COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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

September 15, 2014

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

Dear Representative Duran,

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the Implementation of the Accountable Care Collaborative Payment Reform Pilot Program.

Section 25.5-5-415 of the Colorado Revised Statutes requires the Department to submit a report concerning the pilot program as implemented, including but not limited to an analysis of the initial data and information concerning the utilization of the payment methodology, quality measures, and the impact of the payment methodology on health outcomes, cost, provider participation and satisfaction, and patient satisfaction on or before September 15, 2014.

Over the last 15 months, the Department has been working collaboratively with Rocky Mountain Health Plans and its community partners to implement their proposal. The attached report provides a brief background on the implementation of the pilot program, describes the payment methodology and quality measures, and discusses how the program design may impact clients and providers.

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/hts

Enclosure(s): The Implementation of the Accountable Care Collaborative Payment Reform Pilot Program

Cc: Senator Pat Steadman, Vice-Chair, Joint Budget Committee
Representative Jenise May, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator Mary Hodge, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
Katherine Blair Mulready, Health Policy Advisor, Governor's Office
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John Bartholomew, Finance Office Director, HCPF
Suzanne Brennan, Health Programs Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

House Bill 12-1281
The Implementation of the Accountable Care Collaborative Payment Reform Pilot Program
Annual Report
September 15, 2014

Section 25.5-5-415 of the Colorado Revised Statutes requires the Department to submit a report concerning the pilot program as implemented. The statue requires the Department to report on three things:

1. An analysis of the initial data and information concerning the utilization of the payment methodology;
2. Quality measures; and
3. The impact of the payment methodology on health outcomes, cost, provider participation and satisfaction, and patient satisfaction.

This report will provide a brief background on the implementation of the program, describe the payment methodology and quality measures, and discuss how the program design may impact clients and providers.

Background

HB 12-1281, "Concerning a Pilot Program Establishing New Payment Methodologies in Medicaid" required the Department to accept proposals for an innovative payment reform pilot program that demonstrates new ways of paying for improved client outcomes in the Accountable Care Collaborative (ACC) program.

In accordance with the bill, the Department solicited proposals from the seven ACC Regional Care Collaborative Organizations (RCCOs) in the state that make up Colorado's coordinated care system. Ten proposals were submitted; on July 1, 2013, the Department announced that it had selected the payment reform proposal submitted by Rocky Mountain Health Plans (RMHP). This proposal was selected because it promised the most innovation and opportunity for improving quality while addressing the upward trend in health care costs.

Over the last 15 months, since RMHP's proposal was selected, the Department has been working collaboratively with RMHP and its community partners to implement their proposal. Specifically, the Department and RMHP have:

- Agreed upon rates;
- Established quality targets;
- Created member materials; and
- Drafted, negotiated and executed a contract.

In June 2014, RMHP passed their formal readiness review performed by the Department's third party External Quality Review Organization demonstrating that RMHP was ready to serve in this new capacity.

This new plan will serve an estimated 31,000 clients in a seven-county region (Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties). The Department has started enrolling clients using a phased approach, to allow the Department, RMHP, and providers time to transition from RMHP's current Medicaid program to this new pilot program. The following table estimates the number of clients that will be enrolled by county.

County	Estimate of Clients
Delta	3,599
Garfield	4,051
Gunnison	1,338
Mesa	16,383
Montrose	4,613
Pitkin	681
Rio Blanco	461
Total	**31,126**

The program is focused on the adult Medicaid population and children who qualify for Medicaid based upon disability status. The following table estimates the number of clients that will be enrolled in the program from each eligibility category.

Eligibility Group	Estimate of Clients
Old Age Pension (Age 65+) (OAP-A).	976
Old Age Pension (Age 61-64) - Supplemental Security Income (OAP-B-SSI).	480
Aid to the Needy Disabled/Aid to the Blind - Supplemental Security Income (AND/AB-SSI).	3,081
MAGI Parents/Caretakers	12,432
MAGI Pregnant Women	841
MAGI Adults	13,125
Medicaid Buy-In Program for Working Adults with Disabilities	191
Total	**31,126**

Payment Methodology

The overarching payment methodology is a full risk capitation paid monthly to RMHP for all physical health services. The enrollment process for RMHP is a two-month process that allows clients adequate time to opt out prior to enrollment if they choose to. As a result, the first full risk capitation payment will not be made until September 2014 when clients' thirty day opt out period expires and the first cohort of clients become enrolled in the program. Thus, there is no data to report on the actual utilization of the payment methodology. This payment methodology used in this pilot is innovative in two ways:

1. RMHP providers will be reimbursed by RMHP in a way that promotes flexibility, accountability, and behavioral health integration; and
2. The Department's payment to RMHP is tied to quality using a medical loss ratio.

