



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 COMMITTEE, 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.

April 15, 2017



COLORADO
Department of Health Care
Policy & Financing

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

April 15, 2017

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 April 15, 2017 and each April 15 thereafter.

The Department has implemented two payment reform initiatives under Section 25.5-5-415 C.R.S. This report will provide a brief background on the implementation of the two initiatives, describe payment methodologies and quality measures, provide performance data, and discuss how 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,

A handwritten signature in black ink that reads "Susan E. Birch".

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

SEB/bjh



Enclosure(s): 2017 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 Lundberg, Joint Budget Committee
Senator Dominick Moreno, 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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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

April 15, 2017

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

Dear Senator Smallwood:

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 April 15, 2017 and each April 15 thereafter.

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

SEB/bjh



Enclosure(s): 2017 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator John Kefalas, Health 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

April 15, 2017

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

Dear Representative Ginal:

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 April 15, 2017 and each April 15 thereafter.

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



Enclosure(s): 2017 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Daneya Esgar, Vice Chair, Health, Insurance and Environment Committee
Representative Susan Beckman, Health, Insurance and Environment Committee
Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Stephen Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment 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

April 15, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

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 April 15, 2017, and each April 15 thereafter.

The Department has implemented two payment reform initiatives under Section 25.5-5-415 C.R.S. This report will provide a brief background on the implementation of the two initiatives, describe payment methodologies and quality measures, provide performance data, and discuss how 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,

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

SEB/bjh



Enclosure(s): 2017 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Marcus Catlin, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Joanne Ginal, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Dan Pabon, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF



ACCOUNTABLE CARE COLLABORATIVE PAYMENT REFORM PROGRAM REPORT

*Section 25.5-5-415, C.R.S.:
Medicaid payment reform and innovation pilot
program*

Submitted April 15, 2017 to:

Joint Budget Committee

Senate Health and Human Services Committee

House Health, Insurance, and Environment Committee

House Public Health Care & Human Services Committee



COLORADO

Department of Health Care
Policy & Financing

Section 25.5-5-415 (4)(a)(IV), C.R.S. states:

(IV) On or before April 15, 2017, and each April 15 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 patients utilizing existing state department data. Specifically, the report must include:

(A) An evaluation of all current payment projects and whether the state department intends to extend any current payment project into the next fiscal year;

(B) The state department's plans to incorporate any payment project into the larger Medicaid payment framework;

(C) A description of any payment project proposals received by the state department since the prior year's report, and whether the state department intends to implement any new payment projects in the upcoming fiscal year; and

(D) The results of the state department's evaluation of payment projects pursuant to paragraph (a.5) of this subsection (4).

Executive Summary

The Department of Health Care Policy & Financing (Department) is pleased to submit this annual report on the payment reform initiatives implemented under section 25.5-5-415, C.R.S. (also known as HB 12-1281). The report provides an update on Access Kaiser Permanente (Access KP) and Rocky Mountain Health Plans Prime (RMHP Prime). Both programs are run within the Accountable Care Collaborative but have different payment methodologies than the rest of the program. Both will continue in FY 2017–18. No additional initiatives will be implemented during this time period.

Access Kaiser Permanente

Access KP launched in July 2016. The report focuses on activities undertaken during the first six months of the program (July 2016 to December 2016). Performance data is not available because the program has yet to complete its first year.

For this program, the Department pays Colorado Access a monthly capitation fee for each member to cover most primary care and some specialty care services for its members. Benefits not covered under the capitation, such as inpatient hospital stays, are still covered for members but are paid for by the Department rather than by Colorado Access's subcontractor, Kaiser Permanente.

Access KP serves Medicaid members in Accountable Care Collaborative Region 3 (Adams, Arapahoe and Douglas counties) who have Kaiser Permanente as their primary care medical provider. Access KP had an average monthly enrollment of 22,680 from July–December 2016.

Access KP has worked to build upon Kaiser Permanente's existing care coordination model to better address the needs of its members. It has incorporated Behavioral Health Care Coordinators and Community Specialists to help connect members to other providers, including community mental health centers, single entry point agencies, community-centered boards, and other social service agencies.

Rocky Mountain Health Plans Prime

The RMHP Prime program began in 2014. This report focuses on performance for FY 2015–16 because it is the most recent fiscal year completed by the program.

The Department pays RMHP Prime a set monthly payment in exchange for covering a comprehensive set of physical health services provided to its participating members. Rocky

Mountain Health Plans pays their participating primary care medical providers a single payment each month to cover the care of all the members who are under the practice's care. This payment is calculated based on the number of participating members who are attributed to the practice. Payments to each practice are risk-adjusted, so practices are not incentivized to exclude sicker or older members.

