COLORADO
Department of Health Care Policy & Financing

November 1, 2016

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

Dear Representative Hamner:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information #3 regarding the Accountable Care Collaborative.

Legislative Request for Information #3 states:

The Department is requested to submit a report by November 1 each year to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative 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 2015-16.

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

Sincerely,

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

SEB/srm
Enclosure(s): Health Care Policy and Financing FY 2016-17 RFI #3

Cc: Senator Kent Lambert, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Grantham, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
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Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Jed Ziegenhagen, Community Living Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

ACCOUNTABLE CARE COLLABORATIVE FY 2015–2016

Legislative Request for Information #3

November 1, 2016

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Legislative Request for Information #3 states:

> Department of Health Care Policy and Financing, Medical Services Premiums – The Department is requested to submit a report by November 1 each year to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative 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.

Executive Summary

The Department of Health Care Policy and Financing (Department) is pleased to submit this annual report on the Accountable Care Collaborative to the Joint Budget Committee. As requested, this Legislative Request for Information provides an update for FY 2015–16 on program enrollment, current administrative fees and costs associated with the program, and performance results with an emphasis on the fiscal impact.

The Accountable Care Collaborative is the core of Health First Colorado (Colorado's Medicaid Program). It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and to make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people and, in just five years, has shown real progress in creating a health care delivery program that improves health outcomes, better coordinates care, and reins in cost.

The four primary goals of the Accountable Care Collaborative program are:

- Ensure access to a focal point of care or medical home for all 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, to analyze progress, and to move the program forward.

The program is built to accomplish these goals using three core components:

- Seven Regional Care Collaborative Organizations (RCCOs), each accountable for the program in a different part of the state;

- Primary Care Medical Providers (PCMPs), who function as medical homes for members; and
- The Statewide Data Analytics Contractor (SDAC), which provides the Department, RCCOs and PCMPs with actionable data for individual members and the population as a whole.

Enrollment

As of June 2016, there were **1,025,176** Medicaid members enrolled in the program, accounting for nearly 80 percent of all those enrolled in Colorado Medicaid. This total includes all members in the program, including those enrolled in the Accountable Care Collaborative: Medicare Medicaid Program and in Accountable Care Collaborative: Rocky Mountain Health Plans Prime. Note that the updates and results for Rocky Mountain Health Plans Prime will be addressed in a separate report.

Participation in the Accountable Care Collaborative is optional, and members may opt out of the program if they wish. Less than five percent of those enrolled in the program chose to opt out.

The program works best when members have a medical home with a PCMP. More than three-quarters of Accountable Care Collaborative members are now connected to a PCMP and have a medical home.

Administrative Fees and Costs for the Program

In FY 2015–16, the Department estimates that the Accountable Care Collaborative resulted in overall cost savings. The Accountable Care Collaborative avoided **$205,116,542** in medical costs. After accounting for administrative expenses, the program avoided a total of **$61,883,680** in costs. The Department estimates the Accountable Care Collaborative has avoided a net **total of $139 million** since the program began in 2011.

For FY 2015–16, total administrative costs for the program were **$143,232,862.** This amount includes payments made to the RCCOs, the PCMPs, and the SDAC. RCCOs were paid a total of **$107,141,443**, which represents **75 percent of total administrative costs**. These funds were used for per-member-per-month payments, payments for Key Performance Indicators, and a pay-for-performance pool used to support special incentives or initiatives. PCMPs were paid a total of **$32,715,894**, representing **23 percent** of

administrative costs. These funds were used for per-member-per-month payments, payments for Key Performance Indicators, and payments for those who qualify as enhanced Primary Care Medical Providers. The SDAC was paid the contracted rate of **$3,375,525,** which represents **two percent** of the total administrative costs.

Program Performance

During FY 2015–16, the Accountable Care Collaborative program increased the utilization of many recommended services that can improve health and lower costs, decreased the utilization of some higher-cost services, and maintained member satisfaction.

To assess the impact of participation in the Accountable Care Collaborative, the Department compared performance on program measures for members who were in the program for 0–6 months and 7–11 months of the year. Members who have been in the program longer should use more health promotion and prevention services (such as well-child visits) and fewer high-cost services (such as emergency room visits).

Members in the program for a longer time used prevention and wellness services at a higher rate than those in the program for less time. For example, 62.9 percent of Accountable Care Collaborative: Medicare-Medicaid Program members in the program for 7–11 months had follow-up care after leaving the hospital compared to 48.8 percent of members in the program for 0-6 months. Children ages 3–9 enrolled for 7–11 months received well-child checks at a rate of 45.0 percent compared to 27.4 percent for members in the program for 0–6 months.

Similarly, members who spent more time in the Accountable Care Collaborative used fewer high-cost services than members in the program for less than six months. Emergency room use decreased for Accountable Care Collaborative: Medicare-Medicaid Program members who were in the program for longer: they had approximately 200 fewer visits per 1,000 members per year compared to those in the program less than six months. Those in the program for 7-11 months also had fewer readmissions to the hospital and fewer potentially preventable admissions to the hospital.

The results are trending in the right direction, but the program continues to identify areas for improvement. In particular, the Department and the RCCOs are working together to increase the rate of depression screening, well-child visits, and prenatal care. The program is also continuing to look for ways to decrease emergency room use through a range of

interventions that include better care coordination, after-hours care, partnerships with first responders and community mental health centers, and co-location of patient navigators in the emergency room.

To assess member satisfaction, the Department administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member satisfaction survey to parents of child Medicaid members. By most measures, program enrollees are satisfied with the care they are receiving through the program. Accountable Care Collaborative members are also as satisfied or more satisfied than Medicaid members not participating in the Accountable Care Collaborative.

Practice Support

The Accountable Care Collaborative has grown from one contracted practice in 2011 to 670 contracted primary care practices across the state. RCCOs support PCMPs so they can provide additional services to their patients, improve the delivery efficiency of their practices, grow as patient-centered medical homes, and fully participate in reform initiatives.

In FY 2015–16, the Accountable Care Collaborative supported its practices in a number of ways. The Department and RCCOs incentivized practices to become enhanced Primary Care Medical Providers (ePCMP) that meet five of the nine criteria for patient-centered medical homes. Over 300 practices have met the criteria. The Accountable Care Collaborative has provided practice coaching and financial support to incentivize PCMP participation in the State Innovation Model (SIM) initiative, focused on integrating physical and behavioral health care. Finally, the program has given PCMPs better access to specialist colleagues through programs such as eConsult and the Chronic Pain Disease Management Program (Project ECHO).

Looking Forward

Over the last five years, the Accountable Care Collaborative has shown progress in creating a health care delivery program that improves health, better manages care, and is a smarter use of resources. However, the program must continue to move toward more coordinated and integrated care that increasingly rewards improved health. In service of this goal, the Department is evolving the design of the program. In July 2018, contracts will go into

effect for seven Regional Accountable Entities (RAEs), one serving each of the seven regions. Each RAE will perform as a single administrative organization for behavioral health and physical health. These organizations will take the place of the RCCOs and Behavioral Health Organizations. Moving forward, enrollment into the program will no longer be optional and all Medicaid members will be assigned a RAE. For more information about the next iteration of the Accountable Care Collaborative, visit Colorado.gov/HCPF/ACCPhase2.

The Accountable Care Collaborative was designed with a long-term vision in mind and the understanding that delivery system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate to improve member outcomes and reduce health care costs and is well poised to continue to do so in the future.

1. Introduction

1.1 Program Overview

The Accountable Care Collaborative is the core of Health First Colorado, Colorado's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people.

The Accountable Care Collaborative works on the principle that coordinated care, with needed community supports, is the best, most efficient way to deliver care, especially to those with the complicated health needs many Medicaid members have due to disability or challenging life circumstances.

Over the last five years, the Accountable Care Collaborative has encouraged and rewarded coordinated and better managed care, resulting in a more efficient and effective system that drives improved health for members. Providers are given supports and resources by regional organizations to provide services to their patients that they would not otherwise be able to provide. Those services are linked directly to improved health outcomes.

The program also gives providers essential data to understand how their patients are doing and what they can do to improve health outcomes for them. The regional entities help providers to manage, understand and use these metrics. Data helps the program and its providers identify ways to improve health so they can intervene early. For example, the program has lowered the number of emergency room visits by getting those members supports that helped them better manage their health before they were in crisis.

Using resources efficiently and effectively is a primary goal of the program, so it is designed to help providers get their patients the care they need in the right place at the right time, and identify patterns that drive cost but do not improve health. The program continually monitors for waste and abuse by using data analysis and other predictive tools.

The four primary goals of the Accountable Care Collaborative program are:

- Ensure access to a focal point of care or medical home for all members
- Coordinate medical and non-medical care and services
- Improve member and provider experiences in the Colorado Medicaid system
- Provide the necessary data to support these goals, analyze progress, and move the program forward

The Accountable Care Collaborative program has three core components:

- Seven Regional Care Collaborative Organizations (RCCOs), each accountable for the program in a different part of the state
- Primary Care Medical Providers (PCMPs), who function as medical homes for members
- The Statewide Data Analytics Contractor, which provides the Department, RCCOs and PCMPs with actionable data for individual members and the population as a whole

Regional Care Collaborative Organizations

The purpose of the RCCOs is to meet health and financial outcome targets in their region while ensuring appropriate care coordination and that members have a medical home. RCCOs work at the local level to support program members and providers. The RCCOs have the following responsibilities:

- **Medical management and care coordination**: ensuring that every member 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, member 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

One of the program'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 and coordinated care for a positive member experience and better health outcomes. PCMPs are responsible for ensuring timely access to primary care for members, but may provide care coordination directly, or work with RCCOs to give the best possible support to members.

The following are PCMP responsibilities:

- **Medical home**: be the focal point of care for members
- **Primary care**: provide the majority of their members' primary and preventive care
- **Connection to community and social 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 for individual members and the population as a whole. Population-level data is used to evaluate and improve the performance of RCCOs, PCMPs and the program overall. Member-level data is used to support care management and coordination activities, and can help RCCOs and PCMPs identify members with complex medical needs. Data is provided via an online portal with secure access monitored by the RCCOs and the Department.

The SDAC tracks several performance metrics so RCCOs, PCMPs and the Department are held accountable for meeting program goals. Some of these measures are Key Performance Indicators (KPIs), which are used to determine performance payments for RCCOs and PCMPs. The Department changes the KPIs as the priorities and needs of the program evolve.

The SDAC also tracks performance measures that are not tied to payment but allow the RCCOs, PCMPs, and the Department to monitor performance. The SDAC originally used only Medicaid paid claims data, but in an effort to improve the care coordination services for members, the SDAC has added Medicare paid claims. Additionally, RCCOs receive hospital admission, discharge, and transfer data collected by the Colorado Regional Health Information Organization (CORHIO) network.

1.2 In This Report

This report includes updates on the following:

- Accountable Care Collaborative Enrollment
- Financial Performance
- Program Performance
- Practice Support
- Looking Forward

With the exception of enrollment data, this report does not include an update on the Accountable Care Collaborative: Rocky Mountain Health Plans Prime, a payment reform initiative within the Accountable Care Collaborative. It launched in September 2014 serving six counties in Western Colorado: Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco. This initiative was developed under the Accountable Care Collaborative Payment Reform Initiative and codified at section 25.5-5-415, C.R.S; its progress will be addressed in a separate legislative report.