Innovative Payment Model

RMHP has established innovative payment arrangements with their primary care provider network. They will pay their primary care medical providers (PCMPs) sub-capitation payments. These payments will not be based on the volume of encounters, but instead on the number of clients attributed to each provider. Further, the payments will be risk-adjusted, so that providers do not "cherry-pick" the healthiest clients. PCMPs will have both upside and downside financial risk. RMHP will create a global budget using behavioral and physical health data, and will set cost targets for PCMPs. If actual costs exceed targets, RMHP will recoup five percent of the sub-capitation payments from their PCMPs for their attributed patients. However, RMHP will share savings with PCMPs contingent on meeting quality targets. This structure increases provider accountability of both total cost of care and health outcomes.

Medical Loss Ratio

The Department implemented a medical loss ratio to ensure that RMHP continues to provide high quality care to Medicaid clients. A medical loss ratio is the measure of how much money a health plan spends on providing medical services compared to administrative services and profit. Medical loss ratios are often used in other Medicaid managed care programs as well as in commercial plans. Medical loss ratios are typically set between 85 and 90 percent, meaning a health plan is expected to spend at least 85 to 90 percent of their revenue from the payer of that program on medical services. If the plan fails to spend the required percentage on medical expenses, then it must repay the payer (e.g. the state Medicaid agency) the difference.

The medical loss ratio for this program is tied to four quality measures (below). Annually, at the end of each program year, the Department will adjust RMHP's medical loss ratio down, contingent on RMHP meeting or exceeding the quality targets established for each measure. The medical loss ratio will start at 93.5 percent, and will be decreased by two percentage points for each quality target that RMHP meets or exceeds (i.e. if RMHP meets all four quality targets, the medical loss ratio will decrease to 85.5 percent). This MLR design serves two functions: it increases financial transparency and incentivizes RMHP to improve quality of care.

Quality Measures

For FY 2014-15, the Department has set quality targets for the following four quality measures. The measures were proposed by RMHP for several reasons, including the alignment with quality measures used in other initiatives throughout the state.

Quality Measure	Target(s)
HEDIS: Adult Body Mass Index (BMI) Assessment	• 82.33%
HEDIS: HbA1c Poor Control (>9.0%)	• 28.95%
HEDIS: Anti-depressant Medication Management.	• Effective Acute Phase Treatment: 56.05%. • Effective Continuation Phase Treatment: 40.06%
Patient Activation Measure (PAM)	• Implementation of PAM in 10 PCMPs, serving at least 50% of the clients in the pilot

The Department intends to move towards clinical data reporting in year two of the program. Clinical quality measures differ from the administrative quality measures above, in that they use individual practices' electronic health records systems, instead of claims data. Clinical data is a better indicator of health outcomes, but it remains difficult to collect and aggregate. RMHP has been working with their provider network and their Health Information Exchange, Quality Health Network, to increase the utilization of clinical reporting. For these reasons, it is a great opportunity for the Department to pilot clinical quality measures in Medicaid. In collaboration with RMHP, the Department plans to set quality targets for FY 2015-16, using the following clinical quality measures:

1. Body Mass Index (BMI) Screening and Follow-Up;
2. Screening for Clinical Depression and Follow-Up Plan; and
3. Low Density Lipoprotein (LDL) Management.

These measures are aligned with the multi-payer Comprehensive Primary Care Initiative, in which both RMHP and the Department are participating with CMS and several other private payers.

For the duration of the pilot, the Department will track and monitor additional quality measures through claims data and surveys, including:

- Emergency room visits;
- High cost imaging services;
- All cause hospital readmission rate;
- Post-partum care;
- Inpatient utilization - general hospital/acute care;
- Annual monitoring of patients on persistent medications;
- Patient Satisfaction as measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool;
- Medical assistance with smoking and tobacco use cessation; and
- Behavioral health care coordination.

Impact of the Payment Methodology

As stated earlier, the first clients will not be receiving services and RMHP will not be receiving payments until September 1, 2014. Therefore, at this time, the Department cannot evaluate the impact of the payment methodology on: health outcomes; cost, provider participation and satisfaction; and client satisfaction. Upon completion of the first year of the program (July 2015), the Department will be better positioned to analyze the efficacy of the pilot. For the purposes of this report, the Department will describe how the payment methodology allows RMHP the opportunity to integrate client services, improve the client experience, increase provider satisfaction, all while remaining budget neutral for the Department.

