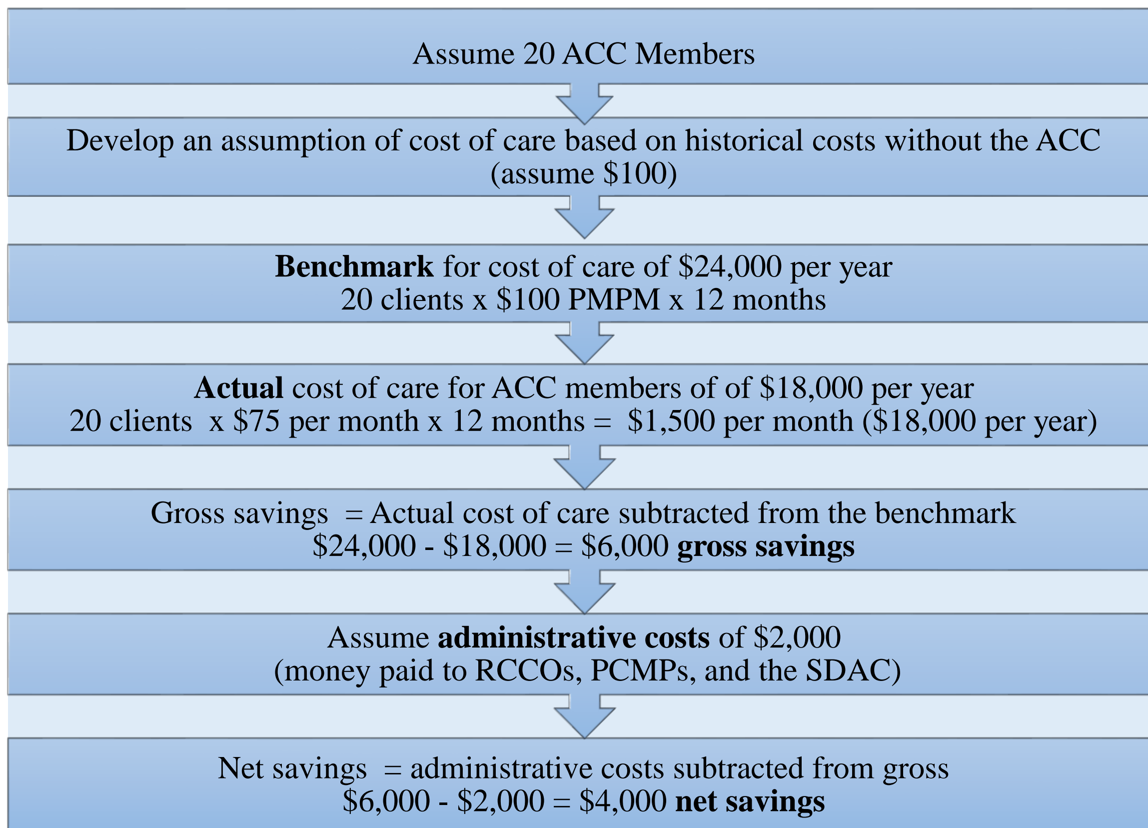
During FY 2013–14, the Department estimates that the ACC generated savings that exceeded all administrative costs. In FY 2013–14, the ACC achieved gross savings in medical costs between **$98,433,017** and **$102,100,305**, with net savings totaling **$29,330,495** to **$32,997,329** after accounting for administrative expenses.

The services provided by RCCOs, PCMPs, and the SDAC work together to lower per capita medical costs for Medicaid clients. Coordinated preventive care and healthful life choices are less expensive than episodic or emergency treatment of medical conditions. With a focus on coordination, education, and network development, the ACC shifts costs from inefficient and expensive periodic treatment to whole-person centered approaches to health care and health outcomes. The result is cost savings.

Savings are calculated by comparing actual per-member-per-month cost of care for ACC members to a benchmark. The benchmark is an estimate of the per-member-per-month cost of care for ACC members if they had received their care through traditional, unmanaged fee-for-service Medicaid instead of the ACC.

The benchmark is derived by analyzing the per-member-per-month cost of care for a comparable population of fee-for-service Medicaid clients over the same period of time, then comparing that figure to ACC members.

Figure 2: Example of How ACC Savings are Calculated



3.3. Fiscal Performance for Specific Populations: Individuals with Disabilities, Non-Disabled Adults, and Non-Disabled Children[2]

While the amount of overall savings is an important number, it is also helpful to understand which client groups are generating the greatest savings in medical costs as a result of their participation in the ACC. Below is an explanation of the fiscal impact of the ACC for three populations: Individuals with Disabilities, Non-Disabled Adults, and Non-Disabled Children.

In FY 2013–14, the ACC generated savings for individuals with disabilities. It also generated savings for adults who had been ACC members prior to January 2014, but did not generate savings for adults who became ACC members after January 1, 2014 (the "expansion" population) or for children. A description of how these savings and costs were calculated is below.

[2] Technical Documentation for Total Cost of Care is included as Appendix A. The savings in this section tie to the overall savings of $102,100,305 – the upper bound of the range. However, the sum of net savings reported for each population group will be higher than the reported range for total program savings, as net savings for the subgroups do not include expenses for the SDAC or incentive payments made to RCCOs and PCMPs.

Fiscal Performance: Members with Disabilities

In FY 2013–14, the ACC achieved gross savings of **$71,422,556** for the population of ACC members with disabilities. Administrative costs for members with disabilities were **$4,204,818.** The result is a net savings of **$67,217,738** for this population.

Figure 3: Fiscal Impact: Calculating Performance for Members with Disabilities

Compare PMPM cost for disabled ACC members to an estimate of what medical costs would have been if they were not ACC members

Difference between this estimate and actual medical costs for the disabled ACC population is the gross savings

Calculate PMPM and incentive payments by region, per disabled ACC member. Subtract this amount, **$4,204,818**, from gross savings to get net savings or costs

Individuals with disabilities require more intensive care, more consistently and more often, than do children and adults without disabilities. As a result, populations with disabilities drive a large portion of spending for any health care plan and within any health care system. These individuals are often more medically vulnerable than people without disabilities, and frequently deal with multiple chronic conditions. They also frequently benefit from enhanced community supports to overcome barriers to care.

As cost savings for this population shows, the ACC works well for people with such needs. The Department plans to expand the reach of the ACC to have an even greater impact on this population.

- With the implementation of the ACC: Medicare-Medicaid Program, the ACC is poised to further affect the type, quality, and consistency of care that is available to members with a disability. This program is designed to better coordinate the benefits, resources, and care that is available to Medicaid clients who are also fully eligible for Medicare benefits. Through this program, the ACC will make care more accessible, streamlined, and effective at all points of access for individuals with disabilities.
- Department staff are working with the Long Term Supports and Services Division to meet the needs of individuals with disabilities or severe acute conditions, who need multiple supports in accessing care and transitioning among providers.

Fiscal Performance: Adults Without Disabilities

In FY 2013–14, the ACC achieved gross savings of **$2,975,677** for all adult members (including those that were part of Medicaid expansion). Administrative costs for ACC adults were **$20,672,636.** The result is a net cost of **$17,696,959** for this population.

Figure 4: **Fiscal Impact: Calculating Performance for Adults Without Disabilities**

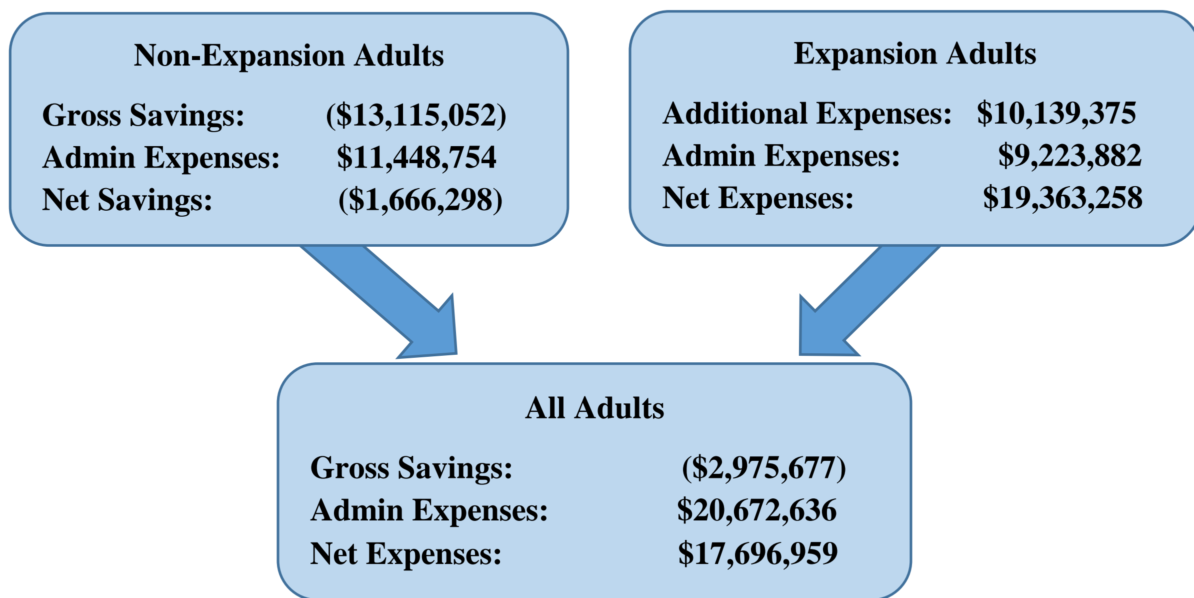
Compare PMPM cost for non-disabled adult ACC members to an estimate of what medical costs would have been if they were not ACC members

