COLORADO

Department of Health Care Policy & Financing

REPORT TO THE JOINT BUDGET COMMITTEE, HOUSE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE, HOUSE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTE, AND SENATE HEALTH AND HUMAN SERVICES COMMITTEE

ON

MEDICAID PAYMENT REFORM AND INNOVATION PILOT PROGRAM

SECTION 25.5-5-415 (4)(a)(III), C.R.S.

SEPTEMBER 15, 2015

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

September 15, 2015

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

Dear Senator Lambert:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Medicaid Payment Reform and Innovation Pilot Program to the Joint Budget Committee.

Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to report that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data by September 15, 2015 and each September 15 thereafter.

This report will provide a brief background on the implementation of the program, describe the payment methodology and quality measures, provide some initial data on the program, and discuss how the program design impacts 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/cal
Enclosure(s): 2015 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Millie Hamner, 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
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Gretchen Hammer, Health Programs Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Jed Ziegenhagen, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

September 15, 2015

The Honorable Beth McCann, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative McCann:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Medicaid Payment Reform and Innovation Pilot Program to the Health, Insurance, and Environment Committee.

Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to report that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data by September 15, 2015 and each September 15 thereafter.

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Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director
SEB/cal

Enclosure(s): 2015 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Joann Ginal, Vice Chair, Health, Insurance and Environment Committee
Representative J. Paul Brown, Health, Insurance and Environment Committee
Representative Daneya Esgar, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Janak Joshi, Health, Insurance and Environment Committee
Representative Gordon Klingenschmitt, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
Representative Susan Lontine, Health, Insurance and Environment Committee
Representative Dianne Mitsch Bush, Health, Insurance and Environment Committee
Representative Dianne Primavera, Health, Insurance and Environment Committee
Representative Kim Ransom, Health, Insurance and Environment Committee
Representative Su Ryden, Health, Insurance and Environment Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

September 15, 2015

The Honorable Dianne Primavera, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203
Dear Representative Primavera:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Medicaid Payment Reform and Innovation Pilot Program to the House Public Health Care and Human Services Committee.

Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to report that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data by September 15, 2015, and each September 15 thereafter.

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

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Sincerely,

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

SEB/cal
Enclosure(s): 2015 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Jonathan Singer, Vice-Chair, Public Health Care and Human Services Committee
Representative Jessie Danielson, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Jovan Melton, Public Health Care and Human Services Committee
Representative Dominick Moreno, Public Health Care and Human Services Committee
Representative Max Tyler, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kathleen Conti, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Janak Joshi, Public Health Care and Human Services Committee
Representative Lang Sias, Public Health Care and Human Services Committee
Representative JoAnn Windholz, Public Health Care and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

September 15, 2015

The Honorable Kevin Lundberg, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Lundberg:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Medicaid Payment Reform and Innovation Pilot Program to the Senate Health and Human Services Committee.

Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to report that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data by September 15, 2015 and each September 15 thereafter.

This report will provide a brief background on the implementation of the program, describe the payment methodology and quality measures, provide some initial data on the program, and discuss how the program design impacts 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/cal
Enclosure(s): 2015 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Senator Larry Crowder, Vice-Chair, Health and Human Services Committee
Senator Beth Martinez Humenik, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Linda Newell, Health and Human Services Committee
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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, 2015

Executive Summary

The Accountable Care Collaborative: Rocky Mountain Health Plans Prime (ACC: RMHP Prime) program has concluded its first year of operation. Enrollment has surpassed initial projections and nearly 34,000 clients are enrolled in the program. Complete quality data is still forthcoming, but initial findings demonstrate some early success.

- Twice as many practices are using the Patient Activation Measure™ than projected.
- Three practice sites have integrated behavioral health providers within the practice.
- Community Health Workers have completed nearly 4,000 interventions with 183 clients.
- 43 percent of practices serving ACC: RMHP Prime clients have done practice transformation work.

The program's unique payment methodology has also positively impacted the level of collaboration between diverse provider types and community organizations. The model has furthered practice transformation efforts and increased the integration of behavioral health in primary care. In the next year, the program will work to further strengthen collaboration between community partners and examine the long-term sustainability of the model.

Background

HB 12-1281, "Concerning a Pilot Program Establishing New Payment Methodologies in Medicaid", codified at 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 provides a brief background on the implementation of the program, describes the payment methodology and quality measures, provides some initial data on the program, and discusses how the program design impacts clients and providers.