2. Accountable Care Collaborative Enrollment

This section provides data on the number of member enrolled and describes the process for enrolling Medicaid members into the Accountable Care Collaborative. It is divided into three subsections, as follows:

2.1 Enrollment Numbers – note that Rocky Mountain Health Plans Prime members are included

2.2 How Members are Enrolled in the Accountable Care Collaborative Program and Into a Regional Care Collaborative Organization (RCCO)

2.3 How Members are Attributed to a Primary Care Provider (PCMP)

2.1. Enrollment Numbers

In FY 2015–16, enrollment in the Accountable Care Collaborative continued to rise and surpassed 1 million members for the first time. As of June 2016, **1,025,176** Medicaid members were enrolled, which is nearly 80 percent of all Medicaid members. This number represents all members, including the Accountable Care Collaborative: Medicare-Medicaid Program, and Accountable Care Collaborative: Rocky Mountain Health Plans Prime program members.

Figure 1 shows the growth in enrollment since FY 2011–12, the first full year of the program.

Figure 1: Accountable Care Collaborative Enrollment and Medicaid Caseload from FY 2011–12 to FY 2015–16

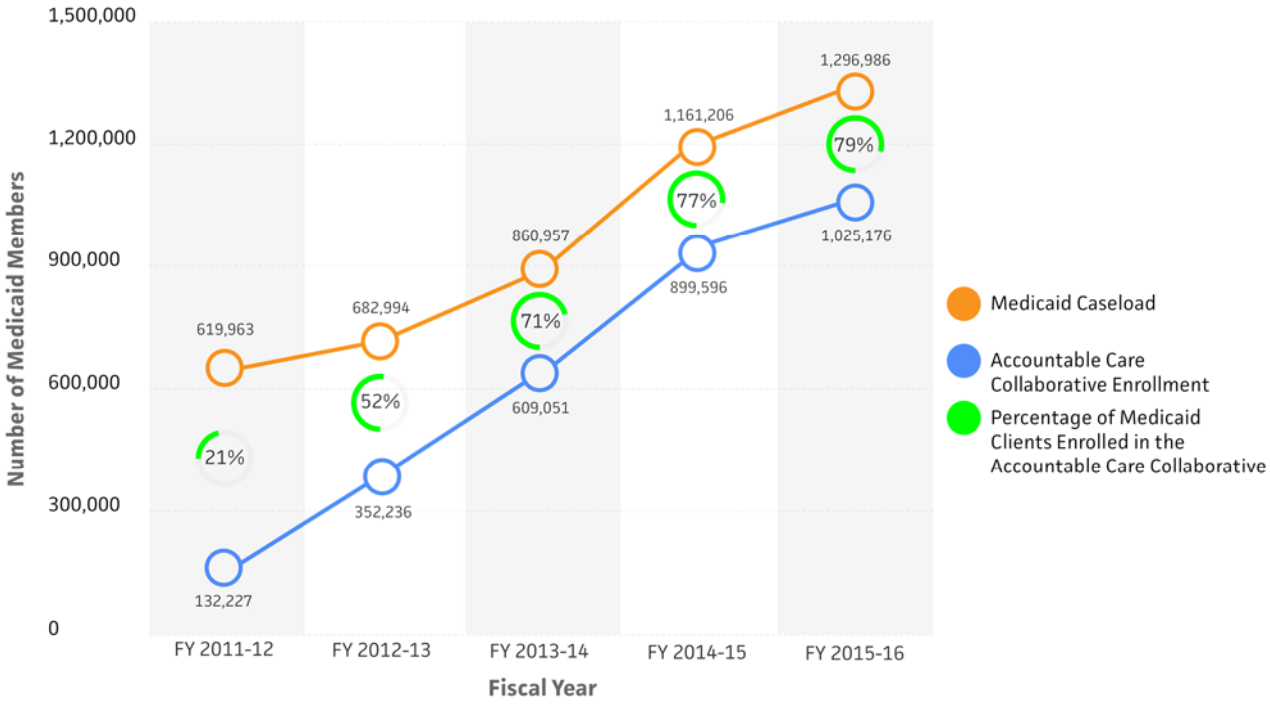
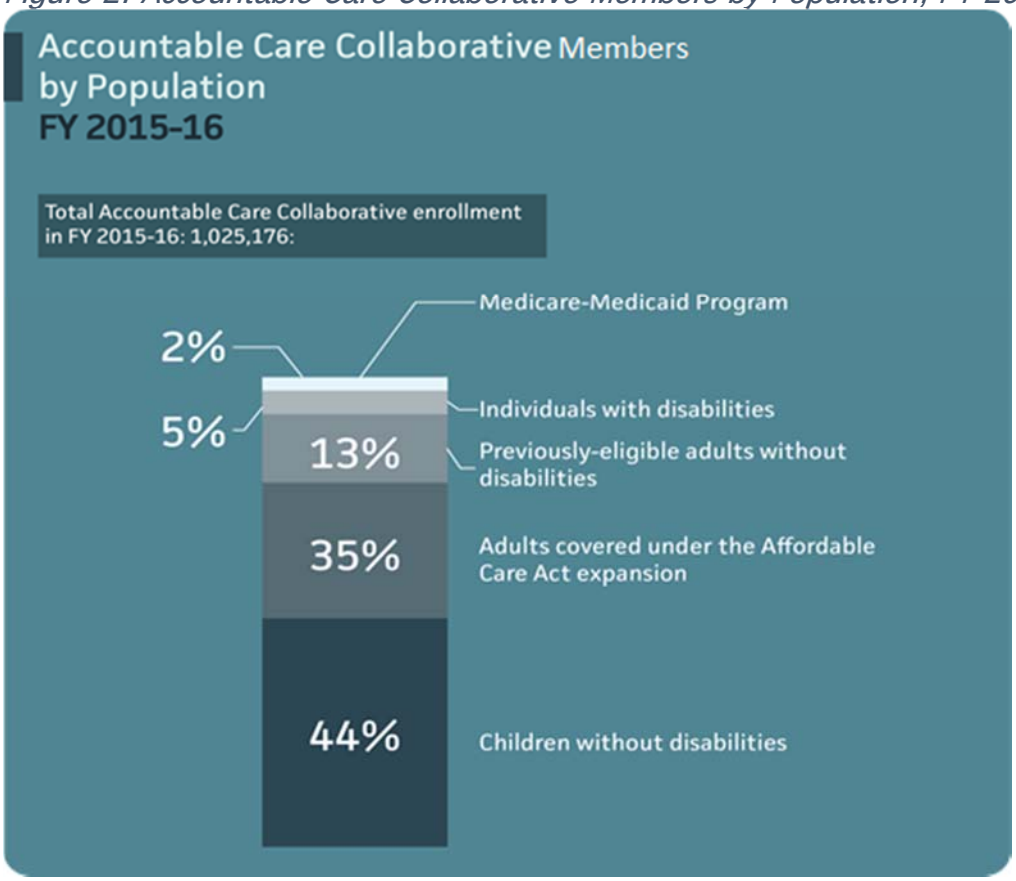


Table 1 shows the enrollment for FY 2015–16 by population. Figure 2 shows the percentage of total program enrollment each population represents.

Table 1: Accountable Care Collaborative Enrollment by Population

Population	Number of Accountable Care Collaborative Members
Children without disabilities	451,476
Adults (without disabilities) covered under the Affordable Care Act expansion	362,363
Adults (without disabilities) eligible before the Affordable Care Act expansion	131,339
Children and adults with a disability	54,422
Medicare-Medicaid Program members	25,576
TOTAL	**1,025,176**

Figure 2: Accountable Care Collaborative Members by Population, FY 2015–16



Note: Numbers do not add to 100 percent due to rounding.

2.2. How Members Are Enrolled Into the Accountable Care Collaborative Program and Into a Regional Care Collaborative Organization

Participation in the Accountable Care Collaborative is optional. The Department enrolls all new Medicaid members who are eligible to participate in the program[1], giving members the ability to opt out within 120 days of their initial notice of enrollment (30 days before enrollment and 90 days after the effective date of enrollment). This process is called *passive enrollment*. After the completion of the 120-day period, most Accountable Care Collaborative members may opt out only during their annual enrollment period. Accountable Care Collaborative: Medicare-Medicaid Program members may opt out of the

[1] All individuals who receive full Medicaid benefits are passively enrolled into the Accountable Care Collaborative, except for those who are or were recently in a nursing home and those already enrolled in another managed care program.

program at any time for any reason. Only 4.6 percent of those passively enrolled in the program choose to opt out.

At the time of enrollment into the Accountable Care Collaborative, all members are enrolled into a RCCO. Enrollment to the RCCO is done by geography; a member who lives in the RCCO's region is enrolled to that RCCO.

2.3. How Members Are Attributed to a Primary Care Medical Provider

One of the program's goals is to link every member to a PCMP that serves as the member's central point of care, a process called *attribution*. The PCMP functions as a medical home, a model that promotes comprehensive and coordinated care for a positive member experience and better health outcomes.

Upon enrollment in the Accountable Care Collaborative, the Department tries to attribute members to a PCMP through the following process:

1. Members are attributed to a PCMP they have recently seen based on claims history within the previous 12 months.
2. Members who do not have a claims history with a PCMP will be attributed to a PCMP that someone in their family has recently seen based on claims history within the previous 12 months.

Sometimes there is no claims history to show a relationship with a primary care provider, either for the member or any family members. These members are at risk of going without a PCMP for a long time. To reduce this risk, the Department checks every month to see if unattributed members or their family members have any new claims that show a relationship with a primary care provider. If so, the member is attributed to that PCMP. The member is notified by mail when they are attributed to a PCMP.

Members may select or change their PCMP at any time. Member choice always takes priority over system assignment based on claims history.

More than three-quarters (77 percent) of members had a PCMP in FY 2015–16.

3. Financial Performance

The Accountable Care Collaborative operates as a Primary Care Case Management program in which medical services are paid fee-for-service (payment for each medical service delivered), and PCMPs and RCCOs also have financial incentives to provide high-value care.

These financial incentives and the structures that support them are the program's administrative costs. The Department invests in these costs to realize savings in medical costs as well as better health outcomes. In FY 2015–16, Department analysis again suggests that the Accountable Care Collaborative avoided medical costs in excess of program administrative costs, resulting in overall cost savings.