Difference between this estimate and actual medical costs for the ACC adult population is the gross savings

Calculate PMPM and incentive payments, by region. Subtract this amount **$20,672,636** from gross savings, for net savings or expenses

The previous includes **all** non-disabled adult ACC members. By itself, the non-expansion adult population achieved gross savings of **$13,115,052** and a net savings of **$1,666,298**. The expansion population incurred additional costs of **$19,363,258.**

Figure 5: Costs for All Adults



Separating the analysis for expansion adults from other adults is important because most expansion adults had no health insurance prior to becoming eligible for Medicaid, and therefore probably did not seek the services they needed, due to cost. The Department expected initial expenses for this population to be high, as people obtained health care services they, otherwise, had been delaying or ignoring. The Department also expects expenses for this population to decline, significantly, and mirror that of other adult Medicaid populations as the pent-up need for services is met. A study from the UCLA Center for Policy Research, in fact, highlights a similar trend for some 200,000 individuals in California who became newly-eligible for Medicaid in 2011. That report states:

> Our results…suggest that the higher costs and utilization among newly enrolled Medicaid beneficiaries is a temporary phenomenon. To the extent that California's experience…is

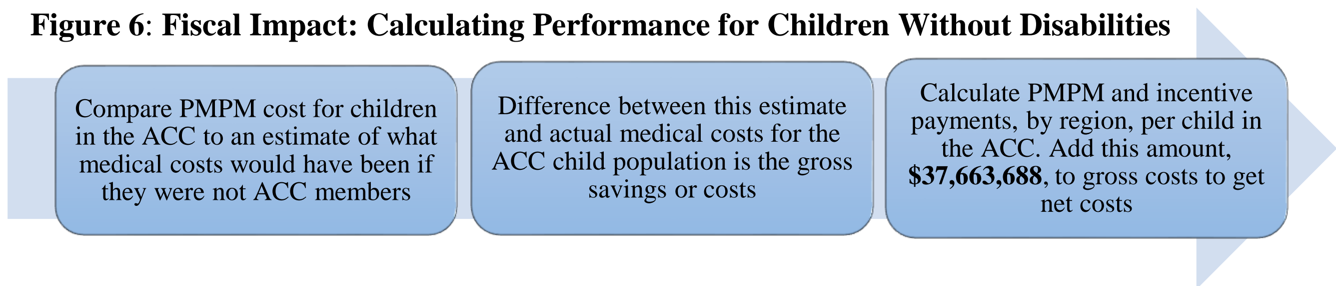
generalizable to other states, policymakers and service providers can expect a reduction in demand for high-cost services after the first year of Medicaid enrollment.[3]

There are opportunities to increase the savings for non-expansion adults and improve health outcomes for the entire adult population. New payment structures will create incentives for PCMPs to offer a full range of services outside of normal business hours, and the Client Over Utilization Program will help mitigate costly misuse of services by certain clients. The ACC is working to increase the number of members who are attributed to a medical home, and to encourage PCMPs to meet higher standards as medical homes. These factors will help steer more adult ACC members away from episodic and emergent care and toward consistent preventive services.

Fiscal Performance: Children Without Disabilities

In FY 2013–14, the ACC achieved gross savings of **$27,702,072** for children**.** The administrative expenses for children were **$37,663,688**. The result is a net cost of **$9,961,616** for this population**.**

Figure 6: **Fiscal Impact: Calculating Performance for Children Without Disabilities**



The ACC strives to save money as a whole. Therefore, some populations may show higher costs in the short term as RCCOs ensure appropriate care and sufficient networks for groups like children, who do not typically have the high medical costs of members with disabilities.

It is a worthwhile investment, however, because children in the ACC have great potential for long-term cost containment. If conditions such as asthma, behavioral and emotional problems, and diabetes, for example, are treated properly and consistently when a person is young, it may reduce expensive chronic conditions in the future. This can lead not only to cost savings but also, more importantly, to better health outcomes and higher quality of life as children move into adulthood.

The Department continues to develop and implement policies to ensure that children receive consistent, efficient, high-quality care in the ACC.

[3] Nigel Lo, Dylan, et al. Increased service use following Medicaid expansion is mostly temporary: evidence from California's low income health program. UCLA Center for Health Policy Research. October, 2014.

- The current Well Child Key Performance Indicator will be adjusted for FY 2014–15, to focus on the 3–9 year-old age group. This will spur preventive, well-child services during a child's formative years.
- The Department will include a KPI focusing on post-partum care, creating an incentive to help mothers and babies establish an early pattern of accessing timely preventive care, while assessing a mother's physical and mental wellbeing.

The Department is involved in partnerships to address issues stemming from hospital care transitions and care coordination for foster children. Each of these are steps toward improving the care children receive across the continuum of services, which should result in a healthier adulthood and a better quality of life—creating potential savings not only for the health care system but for social services as well.

4. Program Performance: Key Performance Indicators

Key Performance Indicators (KPIs) offer another way to gauge the performance of the ACC. KPIs are measures of health service utilization. For example, one KPI looks at how often members use the emergency room. Using these indicators as a proxy for appropriate and timely care, the Department sets performance targets for RCCOs and PCMPs. KPIs reflect the ACC's priorities and focus the efforts of RCCOs and PCMPs to address these priorities.

There were four KPIs for FY 2013– 14:
- Reduction in Emergency Room (ER) visits
- Reduction in high cost imaging
- Reduction in 30 day, all-cause hospital readmissions
- Increase in well-child visits

The first three KPIs have been used since the program's inception. They were selected to measure initial program efforts to reduce cost and improve health outcomes. The fourth KPI, Well Child Visits, was implemented in FY 2013– 14 to reflect a focus on children as the number of children in the ACC increased.

4.1. Methodology

In past years, KPI performance for ACC members has been compared to an expected utilization or benchmark. The benchmark was developed by analyzing the utilization data of clients from before the ACC's implementation. This benchmark allowed the Department to observe the difference in care quality for clients in the program and those not in the program.

For FY 2013 –14, the Department has taken a different approach and compared KPI data for three different groups:
- ACC members enrolled for six months or longer

- ACC members enrolled for less than six months
- Those never enrolled

This analysis is possible this year because program enrollment has increased to give a sufficient sample size, including the sample of clients who have been in the ACC for six months or longer. With this durational analysis it is possible to draw conclusions about the difference the ACC makes, over time, in the health care utilization and health outcomes of its members. The analysis is adjusted to take into consideration the health status of different groups within the ACC population.

For FY 2013–14, the Department excluded the expansion population from the KPI analysis. KPI performance is measured against a benchmark based on historical data, and the Department lacked historical claims data to create benchmarks for this new population. In addition, most expansion enrollees had brief enrollment periods because they did not become eligible until January 2014 and were not enrolled in the ACC until several months after that. Thus, most would fall into the less than six months or not enrolled cohorts, which had the potential to skew the analysis. The Department will include expansion members in the KPI measures in FY 2014–15.