RMHP Prime serves members in six counties in the Accountable Care Collaborative Region 1: Garfield, Gunnison, Montrose, Mesa, Pitkin and Rio Blanco. In FY 2015–16, 51 practices participated in RMHP Prime. During this time period, monthly enrollment in Prime averaged 35,356 members. Expenditures for the program totaled \$198,208,810 in FY 2015–16.

For FY 2015–16, RMHP Prime met or exceeded its targets in all four quality measures for the program: body mass index (BMI) assessment for adults; HbA1c poor control (a measure of diabetes control); antidepressant medication management for acute and continuation phases; and percentage of practices using Patient Activation Measure (PAM®) assessments. RMHP Prime members also accessed behavioral health care at a greater rate than the rest of the population that uses the Behavioral Health Organization in that region (20 percent compared to 15 percent of the population). RMHP Prime members used the emergency department at a higher rate than other Medicaid members in the Accountable Care Collaborative.

RHMP Prime has used existing RHMP resources to provide improved care coordination for its members. RMHP's Health Engagement Team program target members who had a recent emergency room visit. These resources have helped facilitate improved communication among providers and, ultimately, improved member experience.

Overall, members and providers hold favorable views of the program. CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey results showed that 81 percent of members gave their providers a favorable rating, and 72 percent rated RMHP Prime favorably. Members with complex conditions say they are benefiting from care coordinators who help them overcome both medical and non-medical obstacles to health.

Because of the flexibility the payment structure offers, RMHP is able to support its practices so they can improve their processes and quality to better serve patients. Such practice support helps practices become more member-centered and makes the best use of health services for each member. Such support also helps to build strong relationships with providers.

Lessons from the Programs

The payment reform initiatives described in this report have different features and, therefore, different lessons to offer. RMHP Prime is more comprehensive and delivers services to members through its network of providers on the primarily rural Western Slope. This initiative is demonstrating how flexible funding and greater accountability allows an organization like RMHP to support both providers and members in innovative ways.

Access KP's payment model is different because it features a single entity (Kaiser Permanente) that has contracted with a Regional Care Collaborative Organization (Colorado Access) to manage much of the care for members but not all of it. Although this program is new, the experience thus far has demonstrated that transitioning to a different payment model requires good communication and coordination.

Below are some other lessons learned that are being used to shape the next iteration of the Accountable Care Collaborative:

- **Both members and providers benefit from coordinated physical and behavioral health care.** RMHP Prime has been working to improve access to behavioral health services by fostering behavioral health integration through practice transformation support and financial incentives. This may explain why its members have accessed these services at a higher rate than the rest of the population that uses the Behavioral Health Organization in that region.
- **Practice support is essential, and flexible payment makes it possible.** Practices are more successful in adopting new member-centered processes when they have the support, both operational and financial, to implement these changes. RMHP has simultaneously supplied practice transformation support and flexible payments that have allowed practices to build new care models for their members.
- **Care coordination works, especially for members with many health challenges.** Care coordination helps members access the care they need by addressing and overcoming the day-to-day obstacles to good health. Both Access KP and RMHP Prime have worked to develop care coordination models that bring together a variety of providers to more holistically address their members' needs.

1. Introduction

The Department of Health Care Policy & Financing (Department) is pleased to submit this annual report on payment reform initiatives under section 25.5-5-415, C.R.S. (also known as HB 12-1281). The report provides an update for the programs underway as a result of this legislation.

Ineffective payment models cause many problems for the health care system. The Department is committed to testing new payment models to find which ones work for Colorado's health care system and provide the most value for every dollar spent on health care.

The Department currently has two payment reform initiatives underway: Access Kaiser Permanente (Access KP) and Rocky Mountain Health Plans Prime (RMHP Prime). Both programs are run within the Accountable Care Collaborative but have different payment methodologies than the rest of the program. Both will continue through FY 2017–18. No additional initiatives will be implemented during this time period.

2. Access Kaiser Permanente

This report is an update on the first six months of the program implementation (July 2016 – December 2016).

2.1. Access KP Enrollment

Access KP serves Medicaid members in Adams, Arapahoe and Douglas counties (Accountable Care Collaborative Region 3) who have Kaiser Permanente as their primary care medical provider.

Members who were already receiving care from Kaiser Permanente have been automatically enrolled into Access KP. Members who did not wish to participate had 30 days to opt out prior to their July 1, 2016, enrollment date, and an additional 90 days to opt out after enrollment. Members may opt out during the open enrollment period every year. After the initial enrollment, only Medicaid members who selected Access KP were enrolled.