This section is divided into four subsections, as follows:

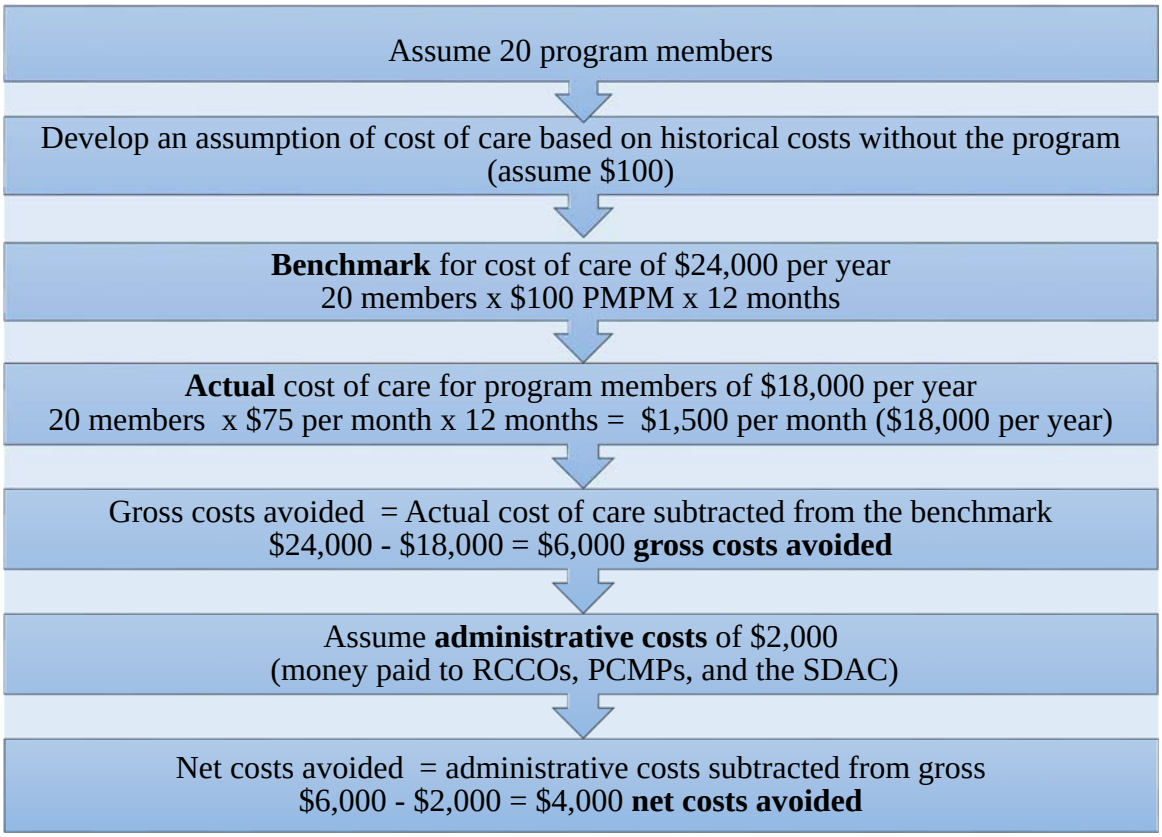
3.1 Methodology – how the Department calculates costs and cost savings
3.2 Program Costs – the administrative costs of the program
3.3 Program Costs Avoided – an estimate of medical cost savings
3.4 Financial Performance by Population – a breakdown of savings by Accountable Care Collaborative populations

3.1. Methodology for Calculating Cost Savings

The results in this report are the Department's best estimate of the impact of the Accountable Care Collaborative given several significant constraints. Because the vast majority of Medicaid members are enrolled in the Accountable Care Collaborative, the Department cannot compare the costs for members enrolled in the program to the costs for members not enrolled. To estimate cost savings, the Department looks at what the medical costs for program enrollees likely would have been if they had not participated in the program and had simply received traditional fee-for-service Medicaid. The Department then compares the actual costs for program enrollees to this hypothetical benchmark. This method, the *counterfactual method*, is widely used and accepted throughout the health care industry to estimate the effect of care management programs on the total cost of care. However, this analysis requires assumptions to create the benchmark, and the more time that elapses from the original program implementation year, the greater the reliance on assumptions to estimate the fiscal impact.

Additionally, this methodology cannot distinguish between results due to the program's interventions and those that have other causes. It is not possible to adjust for all external influences on the results. For example, a bad year for flu or another epidemic could drive up emergency room utilization and related additional costs. These costs are reflected in the analysis even though the costs would have occurred with or without the Accountable Care Collaborative. This could make the program savings seem artificially low. The opposite case – artificially high savings – could occur as well.

Figure 3: Example of How Avoided Costs Are Calculated for the Accountable Care Collaborative



Note that this method for estimating costs savings is retrospective – it looks back at actual costs and compares them to a model of what care would have cost without the program. Therefore, these cost avoidance estimates will differ from those detailed in Budget Requests, which project future program costs and savings. Appendix A has additional information about the methodology for calculating cost savings.

Due to data limitations related to Medicare costs, it was not possible to observe or estimate costs for the Accountable Care Collaborative: Medicare-Medicaid Program population. Therefore, they are excluded from this financial analysis.

Individuals enrolled in Accountable Care Collaborative: Rocky Mountain Health Care Prime are also excluded because that analysis will be included in a separate report to the legislature.

3.2. Program Costs

For FY 2015–16, total administrative costs for the Accountable Care Collaborative were **$143,232,862.** This amount covers payments made to the RCCOs, the PCMPs, and the SDAC.

Regional Care Collaborative Organization Payments

In FY 2015–16, RCCOs were paid a total of **$107,141,443**, which represents **75% of total program administrative costs**. These funds served several different purposes, as follows:

1. **Per Member Per Month (PMPM) Payment:** RCCOs receive a PMPM payment for ensuring care coordination, provider support, network development, and reporting responsibilities. In FY 2015–16, RCCOs were paid $96,676,175 in PMPM payments. Because member attribution to a PCMP is so important to the success of the program, the Department reduces a RCCO's PMPM amount by 35% for any member who had been unattributed to a PCMP for six months or longer.
2. **Payment for Key Performance Indicators (KPIs):** RCCOs receive payments for meeting KPI targets, which are described further in the Program Performance section of this report. In FY 2015–16, RCCOs were paid a total of $3,954,202 paid for performance on KPIs.
3. **Pay-for-Performance Pool:** The Pay-for Performance Pool is created with $0.50 of each RCCO's PMPM and dollars withheld for individuals not attributed to a PCMP for six months or longer. This pool of funds is used as incentive payments for the RCCO or its PCMPs. In FY 2015–16, the Department distributed $6,511,066 of these funds to the RCCOs to incentivize PCMPs to participate in the State Innovation Model (SIM) for physical and behavioral health integration, and to reward RCCOs for performance on follow-up care within 30 days of a hospital discharge.[2]

Primary Care Medical Provider Payments

During FY 2015-16, PCMPs were paid a total of **$32,715,894**, representing **23%** of all Accountable Care Collaborative administrative costs. The breakdown of these funds is as follows:

[2] The pay-for-performance pool dollars will be paid out in FY 2016–17 but because the withhold from the administrative costs occurred during FY 2015–16 they have been included as part of the administrative dollars for the fiscal year covered by this report.

1. PCMPs receive PMPM payments for providing medical home services to members. In FY 2015–16, PCMPs were paid **$26,180,007** in PMPM payments.
2. Like the RCCOs, PCMPs are eligible to receive incentive payments for meeting KPI performance targets. In FY 2015–16, PCMPs received a total of **$2,964,907** for meeting these targets.
3. PCMPs can receive an additional payment for meeting the factors for becoming an enhanced Primary Care Medical Provider (ePCMP), such as co-locating physical and behavioral health providers or offering care after hours. (See Section 5.1 for more detail). Providers that met at least five of nine of the enhanced factors in FY 2015–16 received the payment, which totaled **$3,570,980**.[3]

State Data and Analytics Contractor Payments

The SDAC provides timely, actionable data to the RCCOs, PCMPs and the Department. For FY 2015–16, the SDAC was paid the contracted rate of **$3,375,525,** which represents **2%** of the total administrative costs for the Accountable Care Collaborative.

3.3. Program Costs Avoided

In FY 2015–16, the Department estimates that the savings from avoided medical costs for enrolled members exceeded the program's administrative costs. In FY 2015–16, the Accountable Care Collaborative avoided **$205,116,542** in medical costs. After accounting for administrative expenses, the net costs avoided totaled **$61,883,680**.

The services provided by RCCOs, PCMPs, and the SDAC work together to lower per capita medical costs for enrolled Medicaid members. Coordinated primary care is less expensive than episodic or emergency treatment of medical conditions. With a focus on coordination and education, the ACC shifts costs from inefficient and expensive periodic treatment to whole-person centered approaches to health care and health outcomes. The result is costs avoided.

[3] The enhanced PCMP dollars were paid out in FY 2016–17 but because the withhold from the administrative costs occurred during FY 2015–16 they have been included as part of the administrative dollars for the fiscal year covered by this report.

3.4. Financial Performance Across Populations

While the overall financial performance of the program is important, it is helpful to understand the program's fiscal performance by population. In FY 2015–16, program costs were less than expected for expansion adults and members with disabilities, while program costs were higher than expected for previously eligible adults and children.[4]

Financial Performance: Members with Disabilities

In FY 2015–16, the Accountable Care Collaborative achieved gross costs avoided of **$134,027,494** for members with disabilities in the program. Administrative costs for members with disabilities were **$7,707,725**. The result is net costs avoided of **$126,319,769** for this population.

Individuals with disabilities require more frequent, consistent, and complex care than 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 have multiple chronic conditions. The program works to mitigate these issues by coordinating care among primary care providers and specialists, connecting members to community partners for non-medical services, and fostering communication among agencies and providers that serve to this population. The result is greater access to timely, appropriate care, reducing the need for costly urgent care, emergency treatment and hospitalizations.

Financial Performance: Expansion Adults

In FY 2015–16, the program avoided **$131,157,637** in gross costs for adults that became eligible for Medicaid after the Affordable Care Act expansion. Administrative costs for these adults were **$37,414,646**. Therefore, the program avoided **$93,742,991** in net costs for this population.

Financial Performance: Previously Eligible Adults

In FY 2015–16, the program spent **$69,771,146** more in gross costs for previously eligible adults. Administrative costs for previously eligible adults were **$20,190,399**. Therefore, the program did not avoid costs for this population; rather, there was a total cost of **$89,961,546**.

[4] Incentive payments were not divided among the different subpopulations and were not included in each subpopulation's gross costs. As a result, the sum of the subpopulations' avoided costs will be higher than the total costs avoided for the program as a whole.

Several factors may be driving this result. First, the Department uses a risk adjustment factor for each population to more easily compare the actual population to a benchmark. The risk adjustment factor is based on how likely the population is to stay well or become sick. But the Accountable Care Collaborative itself improves the health outcomes of members over the years – something the risk adjustment does not account for. Therefore, the risk adjustment likely causes an underestimate of program savings. Because previously eligible adults have been in the program for longer than expansion adults, they are already less likely to need and use expensive health care services.

Second, this population actually had a lower monthly cost in FY 2015–16 than it did in FY 2014–15, with notable decreases in hospital costs, an area of expected positive impact for the Accountable Care Collaborative. This suggests that the program achieved some savings that are not captured in the model.

Finally, although the monthly cost for this population decreased on the whole, the population had greater utilization and costs for long-term services and supports. The population of previously eligible adults includes not only parents of Medicaid-eligible children but also older adults. Therefore, it is likely that the results are reflecting the effect of an aging population and increased use of long term services and supports. This phenomenon is independent of the program's impact. Therefore, the cost avoidance model is likely understating the savings generated by the program, and is instead reflecting external cost drivers that are difficult to adjust for.

Financial Performance: Children Without Disabilities

In FY 2015–16, the program avoided **$9,702,559** in gross costs for children without disabilities. Administrative costs for this population were **$57,543,412**. Therefore, the program did not avoid costs for this population; rather, there were net costs of **$47,840,853** for this population.

Children do not tend to show savings because, although the RCCO is paid the same monthly payment for this population as for other members, most children are healthy and do not need intensive care coordination and other support services. For children who do have health problems, the Accountable Care Collaborative is a worthwhile investment because children in the program have their conditions addressed, helping them to stay healthy longer and resulting in long-term cost containment. For example, if conditions such as asthma, behavioral health, and diabetes 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 costs avoided but, more importantly, to better health 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 program.

4. Program Performance

During FY 2015–16, the Accountable Care Collaborative program increased the utilization of many recommended services that can improve health and lower costs, decreased the utilization of some higher-cost services, and maintained member satisfaction. This section describes the performance of the program, and is divided into the following four subsections:

4.1 Methodology for Evaluating Program Performance
4.2 Utilization of Lower Cost Outpatient Services and Wellness and Preventive Services
4.3 Utilization of Higher Cost Services and Emergency Room Services
4.4 Member Satisfaction

4.1. Methodology for Evaluating Program Performance

Populations Included in the Analyses

This report includes data for both the Accountable Care Collaborative population and the Accountable Care Collaborative: Medicare-Medicaid Program population. Note that as used in this section, the term "Accountable Care Collaborative population" refers to the population not enrolled in the Accountable Care Collaborative: Medicare-Medicaid Program.