4.2 KPI: Emergency Room Visits

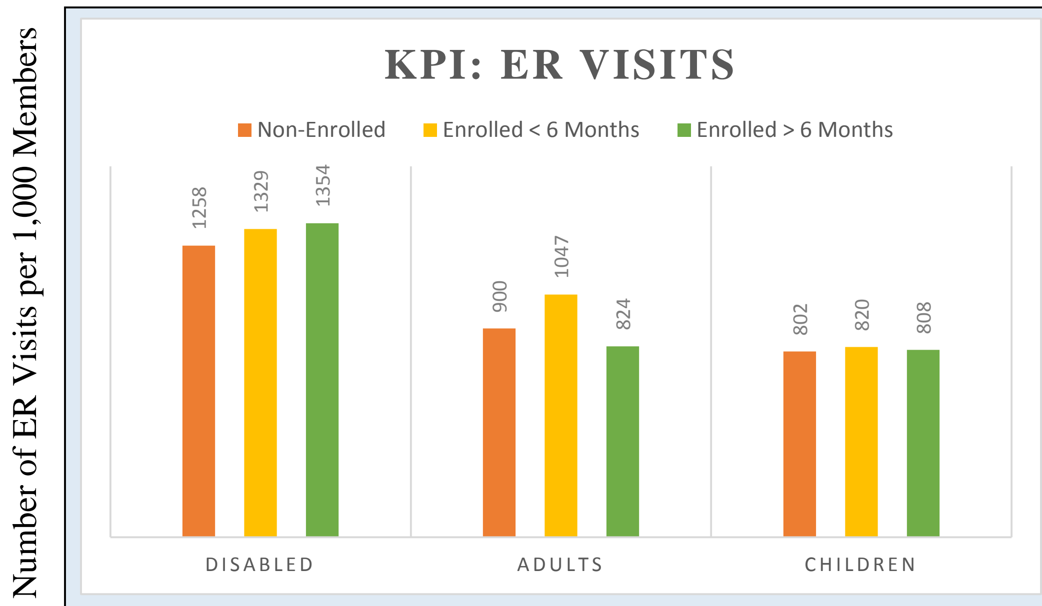
This KPI is defined as the number of outpatient emergency room (ER) claims that did not result in an inpatient stay on the same date of service for the same client.

Unnecessary visits to the ER are expensive and are an inefficient way to treat most health care needs. In addition, every unnecessary ER visit potentially channels resources away from more vital and necessary services. ER utilization can also be an indicator of lack of access to primary care or need for care after-hours or on weekends when office appointments are less available.

The figure below shows ER visits per 1,000 ACC members during FY 2013–14. This can be expressed in visits per member as well. For example, children not enrolled had, on average, 0.802 ER visits per child. Children enrolled for less than six months had, on average, 0.820 ER visits per child, and children enrolled for more than six months had 0.808 ER visits per child.

ER visits for adult ACC members with enrollment greater than six months was lower than the number of ER visits for non-enrolled, fee-for-service Medicaid clients, and for those who had been in the ACC for less than six months. For children, ER visits remained fairly constant; however, children who were enrolled in the ACC for less than six months had the highest rate of ER utilization. As the figure below demonstrates, for the population with disabilities, the lowest ER utilization was among those who had never been enrolled. This finding warrants additional tracking and analysis, which the Department will do as more individuals with disabilities are enrolled.

Figure 7: KPI, ER Visits



Reducing emergency room utilization is a topic that is being addressed nationally, but thus far with mixed results. A number of factors make it difficult to affect the use of the emergency room, including the increase in emergency rooms and departments, more aggressive advertising by hospitals promoting the use of their emergency room, and a co-pay structure that sometimes makes the emergency room a cheaper option for Medicaid clients. In addition, some clients new to the ACC have not had a primary care provider, and use the emergency department for all of their care.

Despite these challenges, ACC members who have been in the program for six months or more have lower emergency room visit rates, suggesting that the ACC is having an impact.

Over the next fiscal year, the ACC will continue to address ER utilization through these initiatives:

- ED notification to the RCCOs will make it easier for care coordinators and PCMPs to immediately reach out to members and help them avoid further trips to the ER.
- Referral Protocols are being implemented by each RCCO to give structure to medical neighborhoods, facilitating timely and appropriate access to specialty care.
- An enhanced PCMP program that stresses, among other things, afterhours care will help incentivize more providers to have extended hours for appointments.
- Increased emphasis on attributing members to a PCMP, with financial penalties for the RCCOs, will build more medical home relationships for more ACC clients, leading to consistent preventive care and better overall health for ACC members.

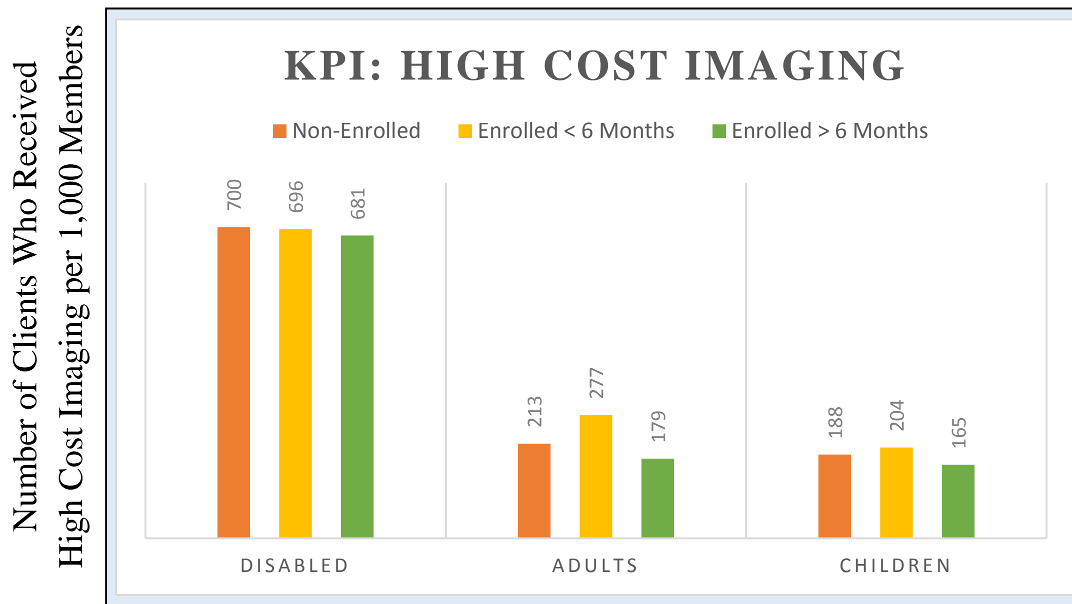
4.3. KPI: High Cost Imaging

High cost imaging services represent any claim that is categorized as a Computed Tomography (CT) Scan or Magnetic Resonance Imaging (MRI) scan.

An overall reduction in high cost imaging means immediate cost savings for the ACC, while also protecting Medicaid clients from the risks of unnecessary imaging. In recent years, the use of these diagnostic services has been one of the fastest growing areas of medical spending. However, more cost effective alternatives are frequently available without compromising clinical efficacy and quality of care for clients. This high-cost imaging KPI exemplifies the Department’s efforts to move away from a volume-driven to a value-based system of care

A comparison of high cost imaging in FY 2013–14 shows consistently lower utilization of these services for members who have been enrolled for six months or longer. This is true across all three cohorts. For example, high cost imaging for the population with disabilities was 3% less for those enrolled for at least six months than it was for those non-enrolled, rates were 12% lower for children, and 16% lower for adults.

Figure 8: KPI, High Cost Imaging



Moving forward, High Cost Imaging will no longer be a KPI, but will be tracked as an indicator of program effectiveness. This metric will be watched closely, to ensure that gains made—and the savings and quality of health implications derived from the metric—remain a consistent aspect of the program and its results.

4.4 KPI: 30 Day, All-Cause Hospital Readmissions

This KPI is defined as any inpatient hospital admission that occurred within 30 days of leaving the hospital, for the same client and the same condition.

As an indicator of the quality and efficiency of a health care delivery system, tracking hospital readmissions reveals

- If a client is receiving care that is appropriate, timely, and effective, particularly after a hospitalization;
- If providers are willing and able to communicate across the health care system;
- Whether or not clients have the help and education they need to transition from acute care, and;
- How actively care coordinators and primary care providers are engaged in a client's recovery.