The legislation required the Department to accept proposals for an innovative payment reform program that demonstrates new ways of paying for improved client outcomes in the Accountable Care Collaborative (ACC) program.

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.

Enrollment and Payment Methodology

Enrollment

The program, ACC: RMHP Prime, serves nearly 34,000 clients in six counties—Garfield, Gunnison, Montrose, Mesa, Pitkin, and Rio Blanco. The program is focused on the adult Medicaid population and children who qualify for Medicaid based upon disability status.

Between September and December of 2014 clients were enrolled into the program using a phased approach. This gave the Department, RMHP, and providers time to transition to the new program. Currently, the program enrolls about 1,000 clients each month. The following table shows how projected enrollment compared to actual enrollment. Enrollment in the program is higher than initial projections indicated largely due to the growth in new clients under the Medicaid expansion.

Enrollment Comparison, ACC:RMHP Prime		
Projected	Actual as of June 30, 2015	Difference (Actual - Projected)
27,527	33,978	6,451

Payment Methodology

The overarching payment methodology is a full risk capitation paid monthly to RMHP for all physical health services. The payment methodology used in this program is innovative in two ways:

1. RMHP providers are 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 pay their primary care medical providers (PCMPs) a global payment for the practice. These payments are not based on the volume of encounters, but instead on the number of clients attributed to each provider. Further, the payments are risk-adjusted, so that providers do not "cherry-pick" the healthiest clients. PCMPs have both upside and downside financial risk. RMHP created a global budget using behavioral and physical health data, and set cost targets for PCMPs. If actual costs exceed targets, RMHP will recoup five percent of the global payments from their PCMPs for their attributed clients. However, RMHP will share savings with PCMPs contingent on meeting quality targets. Any savings are split between PCMPs, Community Mental Health Centers, and RMHP. 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. For FY 2014-15, the medical loss ratio started 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 medical loss ratio design serves two functions: it increases financial transparency and incentivizes RMHP to improve quality of care.

Quality Measures

The Department set targets for the following four quality measures for FY 2014-15. The measures were proposed by RMHP for several reasons, including the alignment with quality measures used in other initiatives throughout the state and the fact that the measures were matched to well-established and certified measures for clinical quality reporting. The asterisks in the table below indicate that information on RMHP's performance on these measures will not be available until after the submission date of this report.

Quality Measure	Target(s)	SFY 2014-15 Performance
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%	• Effective Acute Phase Treatment: * • Effective Continuation Phase Treatment: *
Patient Activation Measure (PAM™)	• Implementation of PAM™ in 10 PCMPs, serving at least 50% of the clients in the program	• 24 practice sites are using the PAM™ and 75% of ACC: RMHP Prime clients are in a practice that uses PAM™.

*Data not available at this time.

Health Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by many health plans to measure care and quality of service. Since the measures are used by the majority of health plans, HEDIS performance can be used to make comparisons between different health plans. HEDIS data can also be used within a health plan to drive internal improvements in care and service delivery.