Members excluded are those enrolled in a managed care plan for more than three months of the reporting period, and those eligible for Medicaid for less than three months of the reporting period.

Accountable Care Collaborative: Rocky Mountain Health Plan Prime members are also excluded from the analyses in this report. Accountable Care Collaborative: Rocky Mountain Health Plan Prime program performance will be reported in a separate report to the legislature.

Comparison Groups

To assess the impact of participation in the Accountable Care Collaborative, the Department measured program performance for members who had been in the program for 0–6 months and members who had been in the program 7–11 months of the year.

When the program is making an impact, members who have been in the program longer should show better utilization than those who have been in the program for less time. It is not feasible to compare Medicaid members who are in the program with those who are not, because the majority of Medicaid members are enrolled in the Accountable Care Collaborative.

Measures Tracked and Reported

This report includes 11 months of FY 2015–16 claims data (July 2015–May 2016) for the Accountable Care Collaborative population (defined as those not enrolled in the Accountable Care Collaborative: Medicare-Medicaid Program) and the Accountable Care Collaborative: Medicare-Medicaid Program population. Although they share many of the same measures, the results for the two populations are reported separately. In some cases, measures were tracked for both populations but the Accountable Care Collaborative: Medicare-Medicaid Program population did not have enough data to report (for example, prenatal care). Some of the measures are Key Performance Indictors (KPIs) or pay-for-performance measures.

Table 2: Measures Tracked and Reported

Measure	Key Performance Indicator?
Measures Reported for Both the Accountable Care Collaborative Population and Accountable Care Collaborative: Medicare-Medicaid Populations	
Follow-up care within 30 days of hospital discharge	No
Depression screening	Yes, for Medicare-Medicaid population
Emergency room visits	Yes, for Accountable Care Collaborative population
All-cause 30-day readmission to the hospital	Yes, for Medicare-Medicaid population
High-cost imaging	No
Measures Reported for Accountable Care Collaborative Population Only	
Well-child visits among children ages 3–9	Yes, for Accountable Care Collaborative population
Postpartum care	Yes, for Accountable Care Collaborative population
Prenatal care	No
Chlamydia screening	No
Measures Reported for Accountable Care Collaborative: Medicare-Medicaid Population Only	
Potentially preventable admissions to the hospital	Yes, for Medicare-Medicaid population

Reporting Period

Claims data for the first eleven months of FY 2015–16 (July 2015–May 2016) were used to report on the performance indicators in this section. Claims data for June 2016 were not available at the time of report submission. In each graph that shows the results, "Months Enrolled in the Program" refers to the number of months members were enrolled during the reporting period (July 2015–May 2016).

Methodology Limitations

While the method used here is the preferred method for measuring the performance of the Accountable Care Collaborative, the analysis has some limitations. Some of the services are annual services (for example, well-child visits), and members who are enrolled for less than six months may not have had a chance, nor were they scheduled, to get their annual

services yet. An increase in services like these after six months may indicate that the program intervention was successful, or may simply indicate that the member had those services scheduled later in the year. Additionally, newly eligible members who are pregnant have more frequent visits later in pregnancy, so the increase in utilization may be due to that timing rather than to the influence of the program.

However, this limitation does not affect many of the indicators, such as emergency room use or 30-day follow-up care after hospital discharge, because they are not tied to a schedule.

4.2. Utilization of Lower Cost Outpatient Services and Wellness and Preventive Services

For this set of indicators, it is desirable for the population to increase its use of these services, because they help to prevent poor health outcomes and are lower-cost services. Data from FY 2015–16 suggest that individuals who spent more time in the Accountable Care Collaborative program received recommended health services more often. Except where indicated, the measure is reported for both the Accountable Care Collaborative population and the Accountable Care Collaborative: Medicare-Medicaid population.

Follow-Up Care Within 30 Days of a Hospital Discharge

This measure tracks the percent of members who received a follow-up visit with a physician within 30 days of an inpatient hospital discharge. Members readmitted within 30 days were excluded from this measure; readmission is measured separately. Also excluded were members transferred to a skilled nursing facility and certain types of health care facilities including hospice, those who transferred to law enforcement and those who died.

A follow-up visit with a primary care provider is an opportunity to address the conditions that led to hospitalization, and to prepare the member and caregiver for home self-care activities. Members who do not see a provider within 30 days of a hospital discharge are at high-risk for hospital readmission.[5] Figure 4 shows that members of the Accountable Care Collaborative population who were in the program for 7–11 months had a slightly higher rate of 30-day follow up visits (43.8 percent compared to 48.3 percent of those in the program for fewer months of the year). Figure 5 shows that for the Accountable Care Collaborative: Medicare-Medicaid population, the rate of follow-up care rose from 48.8 percent to 62.9 percent for those who were in the program for 7–11 months of the reporting period.

[5] http://www.nihcr.org/Reducing_Readmissions.html

Figure 4: Follow-up Care within 30 Days of Hospital Discharge for Accountable Care Collaborative Population Members, Per 1,000 Members Per Year, by Time Enrolled

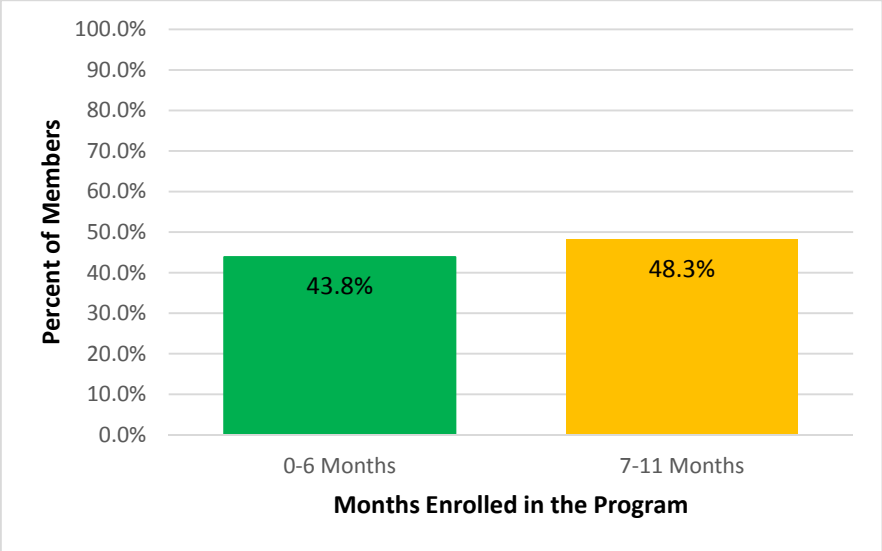
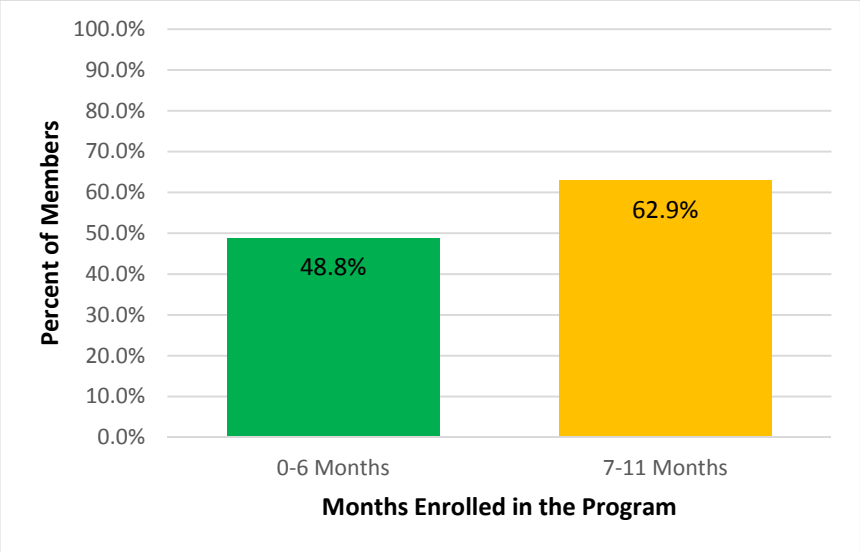


Figure 5: Follow-up Care within 30 Days of Hospital Discharge for Medicare-Medicaid Program Members, Per 1,000 Members Per Year, by Time Enrolled



The SDAC works to give the RCCOs timely data about hospital admission, discharge, and transfer data collected by the Colorado Regional Health Information Organization (CORHIO) network. This is helping RCCOs reach out to ensure timely follow-up care after hospital discharge.

The RCCOs are taking several approaches to ensuring follow-up care after hospital discharge for all members. As an example, Integrated Community Health Partners is working with the Pueblo Transition of Care Consortium to streamline the transition from hospital to community and avoid duplication of transition services. Community Care of Central Colorado partners with the Colorado Springs Fire Department to identify members in need of follow up and at risk for readmission through the Community Assistance Referral Education Services (CARES) program. The program provides them with home visiting and education about community resources to prevent readmission to the hospital after discharge. This RCCO also partners with community organizations on programs for its homeless members and those with chronic diseases, to help members follow through on their care plans after discharge. Colorado Access addresses this need by working with community-based care teams that reach out to Accountable Care Collaborative: Medicaid-Medicare Program members who have a pattern of high hospital utilization. These teams ensure a smooth care transition and provide care management to prevent readmission.

Depression Screening (KPI for Medicare-Medicaid Program)

Physical and behavioral health integration can take many forms. One important step is to integrate screening for the most common behavioral health risks, such as depression, into routine primary care.

Of Accountable Care Collaborative population members enrolled in the program 0–6 months, only 1.9 percent were screened for depression. For those enrolled 7–11 months, that percentage doubles but is still low at 4.0 percent. Similarly, only 1.9 percent of Medicare-Medicaid members in the program for 6 months or less were screened for depression, and 3.4 percent of those in the program for 7–11 months were screened.

Historically, depression screening has not been a widespread practice in primary care and it is a relatively new preventive screening recommendation for all adults (prior to 2016 it was recommended only when staff-assisted depression care supports were in place to assure accurate diagnosis, effective treatment, and follow-up). Because depression screening is a new service for many medical practices, documentation (coding) for the service on claims may be inconsistent or incorrect, even if the screening was done. The reported rates of screening in the program, therefore, are predictably low.