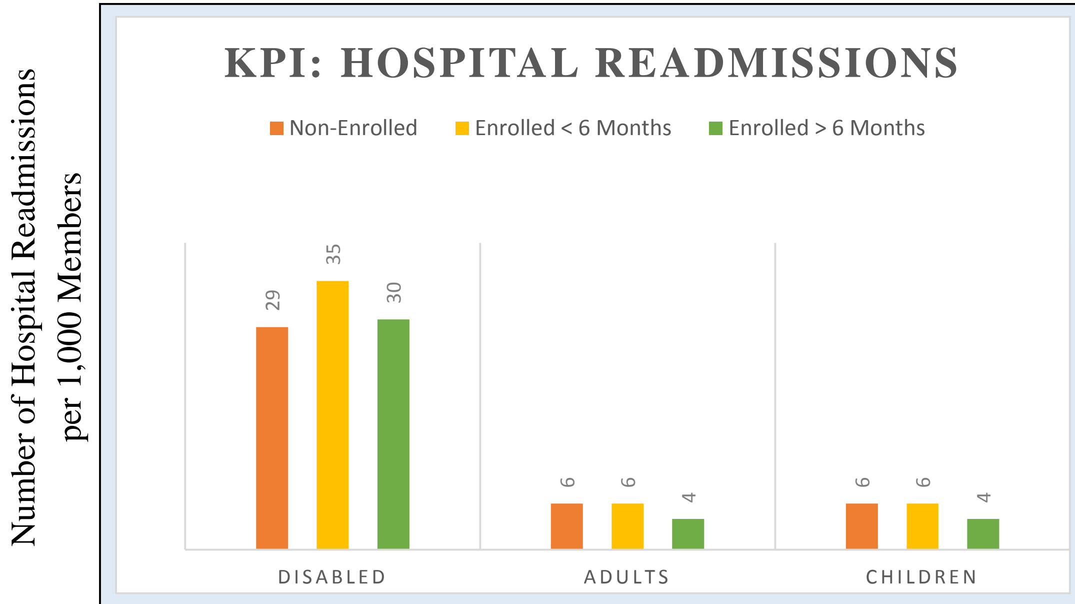
A reduction in 30 day, all-cause hospital readmissions indicates movement toward more coordinated care across the spectrum of delivery and good communication throughout the care network.

In FY 2013–14, the ACC was again successful in reducing hospital readmissions. For the adult and children population groups, there was a 33% reduction in hospital readmissions for clients who had been enrolled in the ACC for six months or longer, as compared to non-enrolled clients and those who had been enrolled for less than six months. For the disabled group, individuals who were enrolled for longer than six months showed a 15% reduction in hospital readmissions when compared to individuals who were enrolled for less than six months; though their readmission rate was slightly higher than for those who were non-enrolled.

Figure 9 highlights that care coordination and a medical home lead to better quality and continuity of care that reduces unnecessary readmissions and readmissions for clients who need them. When a readmission is avoided, it likely the result of effective care coordination before, during, and after a hospital stay.

(See following page, Figure 9: KPI, Hospital Readmissions)

Figure 9: KPI, Hospital Readmissions



As with High Cost Imaging, 30-Day, All-Cause Readmissions will no longer be a KPI, beginning in FY 2014–15. However, the metric will be tracked and reviewed along with other program metrics and KPIs. Additionally, the Department will implement a bonus performance measure that rewards RCCOs for their performance in ensuring member follow-up care within 30 days after being discharged from the hospital.

4.5 KPI Trends: Durational Analysis

The analyses for all three KPIs, above, show a consistent reduction in service utilization for members who have been in the ACC for longer than six months, as compared to Medicaid clients who are not in the ACC. However, service utilization seems to be higher for those enrolled for less than six months than it is for those not enrolled at all. It is not yet clear why this is the case. It is possible that new access to care coordination and having a medical home allows new members to receive needed services they had been foregoing. It may be that when acute and chronic conditions stabilize there is a decrease in service utilization in subsequent months. The Department plans to study this issue further.

4.6 Cost Savings and KPI Trends: Populations with Disabilities

Although the KPIs show that ACC members with disabilities have higher rates of ER visits and slightly higher readmission rates than those not enrolled, the Department still estimates gross savings of $71,422,556 and net savings of $67,217,738 for this population. The savings come from lower utilization of other services, such as prescription drugs and preventable services (those that could have been avoided if other timely interventions had been used).

Table 1: Utilization of Services for Medicaid Clients with Disabilities

	Prescription Drugs Costs (PMPM)	Preventable Services - that could have been avoided (risk adjusted per thousand per year)
Enrolled in ACC more than six months	$255	16,728
Enrolled in ACC less than six months	$269	18,689
Not enrolled	$297	17,886

Though the Department is not tying payment to performance on these performance metrics this year, they contribute to the overall savings of the ACC and also demonstrate improved care for ACC enrollees.

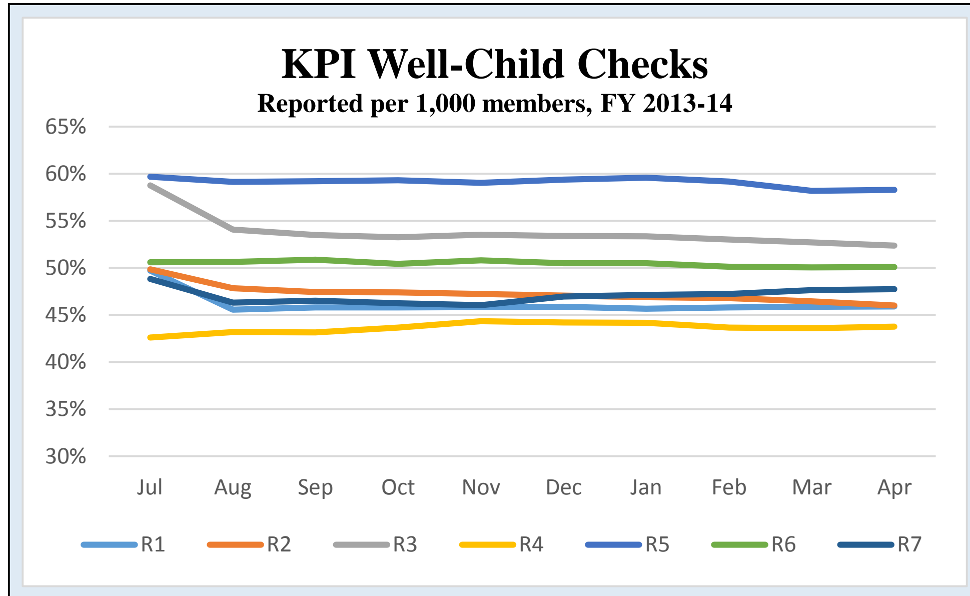
4.7 KPI: Well-Child Visits

This KPI is defined as the number of children who received a well-child check during the year. The Well-Child KPI was implemented in FY 2013–14 to incentivize preventive and wellness checks for all children under age 18. Practices can meet this standard by filing an Evaluation and Maintenance claim for any pediatric ACC member. With this KPI, it is not helpful to look at the data by length of time in the ACC (enrolled for less than six months vs. enrolled six months or more). By definition, those enrolled for six months or more would be expected to have more well-child visits than those enrolled in the ACC for fewer than six months.

In FY 2013–14, the percentage of children receiving at least one well-child visit ranged between 43% and 59%, depending on the RCCO. These percentages remained nearly constant throughout the year, and were below the KPI targeted rates of 60% for Level 1 achievement and 80% for Level 2 achievement.

(See following page, Figure 10: KPI, Well-Child Visits)