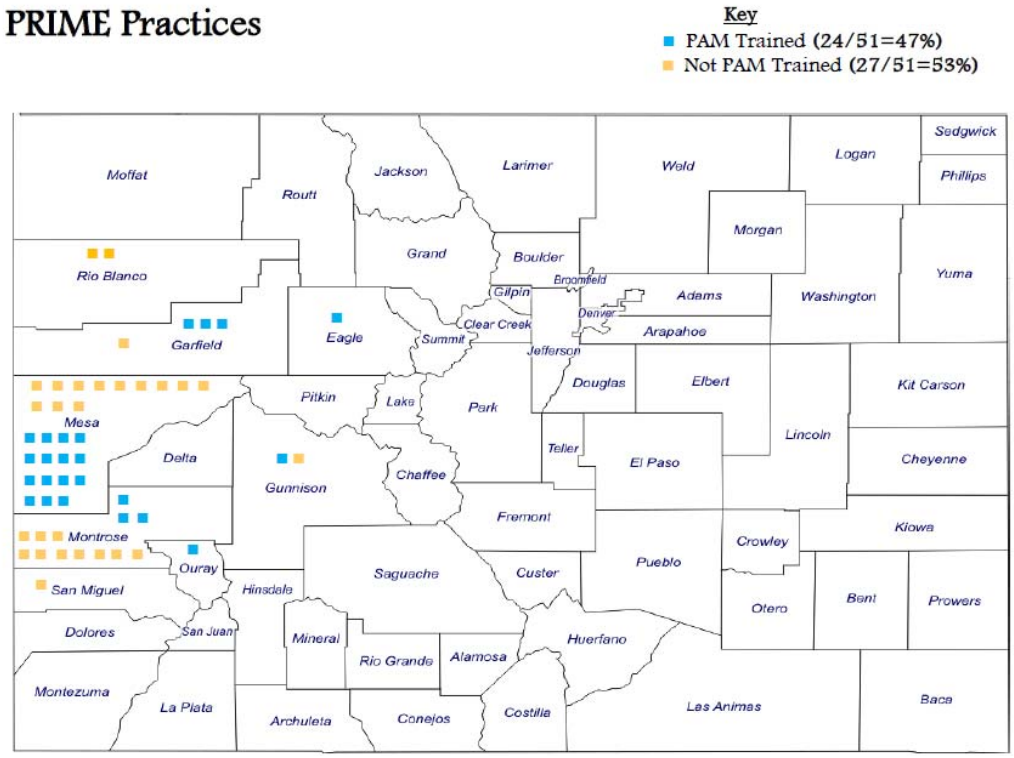
The three HEDIS measures shown above were selected to align with clinical quality measures that PCMPs are working on in other programs, like the Comprehensive Primary Care initiative. A

conscious effort was also made to select only a few measures, so that practices could focus on improvement in just a few key areas. The BMI assessment, HbA1c poor control, and anti-depressant medication management measures approximate practice proficiency in a few areas: preventative care, chronic condition management, and behavioral health. ACC: RMHP Prime HEDIS data is calculated and verified by an outside source and will not be available until after the submission of this report.

Patient Activation Measure

The Patient Activation Measure (PAM™) is a tool used to assess a patient's level of engagement in their health care. Patients complete a short survey and are rated at a Level 1 through 4, with 4 being the most activated or engaged in their care. The PAM™ is an important practice tool that providers can use to match interventions and health care strategies to clients based on their level of health knowledge and readiness to change. The survey can also be used to help providers predict patterns of health and resource utilization.

This year, RMHP achieved their target for the PAM™, by implementing the measure in 24 practice sites—more than twice as many as expected. The larger than expected uptake of the PAM™ is an encouraging sign that PCMPs are interested in engaging clients in new ways and tailoring interventions and practice processes to meet clients where they are. The illustration below shows the distribution of ACC: RMHP Prime practices trained to use the PAM™.



Note: RMHP manages the network of providers for this program. In order to best serve the clients in the ACC: RMHP Prime service area, RMHP also includes providers in surrounding counties in the provider network.

A total of 127 potential PAM™ users have been trained and six practice sites have had repeated training sessions. The uptake of the PAM™ in practices indicates a shift in practice culture toward finding new ways to engage patients and focus on individual health needs. This program year 819 PAM™ surveys were completed, and 11 ACC: RMHP Prime clients received two or more PAM assessments. The average patient's PAM level for an initial assessment was a Level 3. In year two of the program, RMHP intends to focus on four areas related to the PAM™:

1. Increased utilization,
2. Additional practice staff training,
3. Physician buy-in and engagement, and
4. Use of practice level data.

For the duration of the program, the Department will track and monitor additional quality measures through claims data and surveys. This year, the Department looked at two quality measures:

- Emergency Room utilization and
- Behavioral Health Organization (BHO) penetration rate

A full year of program data for these measures is still forthcoming. Due to the need to provide time for claims run out, only the first six months of the program period (September 2014 to February 2015) are captured in the data for these measures. Therefore, it is difficult to draw definitive conclusions about the program based on the data currently available.

Emergency Room Utilization

When clients have their health needs met and managed through their PCMP, they are less likely to rely on the emergency room for routine medical care and chronic disease management. Early program data shows that emergency room visits for ACC: RMHP Prime clients are comparable to those for clients in fee for service Medicaid. The comparison population was matched to the ACC: RMHP Prime clients on characteristics that included eligibility type and county of residence and includes clients of the ACC not enrolled in ACC: RMHP Prime. The populations predominantly enrolled in ACC: RMHP Prime—the expansion population and those with disabilities—might have either a pent-up demand or an increased need to use emergency room services that could explain the similarity in number of visits to the fee for service comparison group. However, more obvious trends should emerge with the addition of data from other program months.