As RCCOs educate providers about the guidelines for depression screening and the proper way to code for it, the rates of depression screening should begin to increase. The RCCOs are currently working with their practices to make depression screening a routine part of

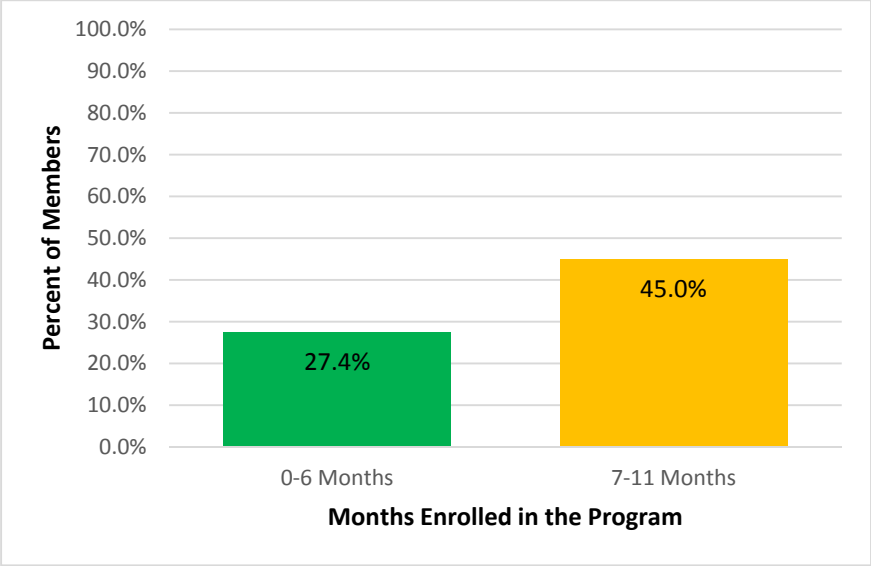
their visits with members. For example, Integrated Community Health Partners has been training its providers on depression screening and plans to focus specifically on providers for the Accountable Care Collaborative: Medicare-Medicaid Program population. Colorado Community Health Alliance does a depression screening for every Accountable Care Collaborative: Medicare-Medicaid Program member who is receiving care coordination services, and partners with mental health centers to improve the screening process and referral for treatment for all members. Community Care of Central Colorado incentivizes its PCMPs to do depression screenings at wellness checkups, postpartum visits, and new patient visits. Colorado Access partners with one of the Behavioral Health Organizations to increase adolescent depression screening and improve referrals to a behavioral health provider for those who need them.

Well-Child Visits Among Children Ages 3–9 (Accountable Care Collaborative: Medicare-Medicaid Program population not reported; KPI for Accountable Care Collaborative population)

This measure tracks the rate of annual well-child visits among children in the program ages 3–9 years. Well-child visits are an important opportunity for caretakers and health providers to communicate about essential preventive care, such as childhood vaccinations. Additionally, caretakers receive information and advice on normal development, nutrition, sleep, safety, and diseases. The Department measures the member population ages 3–9 because rates of well-child visits have been historically low for this age group.

As Figure 6 indicates, the rate of annual well-child visits is higher for children in the program for 7–11 months (45.0 percent) than for those enrolled 6 months or less (27.4 percent). This may be a result of the program's influence or the timing of annual appointments, or a combination of both.

Figure 6: Annual Well-Child Check Rate for Children Ages 3–9 for Accountable Care Collaborative Population Members, by Time Enrolled



The annual well-child visit rate for both groups is below the KPI targeted rates for two levels of incentive payments (set at 60 percent and 80 percent respectively), and the RCCOs are working on interventions to increase these rates. For example, Rocky Mountain Health Plans has developed an integrated care coordination program that helps high-risk children and families identify a primary care medical home and access their well-child benefits. Colorado Access now contacts families of children who missed their well-child visit, and has used an internal database to connect families to well-child care providers.

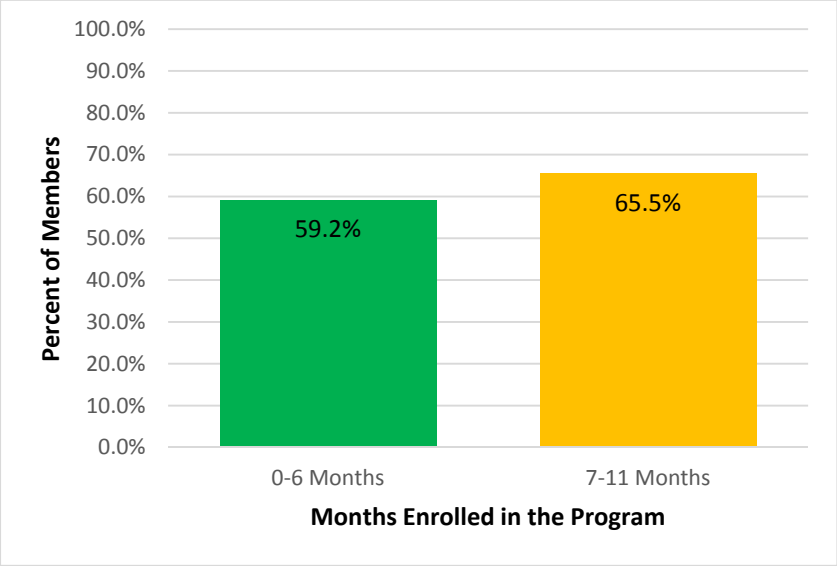
Integrated Community Health Partners has employed care coordinators at behavioral health practices to identify children in need of well-child care and to connect them to a primary care provider. Colorado Community Health Alliance has partnered with local school districts to implement an incentive program in which eligible children can receive rewards for well-child care participation. Community Care of Central Colorado has worked with the Healthy Communities program to provide timely information regarding well-child care and primary care medical home benefits to newly enrolled members.

Prenatal Care (Accountable Care Collaborative: Medicare-Medicaid population not reported)

For this measure, the program tracks the percent of women who received at least one prenatal care visit prior to their delivery. During these visits, women learn about important steps they can take to keep themselves and their baby healthy during pregnancy. Babies

born to mothers who do not get prenatal care are more likely to be born prematurely,[6] three times more likely to have a low birth weight, and five times more likely to die than those born to mothers who receive prenatal care.[7] For pregnant women in the Accountable Care Collaborative population enrolled for 7–11 months, 65.5 percent received prenatal care, compared to 59.2 percent of those in the program for less than 6 months.

Figure 7: Prenatal Care Rate for Women in the Accountable Care Collaborative Population, by Time Enrolled



Prenatal care must take place in a relatively short window of time. Historically, it has been challenging for the RCCOs to identify pregnant women because there is a delay between the date a woman sees a provider and when the RCCO receives the claims data that indicate a woman is pregnant. To help RCCOs reach pregnant women sooner, the Department now provides to the RCCOs a list of members who have notified Medicaid of their pregnancy, because pregnancy changes the member's eligibility category. The eligibility data is often available before the claims data is, and RCCOs can use this information to reach out to pregnant women.

For example, Colorado Community Health Alliance uses this information to connect women with necessary medical and social services during and after their pregnancy. This RCCO also has practice coaches to help the practices establish systems for setting up both prenatal and postpartum visits. Integrated Community Health Partners reaches out to

[6] http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/20120221FactsareImportant.pdf?la=en
[7] http://womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html

pregnant women who do not have a PCMP to ensure they get necessary prenatal care. Rocky Mountain Health Plans uses the B4 Babies program, which helps expecting parents get connected to the care they need before, during and after birth. This program helps with the administrative aspects of finding a doctor and making an appointment, and supports both mothers and fathers in giving their baby a good start.

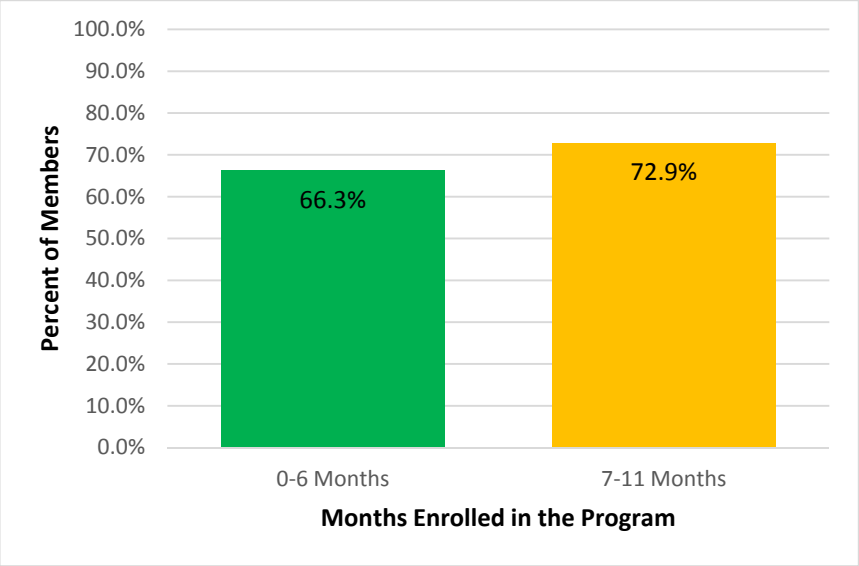
Postpartum Care (Accountable Care Collaborative: Medicare-Medicaid Program population not reported; KPI for Accountable Care Collaborative population)

This KPI measures the percentage of women who received an outpatient postpartum exam in the 90 days following a live birth. Postpartum care visits are recommended by both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. A postpartum exam provides an important opportunity for checking the physical and mental health of new mothers and counseling her on infant care and family planning. These visits are also an opportunity to detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or obesity.[8] As Figure 8 demonstrates, the rate of appropriate postpartum care is slightly higher for women enrolled in the program for 7–11 months (72.9 percent) compared to those enrolled for 6 months or less (66.3 percent).

The RCCOs recognize this as an area for growth and are working together with the Department on interventions to improve performance. As mentioned above, Colorado Community Health Alliance has implemented a maternity care coordination program that helps eligible women connect with necessary medical and social services during and after their pregnancy. Colorado Access is working closely with Denver Health and Hospitals to ensure that post-partum visits take place and that practices correctly and consistently document (code) post-partum visits as well. Rocky Mountain Health Plans' B4 Baby program ensures that its participants receive needed post-partum care, including screening and treatment for post-partum depression.

[8] Chu, SY, et al. Postpartum Care Visits—11 States and New York City, 2004. MMWR Weekly, December 21, 2007. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a2.htm. Reviewed October 6, 2015.

Figure 8: Post-partum Care Rate for Women in the Accountable Care Collaborative Population, by Time Enrolled

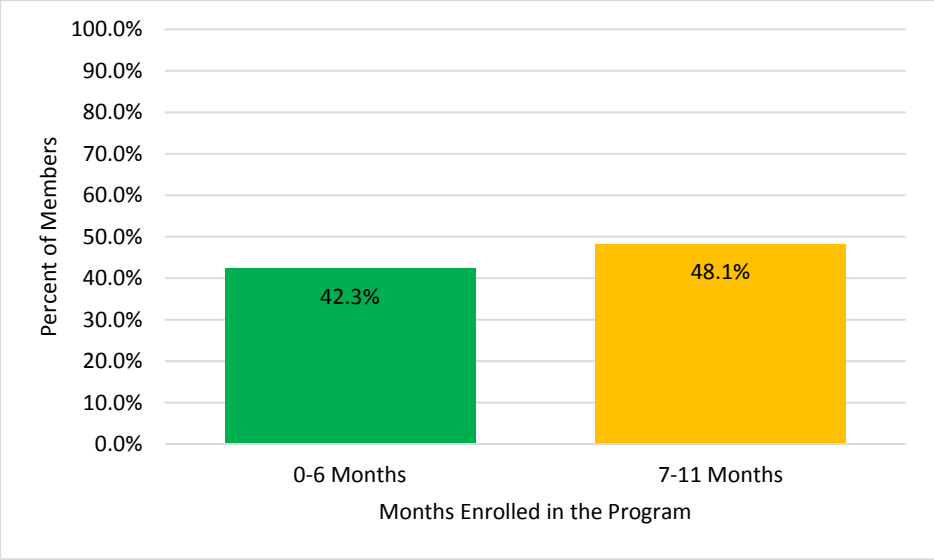


Chlamydia Screening (Accountable Care Collaborative: Medicare-Medicaid Program population not reported)

This measure tracks the percentage of women ages 16–54 who had at least one test for chlamydia during the year. Chlamydia is among the most commonly reported sexually transmitted infections in the United States, yet most people infected with chlamydia are unaware of their infection. The early detection and treatment of chlamydia is cost effective and can help prevent adverse health consequences of untreated infections, including pelvic inflammatory disease and even infertility.[9] Figure 9 shows that the rate of chlamydia screening increased slightly with the amount of time members spent in the program, from 42.3 to 48.1 percent.