Figure 10: KPI, Well-Child Visits



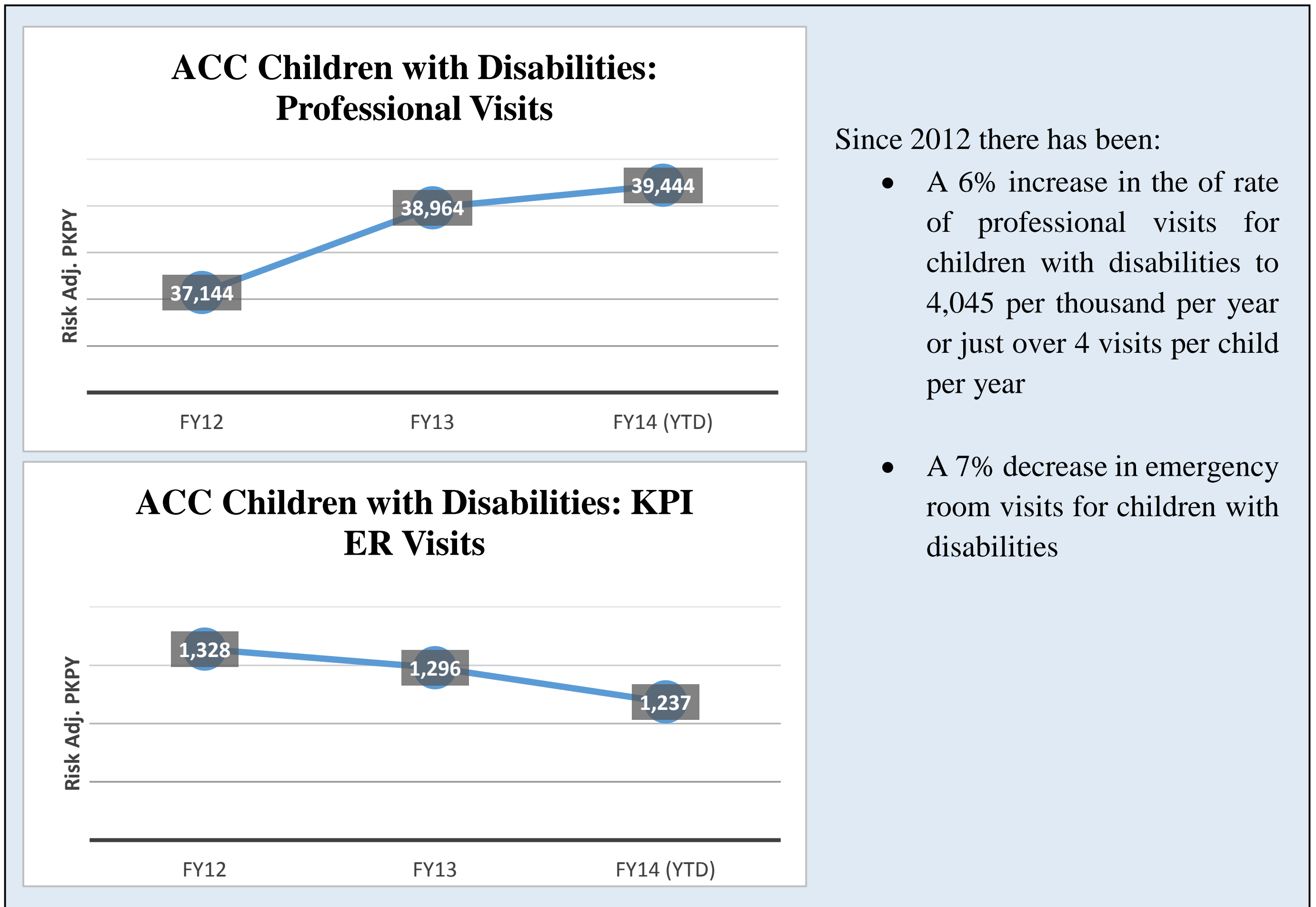
The ACC is looking at how to increase well-child checks, and to capture well-child checks that occur in other settings, such as school-based health clinics. The program will explore strategies such as a care transitions program in partnership with Children's Hospital, promotion of primary care at school-based health clinics, and education materials from the RCCOs to parents about the importance of well-child checks.

4.8 Quality Indicators for Members with Disabilities or Chronic Conditions

For individuals with chronic conditions, consistent primary care can reduce the number of emergency room visits or hospital stays that could have been avoided. The following graphs demonstrate the impact of the ACC for members with disabilities, chronic conditions, or both. These graphs show professional office visits, ER visits and hospital readmissions for these populations from FY 2011–12 to 2013–14. Increases in professional office visits, combined with decreases in ER visits and hospital readmissions indicate a shift from emergency interventions to preventive and primary care. This means more time away from hospitals, more consistent care received from trusted care providers, and greater cost savings to the state.

(See following page, Figure 11: Children with Disabilities)

Figure 11: Children with Disabilities



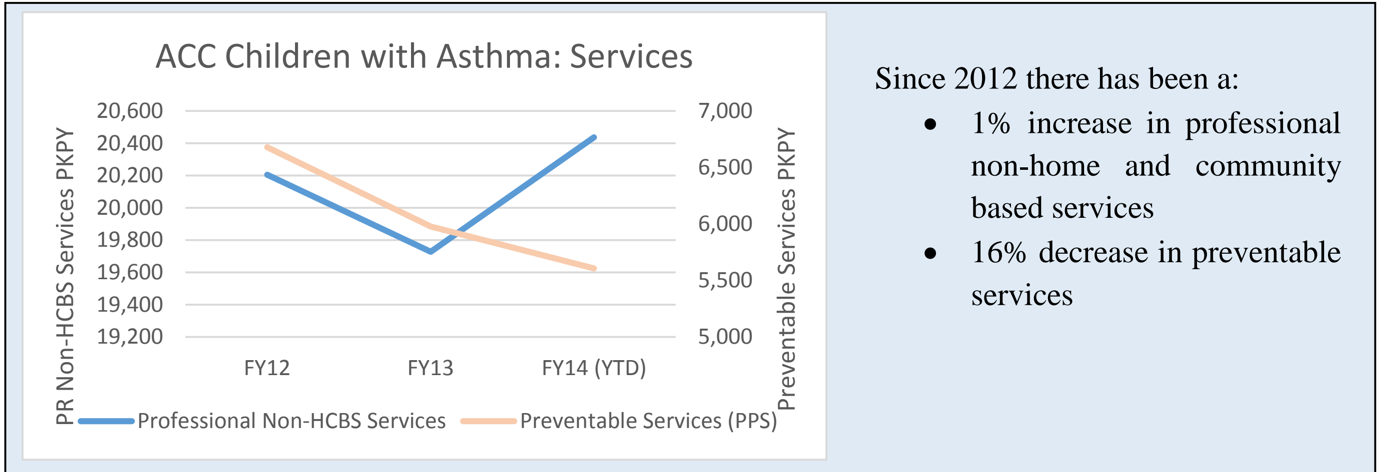
Note: Professional visits are any visits for services in a professional office setting, including primary and specialist care visits.

Children with Chronic Conditions: Asthma

Children in the ACC who have asthma have seen a significant increase in professional visits over the last two years, while experiencing a significant drop in preventable services. Preventable services are those that can be avoided with proper prevention, such as ER visits or hospital admissions.

(See following page, Figure 12: Children with Asthma)

Figure 12: Children with Asthma



Since 2012 there has been a:

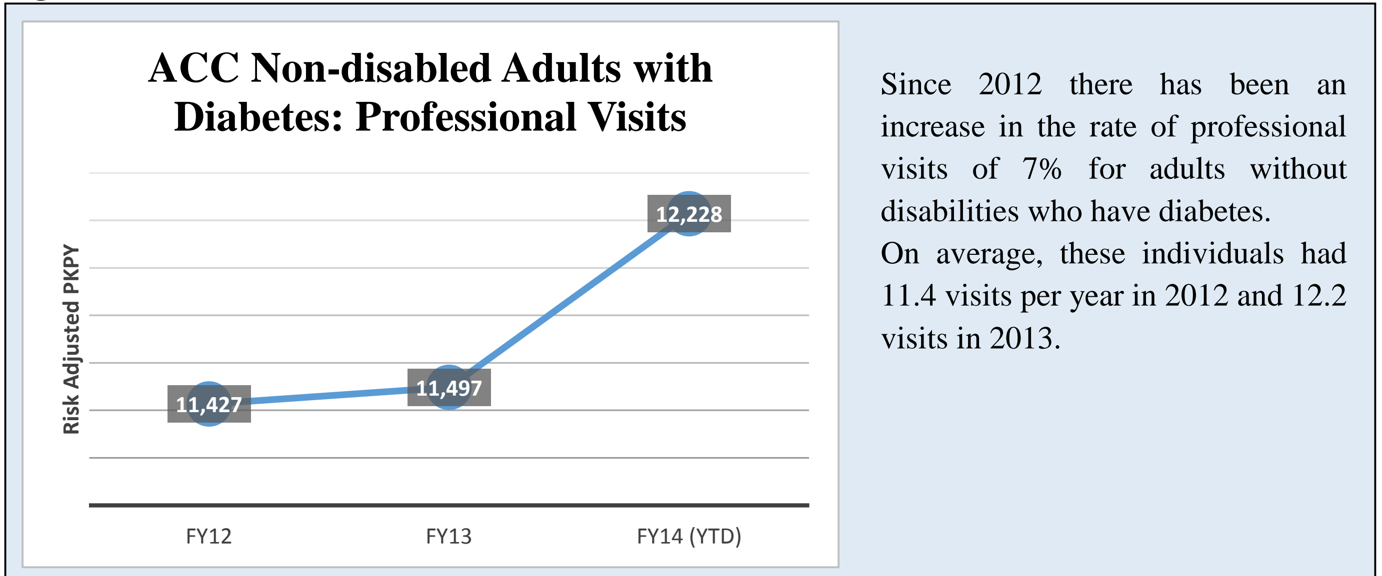
- 1% increase in professional non-home and community based services
- 16% decrease in preventable services

Note: Professional non-HCBS Services are non-Home and Community Based Services utilized in a professional office setting. Preventable metrics are a measure of utilization which could have been avoided if other interventions were utilized beforehand.