Access KP had an average monthly enrollment of 22,680 in the first half of FY 2016–17 (July–December 2016). Almost half of those enrolled are adults without a disability, and

almost half are children without a disability. A small number are adults and children with a disability.

2.2. Payment Methodology for Access KP

The Department pays Colorado Access a monthly expenditure per member in exchange for covering most primary care and some specialty care services for its members. This is a full risk, limited benefit capitation. Benefits not covered under the monthly capitation fee, such as inpatient hospital stays, are still covered for members but are paid for by the Department rather than by Kaiser Permanente. In this hybrid payment model, Colorado Access is financially responsible and its contractor, Kaiser Permanente, delivers the care for about 2,000 primary care and specialty care treatment codes. The Department is financially responsible for all other care.

This model uses the strengths of Kaiser Permanente's existing model for providing care: a wellness-based approach that uses an integrated delivery structure and health information technology to manage the care of its members.

2.3. Quality Measures for Access KP

Access KP does not yet have quality or outcome data to report because members were not enrolled until July 2016.

2.4. Medical Loss Ratio for Access KP

A medical loss ratio is a 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 Medicaid managed care programs and commercial plans to ensure that health plans are spending enough money on health services.

For FY 2016–17, the medical loss ratio for Access KP is set at 85 percent. This means that Access KP must spend at least 85 percent of its revenue on medical services. Data on whether Access KP met the medical loss ratio was not available at the time this report was submitted.

2.5. Access KP Provider Participation and Satisfaction

There are 22 Kaiser Permanente primary care practices in the Denver-Boulder metro areas participating in Access KP, as well as three behavioral health offices.

To ensure a successful rollout of the Access KP program, Access KP created numerous educational materials for providers and community agencies. In addition, seven provider training webinars were conducted. All materials were made available to providers at a specifically designated provider website for the Access KP program.

Access KP solicits provider satisfaction information and suggestions during the quarterly Program Improvement Advisory Committee meetings. Access KP also solicits feedback during provider trainings and through emails and phone calls from providers.

While the initial reaction to Access KP has been largely positive, there has been confusion among some providers related to billing and the need for prior authorization for members seeking care outside of the KP network. Colorado Access has worked with its provider network and Kaiser Permanente to ensure providers understand the billing process. Kaiser Permanente also waived the prior authorization requirement during the first 75 days of the contract period for certain members seeking care out of the Kaiser Permanente network.

2.6. Access KP Member Engagement and Satisfaction

Kaiser Permanente primary care providers have long served as medical homes for their members and are equipped to identify and oversee member care coordination. In addition, Kaiser Permanente's Behavioral Health Care Coordinators provide assessment, navigation and care coordination services to Access KP members who have behavioral health needs or qualify for Medicaid waivers. They work to coordinate care with community mental health centers, single entry point agencies and community-centered boards. Kaiser Permanente's Community Specialists help members to address a variety of social and non-medical needs, including food insecurity, transportation, childcare and housing. They work with a broad range of support organizations including food banks, daycare providers, homeless shelters, respite providers and the non-emergency transportation provider.

Access KP plans to formally solicit feedback on member experience through a CAHPS[®] survey (Consumer Assessment of Healthcare Providers and Systems) in the spring of 2017. Access KP also collects, synthesizes and reports on any feedback received from members via phone, email or provider report. Initial feedback has largely been positive, though some members have been confused about the design of the benefit package and the appropriateness of seeking care outside of Kaiser Permanente's network. Colorado Access and Kaiser Permanente have been working to address this confusion through the member communication, including webinars, FAQs and fact sheets.

3. Rocky Mountain Health Plans Prime (RMHP Prime)

This report covers FY 2015–16, the last completed fiscal year for the program for which all enrollment, utilization and cost data is now available.

3.1. RMHP Prime Enrollment

Since September 2014, RMHP Prime has served members in six counties in the Accountable Care Collaborative Region 1: Garfield, Gunnison, Montrose, Mesa, Pitkin and Rio Blanco. In FY 2015–16, 51 practices participated in RMHP Prime and received payments for attributed members.

Eligible members are automatically enrolled in the program on an ongoing basis. Members who did not wish to participate have 30 days to opt out prior to their enrollment date, and an additional 90 days to opt out after enrollment.

In FY 2015–16, monthly enrollment in Prime averaged 35,356 members. Enrollment numbers have been higher than expected as a result of Medicaid expansion. Overall, the majority of RMHP Prime members are adults. The only children enrolled in RMHP Prime are those with disabilities.