ACC: RMHP PRIME and Target Populations Emergency Room Visits For period from 9/1/2014 to 2/28/2015			
Population	Total Member Months/1000	Visits	Visits per 1000 Member Months
ACC: RMHP Prime	114	4,322	38
Fee For Service and ACC	87	3,431	39

BHO Penetration Rate

The Department is examining the BHO penetration rate within the ACC: RMHP Prime service area to determine the impact of increased behavioral health integration in primary care on BHO service use. Imbedding behavioral health specialists in primary care allows for proper identification of the need for ongoing mental health services and connection to BHO or

Community Mental Health Center services. The BHO penetration rate is a measure of how many clients received services from the BHO since they have been enrolled in ACC: RMHP Prime. As seen in the table below, this rate was comparable to the rate in the larger BHO service area. A full year of program data is needed to better judge the impact of behavioral health services integration on BHO service utilization.

BHO Penetration Rates Comparison For period from 9/1/2014 to 2/28/2015	
	Penetration Rate
ACC: RMHP Prime	17%
Colorado Health Partnerships (BHO in Region 1)	19%

Note: ACC: RMHP Prime clients fall into the Colorado Health Partnerships BHO region, but do not encompass the entire region.

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 as the data source. 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 test clinical quality measures in Medicaid. In collaboration with RMHP, the Department plans to set quality targets for FY 2015-16 in the coming months, using a number of clinical quality measures.

Impact of the Payment Methodology

As stated earlier, the first clients began receiving services and RMHP began receiving payments on September 1, 2014. Therefore, at this time, the Department can only present emerging trends related to the impact of the payment methodology on: health outcomes and client satisfaction; technology; provider participation and satisfaction; and cost. 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, and increase provider satisfaction, all while remaining budget neutral for the Department.

Health Outcomes

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.

- Three sites receive global, monthly payments to support integrated behavioral health providers within their practice.
- RMHP and behavioral health providers are working within the flexibility afforded under this program 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 using these advanced PCMPs have direct access to behavioral health services in the course of routine visits.

In the next year, seven more practices will add integrated behavioral health services using this model.

Further, the program's innovative payment model has allowed the Community Mental Health Centers to contract, alongside the PCMPs, with RMHP to implement an aligned shared savings 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 executive committee that provides region-wide oversight for the program, and work to ensure accountability and transparency within the initiative.

RMHP has also implemented new payments to Community Mental Health Centers to recruit, train and deploy Community Health Workers for the Health Engagement Team program. Whole Health, LLC, a subsidiary of Mind Springs Health, employs the Community Health Workers assigned to primary care practices to extend support for health, behavior, and social determinants of health beyond the walls of clinical settings. The main goal of the Health Engagement Team program is to decrease high emergency room use. Candidates for the program are identified through RMHP claims data analysis. Community Health Workers build rapport with clients by meeting with them in their homes or communities, accompanying them to appointments, providing transportation, and assisting with needed resources. The Community Health Workers focus on health-related behavior change while being client-centered—providing care to the whole person.

Currently, seven Community Health Workers are based in ten primary care practices. The Community Health Workers have completed nearly 4,000 interventions and served approximately 183 individuals identified as high emergency room (ER) utilizers since the start of the program. In addition to supporting physical and behavioral health needs, the Health Engagement Team interventions also include:

- Transportation
- Social relationships
- Chronic pain
- Financial issues
- Housing
- Medication adherence
- Employment
- Nutrition
- Child care
- Legal issues

RMHP reports an overall reduction in ER visits amongst clients enrolled in the Health Engagement Team program. During the first quarter, the average number of ER visits was 1.87 per client enrolled in the program. By March 31, 2015, the number of ER visits per client dropped to 1.32 per quarter. In the same period, visits to clients' attributed PCMPs increased, an indication that these clients were now having their needs met within the primary care setting. Although this program focuses on reducing ER use for a small group of clients in ACC:

RMHP Prime, it has the potential to impact the ER utilization rates stated earlier in this report for the full client population.

The larger community has also taken notice of the work that the Community Health Workers are doing. Although the majority of referrals for the program come from primary care practices and RMHP's Care Management department, hospitals and paramedics have also begun to identify clients that might be good candidates for the program. This has led to better communication between the Community Health Workers and the hospitals as well as the use of shared client lists with paramedics. A future Health Engagement Team program goal is to place a Community Health Worker in the emergency room, to help spot emerging issues and direct clients to appropriate levels of care.