Adults with Chronic Conditions: Diabetes

There has been a sizable increase in the rate of professional visits for adults with diabetes since 2012. This is an important metric for individuals with diabetes since non-emergent, preventive care is vital to overall health and quality of life.

Figure 13: Adults with Diabetes



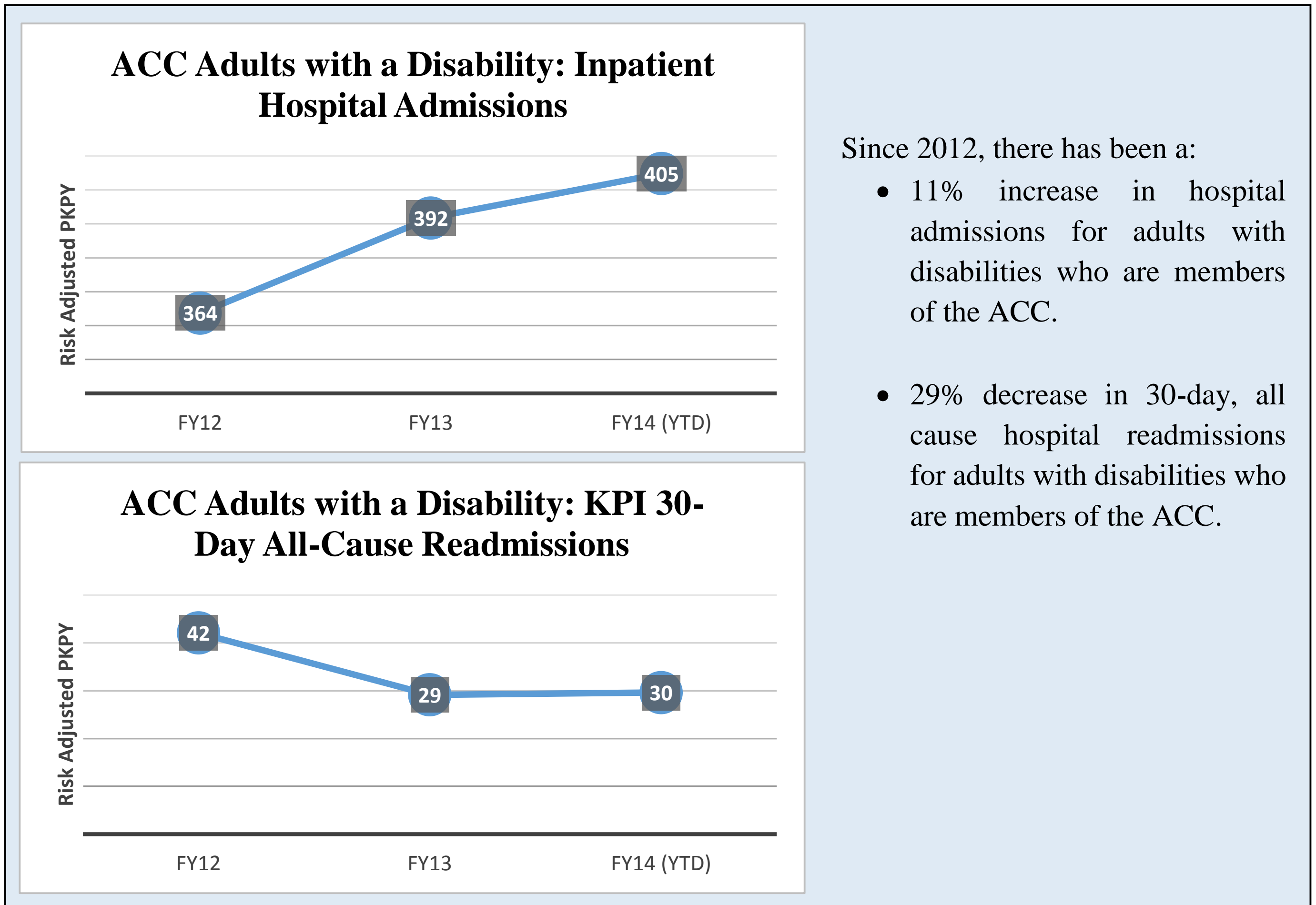
Since 2012 there has been an increase in the rate of professional visits of 7% for adults without disabilities who have diabetes.

On average, these individuals had 11.4 visits per year in 2012 and 12.2 visits in 2013.

Adults with a Disability

While hospital admissions for ACC adults with a disability have increased since 2012, hospital readmissions for that population have decreased 10% over that same span of time. Individuals with disabilities often have multiple chronic conditions and extensive medical needs that require more admissions to a hospital. A decrease in readmissions, however, indicates better care transitioning and utilization of follow up care after hospital discharge

Figure 14: Adults with a Disability



5. Program Performance: Client and Provider Experience

The Department recognizes the importance of and highly values the client and provider experience and strives to enhance that experience within the health care system. To understand that experience within the ACC, the Department use several methods including:

- The 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, administered by the Colorado Health Institute;

- RCCO deliverables that require reports on client issues; and
- Ongoing discussions and meetings with RCCOs, PCMPs, and advocacy groups about client experience.

5.1 CAHPS Data

In August, 2014, the Colorado Health Institute (CHI) released findings from its CAHPS survey conducted in 2013. The survey, developed through a partnership between CHI and the Colorado Health Foundation, asked Medicaid clients questions about customer-service and other health care related topics. CHI compared ACC participant responses to those of Medicaid fee-for-service (FFS) clients.[4] The survey reported a high level of consumer satisfaction within the ACC but in some cases satisfaction was no higher than—and was sometimes lower than—consumer satisfaction in the FFS Medicaid. For example:

- 57% of ACC respondents rated their personal doctor a "9" or "10" on a scale of 1-10 (FFS: 60%)
- 72% of ACC respondents said they believed that their personal doctor was always up to date or informed about the care they received from other doctors (FFS: 76%)
- On a scale from 1-10, ACC members rated the quality of their Medicaid care at 7.5 (FFS: 8.0)
- ACC clients were more likely to say their doctor asked them about their emotional well-being:
    - 54% of ACC respondents reported that their doctor or other provider asked them about depression as compared to 49% for FFS respondents;
    - 51% said their doctor asked them about things in their life that cause stress (47% for FFS); and
    - 42% reported their doctor asked about personal issues, such as substance use or family matters (compared to 39% for FFS).

The CAHPS findings are difficult to interpret, partially because the same providers serve both ACC members and those in traditional fee-for-service. It is possible that ACC members have higher expectation for their experience of care. Regardless, it is always important to improve the experience of ACC Members. The CAHPS survey highlights future areas of opportunity for ACC policy to improve client experience.

[4] "Through a client's eyes, 10 findings from the 2013 survey of clients in Colorado's Medicaid Accountable Care Collaborative program." Colorado Health Institute. August, 2014.

5.2 Client and Provider Feedback

Throughout the year, RCCOs collect stories from clients and providers that demonstrate the program's impact in a way that quantitative data cannot capture. These stories often underscore the value of care coordination and community partnerships in getting people the health care they need:

- During a routine call from a member seeking assistance in selecting a PCMP, a RCCO 7 Service Center Representative learned the individual was having trouble paying his rent and utilities. Because the member was borrowing a phone from a friend and had limited minutes to use, he was unable to call the resources he was unable to call and connect with any community resources. . The representative assisted the member in obtaining a free phone with prepaid minutes. While the member was waiting for the phone to arrive, the representative called community agencies on his behalf and helped connect him to rent and utility assistance resources. The member was ecstatic that the Service Center helped him find a PCMP and put him in contact with community resources to help him with his non-medical needs.
- A RCCO 6 client noted that having a CCHA social worker participate in his child's doctor's appointment and advocate for him was tremendously helpful. He found it extremely difficult to explain, on his own, some of his child's difficult behavior and deeply appreciated having a professional social worker help voice his concerns and help secure appropriate care for his child.
- A provider in the Denver metro area wrote, "We have seen the most significant impact from the co-location program which has been in place with Colorado Community Health Alliance/RCCO 6. This collaborative model has allowed us to house a Health Partner from CCHA on site in our clinic one half day each week…. We are extremely pleased by the efforts and outcomes of the ACC/RCCO program. We extensively use the resources of the RCCOs with which we work to better serve our Medicaid patients and hope that this is a model of collaboration that will grow and expand in the future."
- In RCCO 4, a care coordinator worked with an optometrist to find a member who was not responding to phone calls following a routine eye exam. The optometrist was concerned about possible malignancy and wanted an immediate MRI, but the client's phone was disconnected and the provider had no other means of getting hold of the patient. The RCCO care coordinator eventually located the Member's father who helped locate the member and the care coordinator facilitated the scheduling of an MRI.