[9] http://www.ncqa.org/Portals/0/Publications/Resource%20Library/Improving_Chlamydia_Screening_08.pdf

Figure 9: Chlamydia Screening Rate for Women in the Accountable Care Collaborative Program Population, by Time Enrolled



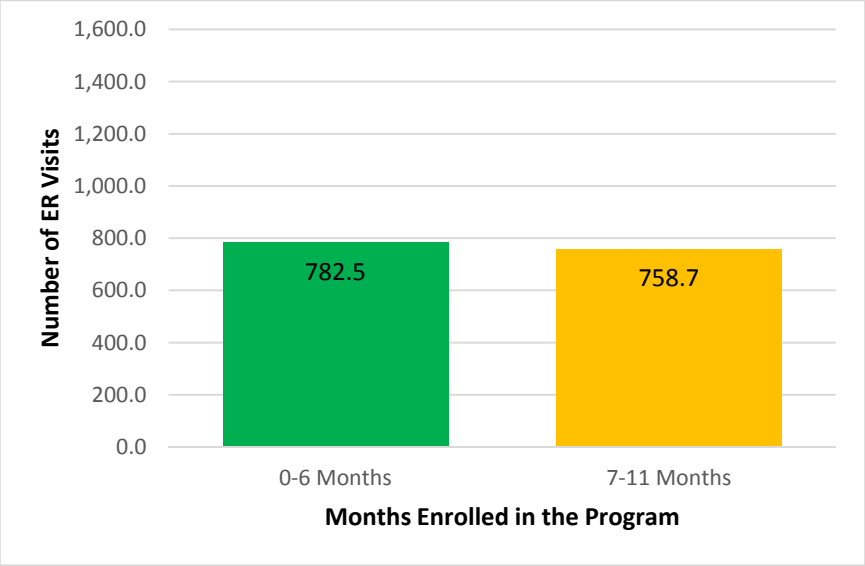
4.3. Utilization of Higher Cost Services and Emergency Room Services

For this set of indicators, it is desirable for the population to decrease its use of these services because they are costly and often not the most appropriate setting for the needed care. Data from FY 2015-16 indicated that people who spent more time in the Accountable Care Collaborative program used fewer high cost services, including emergency room visits. Except where indicated, the measure is reported for both the Accountable Care Collaborative population and the Accountable Care Collaborative: Medicare-Medicaid Program population.

Emergency Room Visits (KPI for Accountable Care Collaborative population)

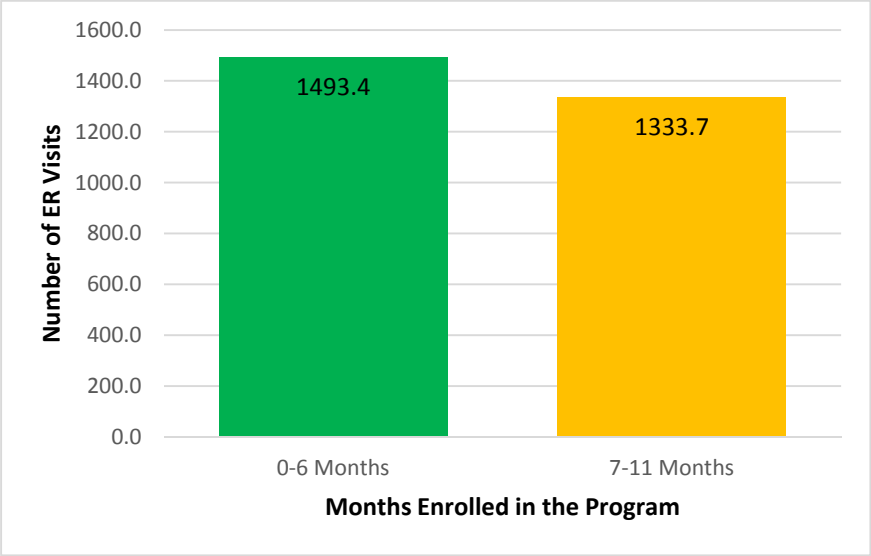
This measure looks at the number of emergency room visits on the same date of service for the same member that did not result in an inpatient admission, per thousand members per year. As Figure 10 shows, the rate of emergency room visits with no inpatient admission was about 782.5 per thousand members for Accountable Care Collaborative population members in the program 6 months or less. For those in the program longer than 6 months, the rate fell slightly to 758.7 per thousand members.

Figure 10: Emergency Room Visits Without Hospital Admission for Accountable Care Collaborative Program Members, Per 1,000 Members Per Year, by Time Enrolled



The rate of emergency room utilization is much higher for Accountable Care Collaborative: Medicare-Medicaid Program members, which is expected given the complex health needs of this population. Among Accountable Care Collaborative: Medicare-Medicaid Program members enrolled for 6 months or less, the rate of emergency room use was 1,493.4 per 1,000 members, which is an average of more than one visit per member. This rate decreased to 1,333.7 visits per 1,000 members for those in the program more than 6 months during the reporting period.

Figure 11: Emergency Room Visits Without Hospital Admission for Accountable Care Collaborative: Medicare-Medicaid Program Members, Per 1,000 Members Per Year, by Time Enrolled



The data suggest that the Accountable Care Collaborative program may be reducing emergency room use. Like Medicaid programs in other states, the Department continues to face a high rate of emergency room use and is continually looking for ways to reduce it. Visits to the emergency room are costly, and visits that do not result in an inpatient admission may be indicative of poor care coordination or inadequate access to primary care, due to transportation challenges or inadequate hours to access care. However, a number of factors contribute to emergency room use, including the increase in the number of emergency rooms and departments, more aggressive advertising by hospitals promoting their emergency rooms, and a co-pay structure that sometimes makes the emergency room a cheaper option for Medicaid members. In addition, it may be easier for members to get the care, lab work, imaging, and other services they need in an emergency room than through multiple physicians and imaging centers.[10]

The Department is addressing this challenge by using a range of solutions. Incentivizing RCCOs to connect members to a PCMP increases the chances that members will have a place to go for routine care. Practices receive an incentive for meeting additional medical home standards (including after-hours care), which may encourage members to go to their PCMP instead of visiting the emergency room.

[10] http://journals.lww.com/lww-medicalcare/toc/2015/06000

At the RCCO level, several RCCOs are working to get all members, especially the most at risk for emergency room use, connected to a PCMP. For example, Colorado Community Health Alliance and its partners are working with the corrections system to promote continuity of care for people leaving correctional facilities and connecting them to a PCMP. This RCCO is also working with community partners on the Jefferson Hot Spotting Alliance initiative, which identifies those members most at risk for using the emergency room and arranges care coordination and other services for them. Community Care of Central Colorado places patient navigators in emergency rooms to provide PCMP information to members who arrive there. Rocky Mountain Health Plans gives its members access to My Digital MD, which allows them to connect with doctors via secure text and possibly avoid a trip to the emergency room. Colorado Access is taking a slightly different approach by identifying groups most likely to respond to education about appropriate emergency room use, such as parents of young children and adults in good health, and reaching out to them.

The Department also helps RCCOs access timely information about members' emergency room use, and RCCOs use this information to inform their interventions. Rocky Mountain Health Plans uses the information to identify members who frequently use the emergency room, and has hired community health workers to help these members find appropriate services. This RCCO is also working with two safety net clinics to identify and work with high utilizers with behavioral health needs. Integrated Community Health Partners is working to identify alternative resources for its members with substance use disorder, so they will not need to use the emergency room as frequently or seek prescription medications there. Colorado Community Health Alliance's Dispatch Health Program uses a number of strategies, from a smartphone app to PCMP outreach, to direct members back to their PCMP when they use the emergency room for non-emergencies.

Colorado Access, Integrated Community Health Partners and Community Care of Central Colorado all work with first responders in their respective regions to identify members who frequently use emergency services, so the RCCO can get them the ongoing care and services they need.

30-Day All-Cause Readmissions (KPI for Accountable Care Collaborative: Medicare-Medicaid Program population)

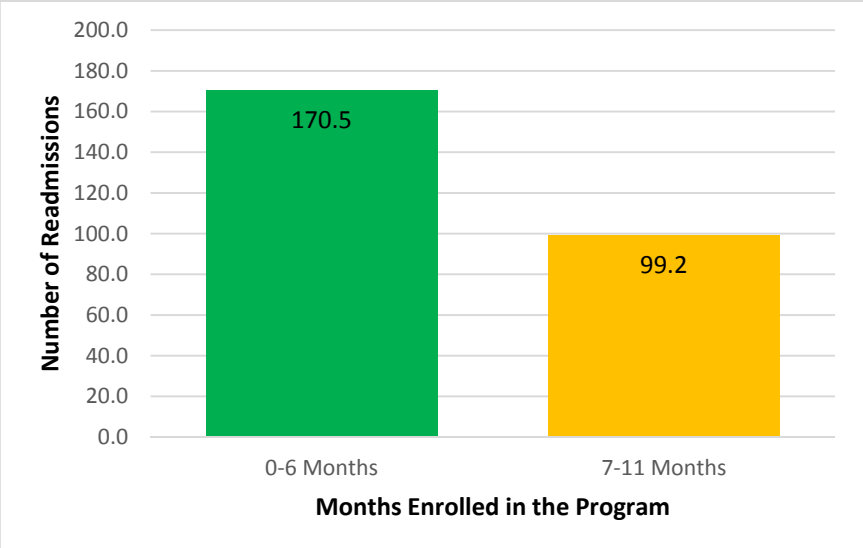
This is a measure of any inpatient admission that occurred within 30 days of discharge after a member's hospital stay. Hospital readmissions are costly and often preventable events that can expose members to unnecessary health risks. They can be caused by

complications arising from the hospital stay, poorly managed chronic diseases, a breakdown in care coordination or discharge instructions, or a lack of social supports and follow-up care as people transition from the hospital back into the community. Measuring all-cause readmissions helps to foster cooperation across the health system, with a focus on care coordination.[11]

For the Accountable Care Collaborative population, the rate of 30-day readmissions is quite low regardless of how long the member was in the program during the reporting period. There were 8.5 readmissions for every 1,000 members who were in the program 0–6 months; for members in the program 7–11 months, it was about 7 readmissions for every 1,000 members.

The rates of readmission are higher for the Accountable Care Collaborative: Medicare-Medicaid Program population, which is expected given the complex conditions often characteristic of this population. However, as Figure 12 shows, the rate of all-cause readmissions decreased from 170.5 visits per 1,000 members to 99.2 visits per 1,000 members for those who were in the program more than 6 months.

Figure 12: 30-Day All-Cause Readmissions for Accountable Care Collaborative: Medicare-Medicaid Program Members, Per 1,000 Members Per Year, by Time Enrolled



The RCCOs have implemented a number of initiatives to prevent readmission to the hospital within 30 days. Most of the RCCOs use hospital admission, discharge, and transfer data from CORHIO to reach out to members discharged from the hospital, improve care

[11] http://www.ncqa.org/portals/0/Publications/2012%20BI_NCQA%20ReAdMi%20_Pub.pdf

transitions and reduce the potential for readmission. Colorado Community Health Alliance has also placed care coordinators at local hospitals and Rocky Mountain Health Plans has used health engagement teams to improve care transitions with high-risk members. This RCCO also uses secure texting through My Digital MD to make it easy for members to ask questions and get medical advice during their transition from the hospital. Colorado Access also provides educational materials to pediatric members about proper use of the emergency room, the hospital and community resources to reduce the number of readmissions.