Client Satisfaction

RMHP engages in efforts to "Coordinate the Coordinators" and foster better collaboration between the different community partners that provide care coordination. In one survey of the region, RMHP found that clients could potentially have up to seven different coordinators assigned to help them navigate their health care services. The "Coordinate the Coordinators" work is one way that RMHP attempts to simplify and improve the health care experience for clients. One part of this effort is the use of a web-based software tool called Crimson Care Management. This software allows care coordinators from a wide range of agencies and provider types to share and act on information that includes admission, discharge, and transfer data, major diagnoses, and socioeconomic barriers.

Extended access to primary care services is also available in ACC: RMHP Prime, through RMHP's MyDigitalMD service. This service allows clients to videoconference, text, and send pictures to a Colorado-based doctor from a computer or mobile device. This telehealth resource provides clients quick and convenient access to a medical professional who can write prescriptions, schedule a visit with a PCMP, or direct clients to seek treatment at an urgent care or emergency room.

Finally, the program also 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 RMHP Medicare 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.

Cost

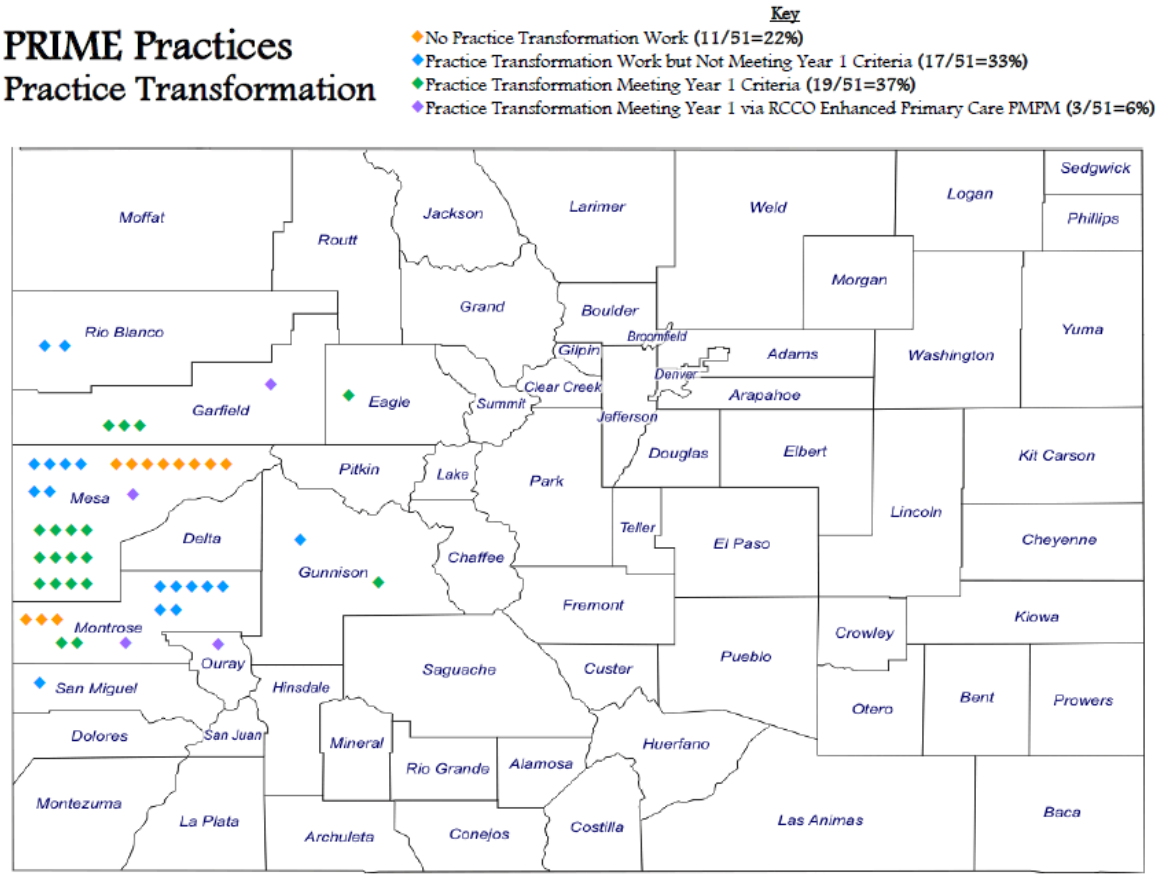
The Department and its actuary worked closely with RMHP and its actuary to develop rates that are sustainable for the program. The ACC: RMHP Prime model works to ensure that clients are receiving high-quality primary care in an advanced practice setting, which should ultimately translate into long term cost savings due to improved clinical outcomes. The estimate of expenditures for FY 2014-15 was $99,236,087 total funds, dependent on monthly enrollment. The actual expenditures for the program in FY 2014-15 were $125,708,596. Higher than anticipated enrollment led to the increase over the estimated expenditures. However, this does not impact program budget neutrality as the additional clients would have had expenditures under fee for service had they not been enrolled in the program.