These are just a few examples, but they underscore the collaborative nature of the ACC and the flexibility the program affords RCCOs in addressing issues that create barriers to care for their Members. Regional emphasis, local partnerships, robust provider networks, and access to non-medical resources are each tools RCCOs can deploy to improve Member experience, access to care, and ultimately, health outcomes.

6. Health Care Delivery System Transformation

The ACC is the care delivery foundation for a rapidly-growing percentage of Colorado's Medicaid clients because of its ability to deliver person-centered care with the potential to shape long-term health outcomes for individuals, families, and populations.

For FY 2014–15, the ACC will evolve to include policy and programming designed to improve the ACC's performance, focusing on improved care delivery for certain higher-risk populations. These changes include the following:

- The 1281 Pilot Program: a program in several western counties that uses a full-risk, capitated payment structure to improve the integration of behavioral and physical health care services for ACC members
- The ACC: Medicare-Medicaid Program: a demonstration project that makes intensive care management available to an estimated 30,000 individuals, statewide, who are fully eligible for both Medicare and Medicaid benefits;
- ACC pay-for-performance measures: a series of payment changes that will incentivize further advancement in the medical home model and increase emphasis on certain, preventive services, such as:
    - Reduction in RCCO PMPM for members who have not been matched with a medical home within six months in the program,
    - Additional PMPM payment for PCMPs who meet enhanced primary care practice standards,
    - Incentive payments that focus on postpartum care and follow-up care for members who have been discharged from the hospital,
    - Payment incentives that spur adolescent wellness and behavioral screenings.

The ACC was designed to be a flexible, evolving health care model capable of aligning medical and community resources on the local level to address health care needs, improve health outcomes, and decrease the overall cost of care.

Just as these successes are the result of lessons learned in previous years, the ACC will evolve and build on these successes in future years. The ACC was designed with a long-term vision in mind, and the understanding that health system change is iterative and constantly evolving. Over the past three years, the program has shown the ability to make these changes, and is well poised to continue to do so in the future.

Appendix A:

Technical Documentation for Total Cost of Care

The Department has identified between $98 million and $102 million in gross program savings in FY 2013-14. The lower end of this range of estimates is the result of the application of results from FY 2012-13 to the FY 2013-14 caseload. The Department previously estimated approximately $30.60 PMPM in gross savings across the ACC. Under the assumption that this amount would decrease as the case mix of enrolled members changes, the Department estimates that the ACC reduced costs for enrolled members by $29.07 PMPM, which translates to $98 million in gross program savings.

The higher end of this range is the result of a more complex statistical method. Rather than compare ACC enrollees to non-enrolled members as it did in FY 2011-12, the Department instead created a benchmark by applying actuarially-certified growth rates to a baseline cost before the existence of the ACC. The growth rates and resulting benchmarks are calculated specifically for each of three ACC eligibility types and each of seven RCCO regions. These more finely-tuned estimates yielded gross savings of $13 per enrolled non-disabled adult per month, $10 per enrolled non-disabled child per month, and $241 per disabled adult or child per month, for combined program-wide gross savings of $102 million.

Note that because these benchmarks are different from those used in shared savings initiatives, the savings estimates presented here should not be expected to match those related to shared savings. The intent of the total impact estimate is to estimate the effect of the ACC compared to a hypothetical scenario in which the ACC does not exist; calculations related to shared savings are intended to measure the incremental impact of specific efforts within the ACC.

Technical Documentation

The goal of the counterfactual estimation technique is to compare actual observed costs under the ACC to a hypothetical benchmark of costs in the absence of the ACC. This method is widely used throughout the healthcare industry to estimate the impact of care management programs on the total cost of care. Counterfactual estimation relies heavily on risk adjustment to render different populations commensurable and on the ability to predict changes in utilization patterns. Furthermore, counterfactual estimation does not account for time-invariant factors such as patient preferences that could contribute to different pre-period costs for the enrolled and non-enrolled groups. Because the counterfactual method does not control for time invariant factors beyond health status, it is possible that differences in pre-period costs were calculated as savings. Counterfactual estimation is the Department’s preferred approach because the widespread adoption of the ACC means that there is no truly comparable population in Colorado Medicaid against which to compare costs.

It is important to note that while similar, this counterfactual estimation technique differs from method the Department anticipates using for its shared savings initiatives. In estimating the impact of the ACC on the total cost of care, the Department is comparing actual observed performance to a hypothetical baseline that would only exist without the ACC. The shared savings initiatives, however, attempt to measure incremental improvements at the RCCO level, within the broader context of the ACC.

Comparable Cohorts

In order to accurately estimate the impact of the ACC on total cost of care, it is necessary to divide the enrolled population into similar groups. Each group of clients is expected to have similar characteristics and health need and therefore similar costs. Furthermore, such a subdivision allows more finely-tuned hypothetical growth rates to be applied to the benchmark cost for each group. Groups were defined in the following way:

1. Clients are grouped into three distinct categories based on their age and disability status. These three groups are:
    - Non-Disabled Children
    - Non-Disabled Adults
    - Disabled Adults and Children

   When noted, Non-Disabled ACA Expansion Adults are reported distinctly from Non-Disabled Adults.

2. Clients are separated into the seven RCCO regions based on their county of residence. Each of the three eligibility types above is separated into seven distinct groups, one for each region.

3. Clients are separated into groups based on the month they were enrolled in the ACC Program. Clients are enrolled on the first of each month. The months during FY 2013-14 are considered for this analysis. For each of the 28 distinct groups above (3 eligibility and 7 region within each eligibility type), clients are separated into enrolled or non-enrolled groups for each of the 12 months during FY 2013-14.

Risk Adjustment

The advantage of establishing groups of clients with very similar diagnoses and severity of illness is that the clients in each group will share similar health and cost expectations for the future. Risk adjustment allows for the comparison of different groups of clients by normalizing for differences in health status. A certain group of clients may be more expensive than another group, but the first group may also be less healthy and require more health care services. A risk score is a measurement of the relative health status of a group of clients compared to the health status of the

entire population. The risk score for the entire population is set to 1.0 and is based on the average cost of the entire population. The risk score for a group of clients is established by summing the total cost PMPM for the group and dividing by the total cost PMPM for the entire population. This method relies on the assumption that sicker clients require more expensive care on average.
In general, differences in health status are normalized by dividing the total average cost for a group of clients by the average risk score for the group. Once risk has been normalized it is possible to consider which group was more expensive on average, without potentially confounding factors like differences in health status.

The risk adjustment methodology used to control for differences in health status is Clinical Risk Groups (CRGs) developed by 3M. This methodology groups clients into similar subpopulations based on diagnosis codes and procedure codes. Further refinement of each group is accomplished by considering the relative severity of illness and risk of mortality for each of the members in a given subpopulation. Risk scores are calculated using 3 years of historical claims data. Scores are calculated separately for disabled and non-disabled populations.

Growth Rates

Counterfactual estimation relies heavily on the use of accurate growth rates to estimate a benchmark in the absence of a comparison population. Using claims data from FY 2010-11 and FY 2011-12, Optumas created population- and RCCO-level estimated growth rates for the entire ACC-eligible Colorado Medicaid population. Optumas normalized the data using the CRG methodology described above, adjusted the data to account for services that were incurred but not reported (IBNR), and abstracted out program changes not related to the ACC. This analysis allowed Optumas to estimate rates of change for each population within each RCCO in all of 21 distinct services lines. Population-wide, these estimates indicate that medical expenditures for the entire ACC-eligible population would have grown approximately 2.27% in FY 2012-13 and 6.30% in FY 2013-14 in the absence of the ACC.

To avoid an overstatement of savings due to factors that the Department cannot control for in the analysis, the Department chose a growth rate at the midpoint of actual growth rates and the actuary's estimates. This results in a more conservative estimate of savings that acknowledges that the Department has implemented multiple cost savings efforts in addition to the ACC since the benchmark period.