3.2. Payment Methodology and Program Costs for RMHP Prime

Payment Methodology

The RMHP Prime payment reform initiative began in 2014. The Department pays RMHP Prime a set monthly fee in exchange for covering a comprehensive set of physical health services to its participating members. This is *full risk capitation*. RMHP Prime, in turn, pays their participating primary care medical providers a single *global payment* each month to cover the care of all the members who are under the practice's care. This payment is calculated based on the number of participating members who are attributed to the practice. Payments to each practice are risk-adjusted, so the practices are not incentivized to take only healthy members or exclude sicker or older members.

Under RMHP Prime, PCMP practices have both *upside* and *downside* financial risk. If a PCMP practice's actual costs exceed the global payment, RMHP Prime takes back five percent of the practice's global payment for that month. However, if a PCMP practice's expenditures were lower than expected and the practice met relevant quality targets, RMHP Prime will share savings at the end of the year. Savings are also shared with community mental health centers in the region that meet contractual requirements to work

with the RMHP health engagement team and to support the coordination of physical and behavioral health care. This dual emphasis on cost and quality increases provider accountability for both fiscal outcomes and care delivery outcomes.

Program Costs

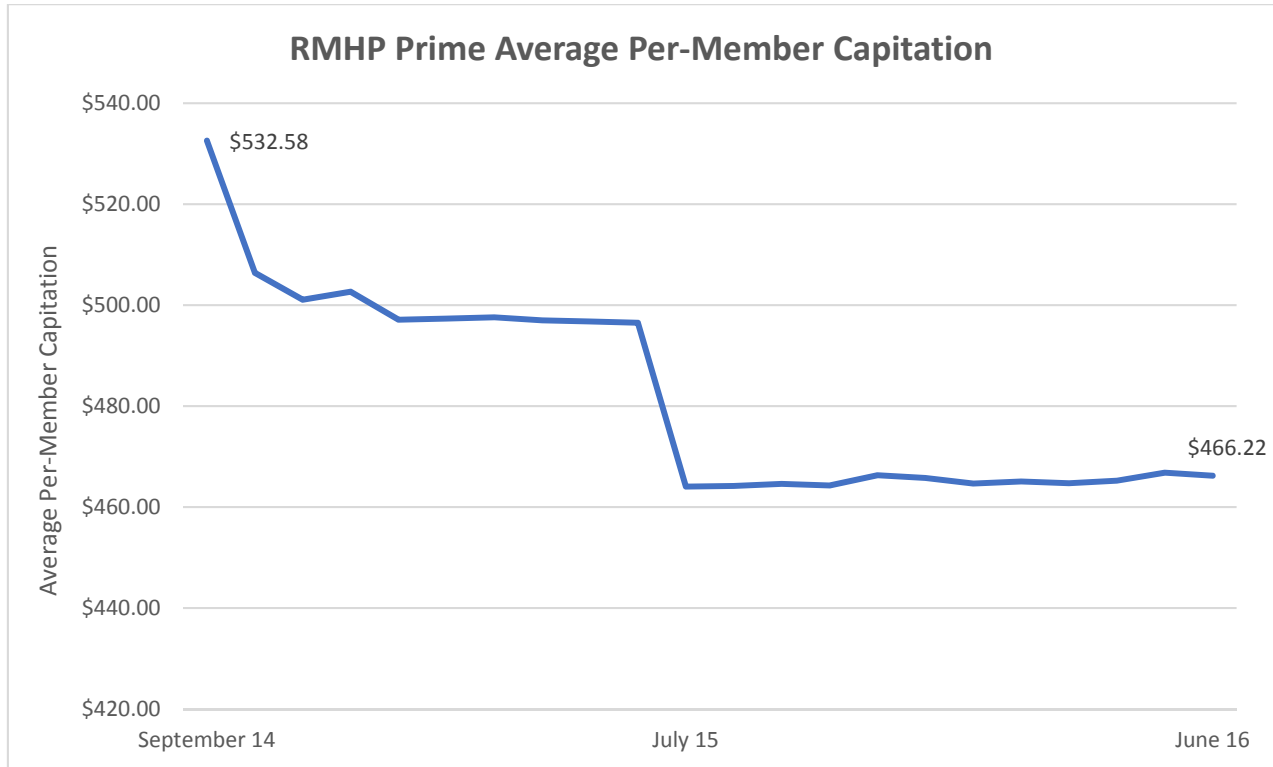
In FY 2015–16, expenditures for the Prime program totaled \$198,208,810. As reported last year, expenditures for the first year of the program (FY 2014–15) were approximately \$128 million. Expenditures increased this fiscal year because the program had full enrollment for the entire fiscal year. During the first program year, the Department used a phased approach to enroll members into RMHP Prime. Enrollment began September 2014 with 7,675 members and reached full enrollment of 33,978 members in June 2015.