The Department is also tracking the total cost of care for program members' physical health services. Ideally, the total cost of care will be lower for clients that are receiving appropriate care within a medical home. During the first six months of the program, the total cost of care for ACC: RMHP Prime clients was trending less per member per month than the cost for equivalent physical health services if administered by fee for service providers. As stated previously, these findings should be interpreted with caution, since the Department still lacks a full year of program data for analysis. As we continue to evaluate the program, the Department will account for any savings through the budget process as appropriate.

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 receive global payments from RMHP to manage their clients' health, instead of being paid for volume-based encounters. Further, PCMPs also have access to additional resources, such as technical assistance from RMHP-employed quality improvement advisors, who help practices develop process improvement, data use competencies and other practice transformation objectives.

There are 51 primary care practices contracted to serve ACC: RMHP Prime members. In order to participate in the program's shared savings opportunity, practices must demonstrate that they engage in comprehensive primary care processes. Currently, 43 percent of the contracted practices have done practice transformation work that would allow them to qualify for shared savings. An additional 33 percent of practices have done some transformation work, but have not yet met shared savings criteria. RMHP believes in meeting practices where they are along the transformation continuum in order to promote lasting change. Practices not meeting the criteria in year one will have the opportunity to participate in a practice transformation program and meet the criteria in year two. A distribution of practices participating in transformation work can be seen below.



Practices participating in the program report that the payment model allows their staff members to practice at the top of their licenses and to provide high-quality care for the whole client. ACC: RMHP Prime pushes these practices to become advanced primary care medical homes that deliver wraparound care. Although work still needs to be done to help providers learn how to deliver care under the ACC:RMHP Prime model—using care managers, integrated behavioral health specialists, and alternative visit types—most practices like the fact that they are moving away from a volume driven model and towards a value based model. In partnership with RMHP, the University of Colorado is currently conducting an evaluation that will measure provider satisfaction with the program.

Having access to real-time admission, discharge, and transfer data is important for PCMPs and Community Health Workers to provide timely care management for clients. Quality Health Network, the Health Information Exchange on the Western Slope, provides this service. Quality Health Network is currently working to include psychiatric hospital admission, discharge, and transfer information in their data feed, which would give PCMPs an even greater ability to manage the care of their clients.

Stakeholders involved with ACC: RMHP Prime highlight community partnership and collaboration as key components of the program. Since the shared savings arrangement necessitates that all partners perform well on quality measures, primary care and behavioral health providers are incentivized to work together in ways they have not in the past. This has led to process and

procedure updates, new referral policies, greater dialogue, and other changes that have improved the way that clients receive care.

Conclusion

The ACC: RMHP Prime program has been and will continue to be a good opportunity to test innovative payment reform models within the construct of the ACC program. The model provides the chance to assess one method of accelerating movement towards the provision of value based instead of volume based care. RMHP and its regional partners are particularly well-positioned to carry out this type of model, due to existing infrastructure and relationships, but lessons learned from this program are potentially applicable to the larger ACC program.

The program has fostered new collaborations between providers and organizations that have never worked together before, developing a medical neighborhood within the community. As the program progresses past the start-up phase, the next areas of concentration will be:

- Collaboration with additional provider types, such as dentists and hospitals;
- Enhanced provider training to use new staff and data resources to deliver value based care; and
- Long-term sustainability and support of the program.

In light of the initial results of the first program implemented through the authority of HB 12-1281, the Department anticipates implementing other innovative payment reform programs in the future. Additionally, the Department looks forward to the receipt of additional program data and will provide the next program update on September 15, 2016.