These growth rates may initially seem to contradict growth rates presented in Exhibit C of the Department's FY 2014-15 budget request[5]. Exhibit C shows that cash-based actual per capita costs are projected to increase at different rates for many of the eligibility types that the ACC impacts. There are numerous reasons for the differences between the Department's projections based on

[5] HCPF FY 2014-15 Budget Request, Exhibit C

actual growth rates and Optumas' estimated growth rates. Most importantly, the Department's estimated growth rates take into account estimated effects of the Accountable Care Collaborative, while Optumas's do not. Other important differences between the two estimates include the case mix of populations examined and the relative weight given to non-ACC Department cost containment measures. For another point of comparison, the Bureau of Labor Statistics estimates that population-wide expenditures on medical services increased by 2.1% during the same time period[6]. The Department's observation of negative growth rates is actually unusual in the broader context of increasing medical expenses.

Counterfactual Estimation

The counterfactual estimation technique relies heavily on both risk adjustment described above and on accurate predictions of cost trends in the absence of the ACC. Two different counterfactual benchmarks are applied to arrive at the estimate range of $98 million to $102 million of gross savings. In general, savings estimates are developed by comparing actual, risk-adjusted costs to a benchmark cost. The Department used two primary methods to estimate the impact of the ACC on total cost of care.

First, the Department derived a population-wide estimate of $29.07 PMPM saved, taken from analysis supporting last year's annual report impact estimate. This variation of counterfactual estimation relies on the existence of a comparison population. The initial results from the FY 2012-13 comparison ($30.60 PMPM saved) were assumed to be reduced as more clients are enrolled in the ACC. Multiplying this number by average monthly program enrollment yields approximately $98 million of gross savings.

Second, the Department derived separate benchmark PMPMs for each of the 28 cohorts identified above (4 eligibility types and 7 RCCOs). These benchmarks were then trended forward using service line-, population-, and RCCO-level growth rates described above. These growth rates account for other non-ACC Department initiatives. As a result, estimates calculated using these growth rates are expected to reflect the impact of the ACC apart from other cost containment efforts the Department has undertaken in recent years. The difference between these benchmarks and actual observed costs varies for each population and RCCO, but on average the ACC saved $13 per enrolled non-disabled adult per month, $10 per enrolled non-disabled child per month, and $241 per disabled adult or child per month. The population-wide weighted average for all groups is $32.94 PMPM saved. In total, this method estimates $102 million of gross savings.

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[6] Consumer Price Index - First Half 2014

Appendix B:

Program Background

The Department implemented the Accountable Care Collaborative (ACC) Program in May 2011 as the predominant Medicaid system reform. The ACC Program represents a committed effort to transform the Medicaid Program into an integrated system of better care for all its members and to lower costs for the State of Colorado.

In the early 2000s, a number of managed care plans withdrew from Medicaid, leaving 80% of the Colorado Medicaid population in a fee-for-service payment system. Fee-for-service reimbursement has been shown to be an inefficient and ineffective payment method for health care. After seeing an increase in the number of Medicaid enrollees and the resulting rising costs, the Department took the initiative to develop a plan for achieving greater efficiency.

The Department developed a Colorado-specific solution, the ACC Program, in collaboration with stakeholders. In 2009, the legislature passed a budget action authorizing the Medicaid Value-Based Care Coordination Initiative, now known as the ACC Program. Stakeholders have been vital to the design, implementation, and ongoing evolution of the ACC Program, and ongoing stakeholder engagement is continuously achieved through a robust advisory committee process.

Higher quality and lower cost health care can be accomplished, but changing a system as large as the state's Medicaid Program necessitates progressive evolution rather than overnight metamorphosis. The Department has outlined four goals for the ACC Program. The program will:

1. Ensure access to a focal point of care or medical home;
2. Coordinate medical care and non-medical care;
3. Improve member and provider experiences; and
4. Provide the necessary data to support these goals.

The ACC Program is a short-term solution to improving care and reducing costs as well as a long-term investment in better health futures and savings for Colorado's population. The program design includes an immediate focus on cost- and clinically-effective utilization of services. Coordination of care and an enhanced emphasis on wellness and prevention is expected to result in better health and reduced costs across the lifespan of current members.

Program Design

The three core components of the ACC Program include:

- Regional Care Collaborative Organizations (RCCOs), to ensure cost and quality outcomes for their Medicaid members;

- Primary Care Medical Providers (PCMPs), to serve as the focal point of care for each member;
- Statewide Data and Analytics Contractor (SDAC), to provide actionable data at both the population and client level.

Regional Care Collaborative Organizations

For the purpose of the ACC Program, the state is geographically divided into seven regions, each having one Regional Care Collaborative Organization (RCCO) responsible for all of the ACC members in that region. The program was designed this way to promote collaboration and avoid a scenario in which multiple entities compete for Medicaid clients. The seven RCCO contracts were awarded in late 2010 and early 2011 through a competitive procurement process.

The RCCOs' four main responsibilities are:

- Medical Management and Care Coordination: The RCCOs must ensure that every client receives an appropriate level of medical management and care coordination. This links to the program goal of ensuring a positive provider experience as well as a positive member experience. RCCOs can assist providers with addressing the non-medical needs of their clients that they may not have the in-house capacity to address

- Network Development: Develop a formal contracted network of primary care providers and an informal network of specialists and ancillary providers. This addresses the core program goal of ensuring access to primary care.

- Provider Support: Support the PCMPs in providing efficient, high quality care through activities such as providing clinical tools, client materials, administrative support, practice redesign, etc. This responsibility ties to the core program goal of ensuring a positive provider experience.

- Accountability and Reporting: the RCCOs are responsible for reporting to the state on the region's progress.

Primary Care Medical Providers

The role of PCMPs is to serve as a focal point of care or medical home for ACC clients. Every member should be linked with a PCMP as his or her central point of care. PCMPs are directly responsible for ensuring timely access to primary care, one of the core goals of the ACC program. Currently, PCMPs must 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. This primary relationship is essential to building an integrated care system. The

system must grow around the client, and establishing a strong connection to the system will ensure that right services may appropriately form around the client's needs.

Clients in the ACC Program are enrolled with both a RCCO and a PCMP in the Medicaid Management Information System (MMIS). Clients are assigned to a PCMP at the time of enrollment if they have a clear pattern of use with that provider. Clients with a clear pattern of use with a provider who is not in the ACC Program are not enrolled, so existing provider/client relationships are not broken. Clients with no claims history with a provider are only enrolled in the RCCO, and the RCCO is responsible for connecting them with a PMCP. Approximately 75% of enrolled clients are linked with a PCMP. This prospective enrollment allows providers to know who they are responsible for and to implement proactive strategies for ensuring that clients are receiving the care that they need.

Medicaid providers contracted as PCMPs have been integral to developing and improving the ACC Program. The Department continues to receive feedback from the practice level around the positive impacts to members, especially those with high needs and non-medical needs that affect health outcomes. These successes continue to generate positive enthusiasm, engagement, and commitment to the improvement and realization of a better Medicaid program.

Statewide Data and Analytics Contractor

The Statewide Data and Analytics Contractor (SDAC) is responsible for providing the Department, RCCOs, and PCMPs with actionable data at both the population and client level. Population level data is used to evaluate and improve the program, individual RCCOs, and individual PCMPs. Client level data supports care management activities. The data is provided to the Department, RCCOs, and PCMPs via an online portal with secure, role-based access. Currently, only paid claims data are included. The online Web portal was launched in January of 2012.

The SDAC tracks program Key Performance Indicators (KPIs). The KPIs for FY12-13 were:

- ER visits;
- Inpatient hospital readmissions; and
- High-cost imaging services.

These KPI metrics were identified because they strongly correlate with the total cost of care, can be measured using existing claims data, and represent opportunity for providers to impact care delivery. In addition, appropriate utilization of these services may be influenced through care coordination and care management practices. Both the PCMPs and the RCCOs have access to a Web portal that details the KPIs of their enrolled members. They are able to monitor and improve their own performance and identify members who may need additional assistance.

The KPI metrics are tracked for each RCCO and PCMP. The metrics are calculated based on the clients attributed to each RCCO and PCMP. The Department is able to compare RCCOs and PCMPs by comparing their KPI metrics. Beginning in FY 2012-13, one dollar of the administrative PMPM is being withheld from both the RCCOs and PCMPs. Both entities are eligible to earn the dollar back by meeting utilization reduction targets for each KPI.

The SDAC is responsible for dissemination of best practices across the ACC Program. By scheduling regular training sessions with RCCOs and PCMPs, the SDAC can share methods of using data to create actionable care plans for ACC clients.