For the Accountable Care Collaborative: Medicare-Medicaid Program, the RCCO forges new partnerships across the wide range of providers this population relies on, such as Single Entry Points, Community Centered Boards, nursing facilities, hospitals, and long-term services and supports providers. Each RCCO coordinates the care of the Accountable Care Collaborative: Medicare-Medicaid Program members in its region, so all providers are working together without duplication to address the physical, behavioral, and social health needs of the members. This work helps to prevent hospital readmission and promotes the wise use of resources.

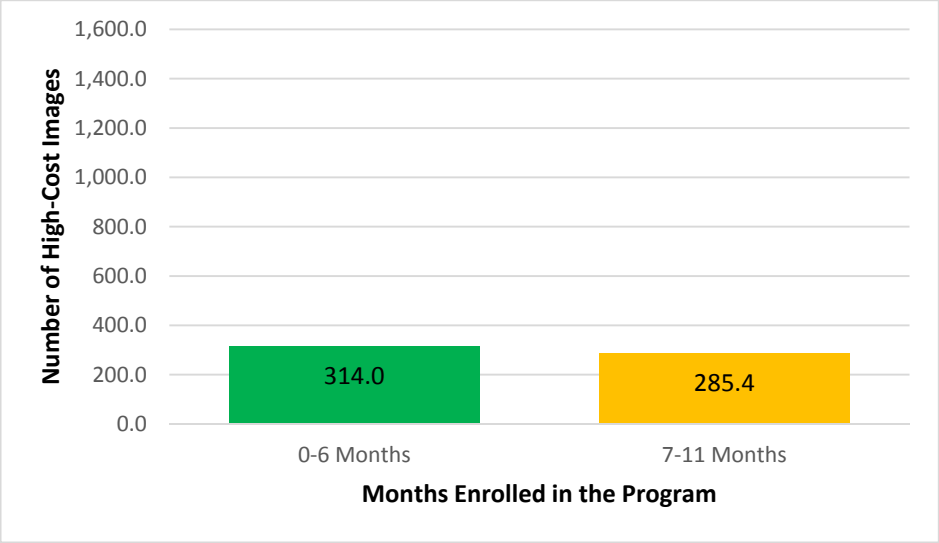
High-Cost Imaging Services

The Department measures the number of high-cost imaging services (MRIs and CT scans) received per 1,000 Accountable Care Collaborative members. While there is no way to determine whether these screenings were appropriate, the overuse of high-cost imaging in the United States is often cited as one of the potential drivers of outsized health spending.[12] Care coordination and good communication among providers reduces the likelihood that members will have a scan they do not need or have already had.

For the Accountable Care Collaborative population, the rate of utilization of high-cost imaging decreased slightly with the amount of time spent in the program, going from 314.0 per 1,000 for those enrolled 0–6 months to 285.4 per 1,000 for those enrolled for 7–11 months.

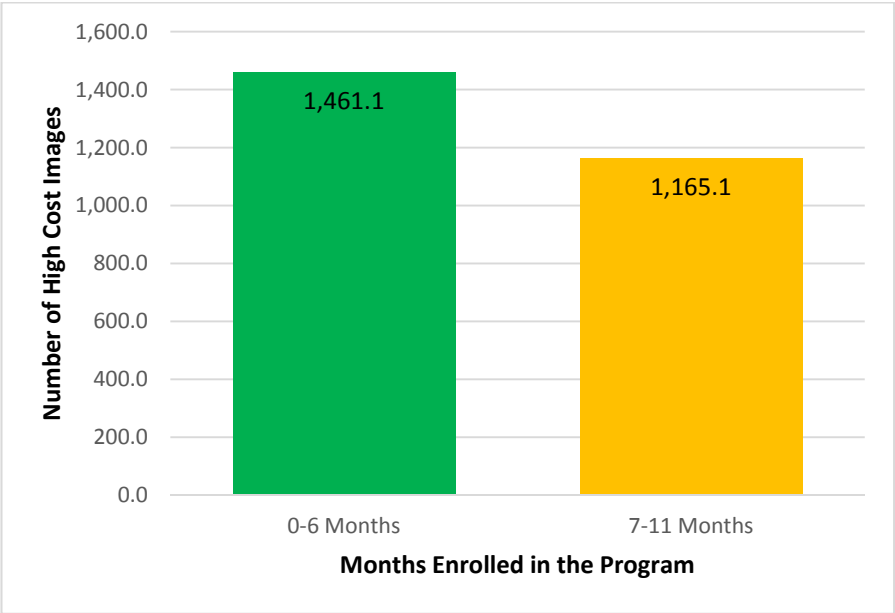
[12] See, for example: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf

Figure 13: High-Cost Images Per Thousand Accountable Care Collaborative Population Members Per Year, by Time Enrolled



Utilization of these services was much higher among the Accountable Care Collaborative: Medicare-Medicaid Program population, but the rate of utilization decreased with the amount of time spent in the Accountable Care Collaborative program. The rate went from 1461.1 for those enrolled 0–6 months to 1165.1 for those enrolled for 7–11 months.

Figure 14: High-Cost Images for Accountable Care Collaborative: Medicare-Medicaid Program Members, Per 1,000 Members Per Year, by Time Enrolled

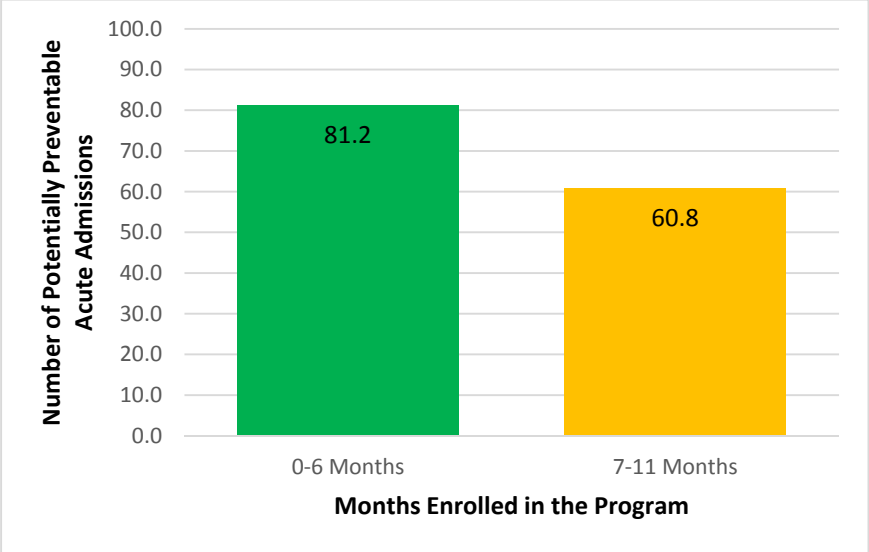


Potentially Preventable Acute Admissions to the Hospital (Accountable Care Collaborative population not reported; KPI for Accountable Care Collaborative: Medicare-Medicaid Program population)

This measure looks at hospital admissions for a problem that might not have required hospitalization if it had been addressed appropriately in a primary care or other outpatient setting (for example, complications from a chronic condition). The rate of such hospitalizations decreased from 81.2 to 60.8 visits per 1,000 Accountable Care Collaborative: Medicare-Medicaid Program members for those who spent a longer time in the Accountable Care Collaborative program, possibly indicating that the program has been able to help Accountable Care Collaborative: Medicare-Medicaid Program members better manage their chronic conditions.

RCOOs work to prevent these hospital admissions by coordinating care and identifying gaps in community services for Accountable Care Collaborative: Medicare-Medicaid Program members. For example, Integrated Community Health Partners meets quarterly with organizations that provide services for the Accountable Care Collaborative: Medicare-Medicaid population, to address gaps and streamline interagency referrals. Rocky Mountain Health Plans has created a system to make it easier to connect with community service organizations about members at risk. These organizations send "social alerts" to the RCCO about members who experience challenges such as loss of Medicaid eligibility, housing transitions or safety concerns. This allows care coordinators to put supports into place before the situation becomes a health emergency.

Figure 15: Potentially Preventable Acute Admissions to the Hospital for Accountable Care Collaborative: Medicare-Medicaid Program Members, Per 1,000 Members Per Year, by Time Enrolled



4.4. Member Satisfaction

In FY 2015–16, the Department administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member satisfaction survey to parents/caretakers of child Medicaid members. The survey was administered from March through May of 2016 and measured the member experience of care for the period from July through December of 2015. The survey was completed by parents/caretakers of child Medicaid members participating in the Accountable Care Collaborative program and those not participating in the program. The survey captured satisfaction data for the program as a whole and for each individual RCCO.

Table 3 shows the percentage of parents/caretakers of child members in the Accountable Care Collaborative who rated each general satisfaction measure favorably (9 or 10 out of 10). For all three measures, there was no statistically significant change from last year's survey results.

Table 3: CAHPS General Satisfaction Ratings for Parents/Caretakers of Child Members in the Accountable Care Collaborative Program, FY 2015–16

Satisfaction Rating	% Parents/Caretakers Who Rated This Measure a 9 or 10 out of 10
All health care	60.3%
Personal doctor	71.1%
Specialist seen most often	68.9%

In addition to these general satisfaction measures, the survey asked specific questions about the care experience. These results are shown in Table 4. Most measures did not have statistically significant changes compared to the results from FY 2014–15. The two exceptions are "Ability to get needed care," which dropped 4.8 percentage points, and "Doctor discussed starting or stopping a medication (shared decision making)," which increased 5.1 percentage points over last year.

Table 4: CAHPS Experience Measures for Parents/Caretakers of Child Members in the Accountable Care Collaborative Program, FY 2015–16

Experience Measure[13]	% Parents/Caretakers Who Responded "Usually" or "Always"
Ability to get needed care	78.9%
Getting care quickly	87.0%
Doctors communicate well	92.3%
Doctor informed about care received from another doctor (care coordination)	77.4%
Doctor discussed starting or stopping a medication (shared decision making)	82.9% (responded "yes")
Doctor discussed ways to prevent illness (health promotion and education)	70.6% (responded "yes")

5. Practice Support

From one practice at the program's inception in 2011, the effort has grown to 670 contracted primary care practices across the state. RCCOs support PCMPs so they can provide additional services to their patients, transform their practices, grow as patient-centered medical homes and fully participate in reform initiatives. This section describes how the program supported practices in FY 2015–16. It includes the following four subsections:

5.1 Enhanced Primary Care Medical Providers
5.2 State Innovation Model
5.3 Chronic Pain Disease Management Program (Project ECHO)
5.4 eConsult

5.1. Enhanced Primary Care Medical Providers

This fiscal year was the second year the Department recognized and rewarded PCMPs that met at least five of the nine enhanced patient-centered medical home factors. These factors are based on the medical home standards from National Committee on Quality Assurance, recommendations from the RCCOs and other stakeholders, and Colorado Senate Bill 07-130, which defined the criteria for medical homes for children. The factors are:

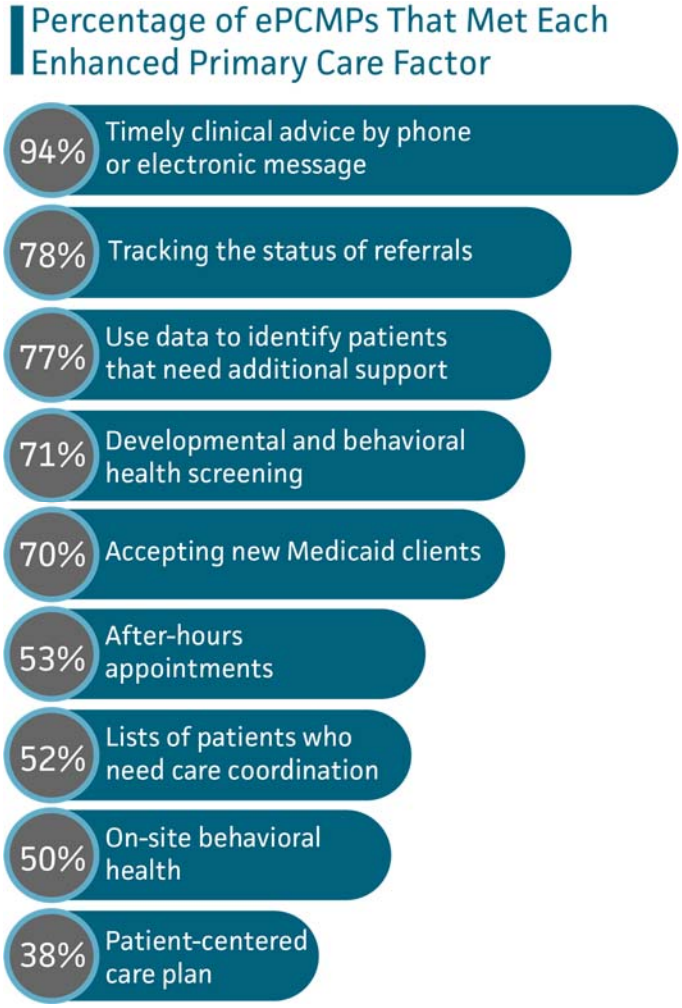
1. **Extended Hours.** Has regularly scheduled appointments (at least once per month) on a weekend and/or a weekday outside of typical workday hours.