Health Outcomes and Client Satisfaction

Health care integration is critical to the creation of better value within the Medicaid program, and a better client experience. The integration of behavioral health services in an accountable system of care is of primary importance, since a significant share of total health costs and population health outcomes are attributable to behavior, decision-making and substance use. RMHP has included additional payments to PCMPs in advanced practices for the employment of behavioral health providers on comprehensive care teams. RMHP and behavioral health providers are working within the flexibility afforded under this pilot to align services at all levels of integration—from "high touch" personal interventions in primary care and community settings, to data sharing, governance and payment agreements at the executive level. Clients utilizing these advance PCMPs have direct access to behavioral health services in the course of routine visits.

Additionally, RMHP has implemented new payments to Community Mental Health Centers to recruit, train and deploy community health workers. The community health workers are assigned to primary care practices to extend support for health, behavior and social determinants of health beyond the walls of clinical settings. RMHP and PCMPs use data to prioritize cohorts of patients for the Community Health Worker support, and meet regularly with the Community Health Workers in a "Health Engagement Team" process to monitor the status of each client, remove barriers and track outcomes. The Community Health Worker intervention also includes transportation and cell phone minutes when necessary to close gaps in timely access to services, and functions as a "bridge" to expedite access to more advanced mental health and substance use treatment services when necessary.

Further, the Community Mental Health Centers have contracted, alongside the PCMPs, with RMHP to implement an aligned gainsharing arrangement. In the event that savings are achieved across the entire global budget for services, and minimum quality targets are achieved, the Community Mental Health Centers are eligible for a 30 percent share of total financial gains. Community Mental Health Center leaders work directly with RMHP at the executive level to manage the planning, data sharing and operations necessary to support this model. Community Mental Health Center leaders also sit on the pilot's executive committee that provides region-wide oversight for the pilot, and work to ensure accountability and transparency within the initiative.

Finally, the program has the potential to improve the client experience by focusing on continuity of care. RMHP is the RCCO for the western slope, the prominent private insurance payer, and serves Medicare Advantage clients in the targeted counties. As clients move between Medicaid and private insurance, or age into Medicare, they can continue to seek care from the same network of providers.

Provider Participation and Satisfaction
The payment methodology and program were designed to reduce the administrative burden on PCMPs, by moving away from the traditional Medicaid fee-for-service model. As stated earlier, PCMPs will receive sub-capitation payments from RMHP to manage their clients' health, instead of being paid for volume-based encounters. Further, PCMPs will have access to additional resources; for example, PCMPs can receive technical assistance from quality improvement advisors, employed by RMHP, which help practices develop process improvement, data use competencies and other practice transformation objectives.

From the beginning, this pilot has been a joint effort between RMHP and its community partners. RMHP formed an executive committee to provide leadership and oversight throughout the implementation process, which will continue to manage the pilot program through its duration. Specifically, the Committee will provide monthly monitoring of the global budget, and quarterly reports to the Department, with the expectation that the pilot will be monitored closely and shared publicly with other stakeholders to accelerate learning throughout the ACC program. The members include:

- A Medicaid member;
- Representatives from:
  - Community Health Initiatives, Inc.;
  - Mountain Family Health Centers;
  - Midwest Colorado Center for Mental Health;
  - Mesa County Health Department;
  - St. Mary's Hospital & Regional Medical Center;
  - University of Colorado, Department of Family Medicine;
  - Mindsprings Health;
  - Mesa County Physicians Independent Practice Association;
  - Western Colorado Independent Physicians Association;
  - Hilltop Community Services;
  - Quality Health Network; and
  - Valley Health Alliance.

This committee structure has representatives from two of the independent practice associations in the target region, giving providers a forum for direct and timely feedback of the program's performance.

Cost
Budget-neutrality is a requirement of section 25.5-5-415, C.R.S. The Department and its actuary worked closely with RMHP and its actuary to develop rates that are both budget neutral and sustainable for the pilot. The estimate of expenditures for FY 2014-15 is $99,236,087 total funds, dependent on monthly enrollment. The Department will report on the actual cost of FY 2014-15 in next year's report.

Conclusion

The ACC Payment Reform Pilot Program has and will continue to be a great opportunity to test innovative payment reform models within the construct of the ACC program. The Department looks forward to a full evaluation of the program next year and will provide a thorough update on September 15, 2015.