[13] Each experience measure is a composite of two or more CAHPS questions.

2. **Timely Clinical Advice.** Provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures.
3. **Data Use and Population Health.** Uses available data to identify special patient populations that may require extra services and supports for medical or social reasons. The practice has procedures to proactively address the identified health needs.
4. **Behavioral Health Integration.** Provides on-site access to behavioral health care providers.
5. **Behavioral Health and Developmental Screening**. Collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents, and/or developmental screening for children (newborn to five years of age) using a Medicaid approved tool. In addition, the practice has documented procedures to address positive screens and has established relationships with providers to accept referred patients or utilizes the standard referral and release form created by the behavioral health organizations.
6. **Patient Registry.** Generates a list of patients actively receiving care coordination.
7. **Specialty Care Follow-Up**. Tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.
8. **Consistent Medicaid Provider.** Accepts new Medicaid members for the majority of the year.
9. **Patient-Centered Care Plans.** Collaborates with the patient, family or caregiver to develop and update an individual care plan.

Providers who meet these standards are called *enhanced Primary Care Medical Providers*, or ePCMPs. In FY 2015–16, 329 practice sites met the ePCMP criteria, up from 265 the previous year. These practices served over 612,000 program members. Figure 16 below shows what percentage of the qualifying PCMPs met each factor.

Figure 16: Percentage of ePCMPs That Met Each Enhanced Primary Care Factor



The Department will continue to evaluate the efficacy of this initiative and determine whether the factors should be adjusted to create further incentives for practices.

5.2. State Innovation Model (SIM)

Between February 2015 and January 2019, Colorado is using State Innovation Model (SIM) funding from the Center for Medicare and Medicaid Innovation (CMMI) to implement and test its State Health Innovation Plan. The plan aims to transform Colorado's health care system and improve the health of Coloradans by integrating primary care and behavioral health services, and supporting this integration with value-based payment structures. The SIM plan promotes health data sharing among participating practices, and uses telehealth and other health technologies to deliver care. The plan also leverages the public health system to support the delivery of clinical care and improve population health.

By the end of the three-year implementation period, Colorado SIM will have provided practice transformation support to approximately 400 primary care practices, divided into three cohorts; the first cohort of 100 practices launched in February 2016. The RCCOs are incentivizing a total of 88 of the practices in the first cohort with funds from the program's pay-for-performance pool, and plan support future cohorts as well.

5.3. Chronic Pain Disease Management Program: Project ECHO®

In March 2015, the Accountable Care Collaborative program implemented the Chronic Pain Disease Management Program to improve the health of members with chronic conditions and address rising rates of prescription abuse in Colorado. Modeled after the Project ECHO® programs developed by the University of New Mexico, the program uses private interactive video technology to connect PCMPs to a team of specialists in a variety of disciplines. Through the program, PCMPs can manage care for chronic pain conditions so members can receive care in their medical home. The first year of the program was a great success, with 84 providers from 42 practices across the state participating.

The second year of the program began in April 2016 with two options:

- Chronic Pain Telehealth Program: Connects PCMPs with a multi-disciplinary team of chronic pain specialists, including behavioral health professionals and pharmacists, to review member cases and learn evidence-based interventions for treating members with complex conditions. Twenty-five practices are participating.
- Buprenorphine Telehealth Program: PCMPs licensed to prescribe Buprenorphine/ Suboxone connect with specialists to gain greater insights and experience in treating members with opioid addiction. Nine practices are participating.

5.4. eConsult

The Accountable Care Collaborative eConsult initiative is in development to ensure appropriate access to specialty care for members. The eConsult Program allows PCMPs to quickly and easily consult with specialty physicians using an online, HIPAA-compliant electronic consultation system. With this technology, PCMPs and specialists can co-manage care for members in need of specialty care. During FY 2016–17, the Accountable Care Collaborative has been building the design of the program over the past year to prepare for a test group focused on rheumatology that launched in July 2016. Medicaid members have traditionally had difficulty accessing rheumatology services; this is an important step toward getting program members the specialty care they need.

6. Looking Forward

The next phase of the Accountable Care Collaborative program begins in July 2018 when new contracts go into effect for the Regional Accountable Entities, the new iteration of RCCOs and Behavioral Health Organizations. Over the last five years, the Accountable Care Collaborative has shown progress in creating a health care delivery program that improves health outcomes, better manages care and is a smarter use of resources. Like every other organization in today's health care landscape, Colorado Medicaid, must continue to serve members and navigate the increasingly complex health care landscape. One important improvement will be to continue to move toward more coordinated and integrated care that increasingly rewards improved health.

Below are some design decisions for the next phase of the program that will enable these important improvements:

- **Single entity**: What was previously called a Regional Care Collaborative Organization will now be called a Regional Accountable Entity, which will be a single administrative entity for behavioral health and physical health.
- **Seven regions**: The Department will continue a seven-region structure based on the current Accountable Care Collaborative regions with one change: Elbert County will move to Region 3.
- **Mandatory enrollment**: All full-benefit Medicaid members will be immediately enrolled in the Accountable Care Collaborative upon Medicaid eligibility.
- **Primary care payments**: New primary care payments will incentivize greater team-based care, integration of services and higher standards.
- **Behavioral health capitation**: The Department will use a modified capitation structure to pay for behavioral health services. Modifications in the covered diagnosis requirements will increase access to behavioral health services, particularly those delivered in primary care settings.
- **Disbursement of provider per-member-per-month payments**: The Regional Accountable Entities will pay PCMPs their per-member-per-month payments, rather than the Department disbursing these funds.
- **Enhanced care coordination**: The Accountable Care Collaborative will enhance care coordination requirements for the whole population in a Regional Accountable Entity's service area.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that delivery system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate to improve member outcomes and reduce health care costs, and is poised to continue to do so in the future.

Appendix A:

Technical Documentation for Total Cost of Care

The goal of the counterfactual estimation technique is to compare actual observed costs under the Accountable Care Collaborative to a hypothetical benchmark of costs in the absence of the program. 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 is the Department's preferred approach because the widespread adoption of the Accountable Care Collaborative means that there is no truly comparable population in Colorado Medicaid against which to compare costs.

Counterfactual estimation relies heavily on risk adjustment to make different populations comparable, and on the ability to predict changes in utilization patterns. Furthermore, counterfactual estimation does not account for things that do not change predictably over time, such as individual preferences. Factors like this can 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.

This counterfactual estimation technique differs slightly from the method the Department plans to use for its shared savings initiatives. In estimating the impact of the Accountable Care Collaborative on the total cost of care, the Department is comparing actual observed performance to a hypothetical baseline that would only exist without the Accountable Care Collaborative. The shared savings initiatives, however, attempt to measure incremental improvements at the RCCO level, within the broader context of the program.

Comparable Cohorts

In order to more accurately estimate the impact of the program on total cost of care, it is necessary to divide the enrolled population into similar groups. Each group of members is expected to have similar characteristics and health needs 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. Members are grouped into four distinct categories based on their age disability status, and eligibility type. These four groups are:

    - Children Without Disabilities
    - Expansion Adults (Adults without children, parents, and caretakers eligible after Medicaid expansion)
    - Previously Eligible Adults (Parents and caretakers without disabilities, below 68% FPL and some low-income adults over the age of 65)
    - Adults and Children with Disabilities

2. Members 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. Members are separated into groups based on the month they were enrolled in the program. Members are enrolled on the first of each month. The months during FY 2015-16 are included in the analysis. For each of the 28 distinct groups above (4 population groups and 7 regions within each), members are separated into enrolled or non-enrolled groups for each of the 12 months during FY 2015–16.

Risk Adjustment

The advantage of establishing groups of members with similar diagnoses and severity of illness is that they share similar health and cost expectations for the future. Risk adjustment allows for the comparison of different groups of members by normalizing for differences in health status. A certain group of members may be more expensive than another group, requiring more health care services. A risk score is a measurement of the relative health status of a group of members 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 members is established by adding the total cost per member per month for the group, and dividing by the total per member per month cost for the entire population. This method relies on the assumption that sicker members require more expensive care on average. 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 members into similar subpopulations based on diagnosis codes and procedure codes. The methodology further refines each group by considering the relative severity of illness and risk of mortality for each of the members in a given subpopulation. The benchmark population used for risk adjustment is noticeably smaller than the population enrolled in the program in FY 2015–16. Therefore, the analysis calculated risk scores by adjusting the personal risk core to be consistent to the FY 2015–16 Accountable Care Collaborative population and comparable across years. 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, the Department's actuary created population- and RCCO-level estimated growth rates for the entire population eligible for the Accountable Care Collaborative. The actuary 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 changes not related to the Accountable Care Collaborative. This analysis allowed for an estimate rate 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 program-eligible population would have grown approximately 4.69% in FY 2015–16 and 3.95% in FY 2014–15 in the absence of the Accountable Care Collaborative.

To better capture the savings from lower utilization due to program's influence, the Department chose a growth rate at the upper bound of the actuary's estimates. This results in a more appropriate estimate of savings that acknowledges that the risk scores used in the model are potentially biased and understate savings.

Counterfactual Estimation

Using the risk adjustment described above and accurate predictions of cost trends in the absence of the program, the analysis develops the counterfactual estimates. In general, savings estimates are developed by comparing actual, risk-adjusted costs to a benchmark cost.

The Department derived separate per-member-per month benchmarks 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, to the extent possible, for other Department initiatives unrelated to the Accountable Care Collaborative. As a result, estimates calculated using these growth rates are expected to reflect the impact of the program apart from other cost containment efforts.

The difference between these benchmarks and actual observed costs varies for each population and RCCO, but on average the program saved $193.28 per disabled adult or child per month, $35.77 per ACA-expansion adult per month, and $1.89 per non-disabled child per month. In addition, the program invested an additional $37.25 per non-disabled previously eligible adult, per month. The population-wide weighted average for all groups is $18.04 per member per month saved. In total, this method estimates $205 million of gross savings for FY 2015–16.