Despite the increase in overall programmatic expenditures due to full enrollment, the average monthly capitation for each enrolled member has decreased over the life of the program. The Department enrolled a high number of Medicaid expansion adults, who were to new coverage, into RMHP Prime. Like other states^{1,2}, the Department had little experience with this population. However, the Department has monitored this population's utilization habits over the life of the program and has made the necessary adjustments to the program's capitation payments. See Figure 1.

¹ Finkelstein, A., et al. "Effect of Medicaid Coverage on ED Use – Further Evidence from Oregon's Experiment." *The New England Journal of Medicine*. Volume 375: 1505–1507: October 20, 2016.

² Lo, Nigel, et al. "Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program." *UCLA Center for Health Policy Research*: October 15, 2014.

Figure 1. RMHP Prime Average Per-Member Capitation, September 2014 to June 2016³



3.3. Quality Measures and Outcomes for RMHP Prime

Quality measures help the Department and RMHP monitor how well the program is meeting the health needs of the populations it serves. The FY 2015–16 quality measures for RMHP Prime are the same as the measures used in the previous years of the program:

- Body mass index (BMI) assessment for adults
- HbA1c poor control (a measure of diabetes control)
- Antidepressant medication management for acute and continuation phases
- Implementation of a Patient Activation Measure (PAM[®]) assessment

These measures are used to calculate RMHP Prime's medical loss ratio, which determines how much money RMHP must spend on providing medical services compared to administrative services and profit. RMHP Prime's measures also align with quality measures used in other initiatives throughout the state and have established data sources.

³ Enrollment and expenditure data is pulled from the Department's Medicaid Management Intelligence System (MMIS).

Table 1. Quality Measures and Performance Targets for RMHP Prime’s Medical Loss Ratio⁴

Quality Measure	Target(s)	FY 2015–16 Performance
Adult Body Mass Index (BMI) Assessment (HEDIS)	<ul style="list-style-type: none"> Assessment completed for at least 82.33% of members 	<ul style="list-style-type: none"> 91.93% of adults were assessed
HbA1c Poor Control (>9.0%) (HEDIS)	<ul style="list-style-type: none"> No more than 28.95% of members have an HbA1c above 9.0% 	<ul style="list-style-type: none"> 28.79% of members had HbA1c above 9.0%
Antidepressant Medication Management (HEDIS)	<ul style="list-style-type: none"> At least 56.05% of members with major depression remain on medication for at least 3 months (acute phase) At least 40.06% of members diagnosed with major depression remain on medication for at least 6 months (continuation phase) 	<ul style="list-style-type: none"> 69.92% remained on the medication for at least 3 months 57.47% remained on the medication for at least 6 months
Patient Activation Measure (PAM®)	<ul style="list-style-type: none"> At least 10 PCMPs, serving at least 50% of RMHP Prime’s attributed members, implement PAM® 	<ul style="list-style-type: none"> 33 PCMPs, serving 94.0% of RMHP Prime’s attributed members, implemented PAM®

Health Effectiveness Data and Information Set (HEDIS) Measures for RMHP Prime

The first three quality measures are from HEDIS (Health Effectiveness Data and Information Set). These measures were developed by the National Committee for Quality Assurance and are used widely in managed care. The three measures were chosen to measure approximate practice proficiency in several areas:

- BMI assessment measures preventive care
- HbA1c control measures how well chronic conditions are managed
- Antidepressant medication management measures how well behavioral health care is managed

RMHP Prime’s Use of the Patient Activation Measure®

The Patient Activation Measure (PAM®) is a tool used to assess a member’s level of engagement in their health care. Members complete a short survey and are rated at a

⁴ During FY 2015–16, RMHP used a nationally recognized vendor to collect and report clinical data for all three HEDIS quality measures. However, across the country, the vendor failed to appropriately report data for the first two quality measures (BMI assessment and HbA1c control) for providers and health plans, including RMHP Prime. To rectify this, RMHP re-collected and submitted its own data for these measures. The Department accepted the revised data but placed RMHP Prime on a corrective action plan because its vendor could not validate the data. For future performance years, the Department is requiring third-party validation for all measures that require it.

Level 1 through 4, with 4 being the most activated or engaged in their care. The PAM® is an important tool that providers can use to match interventions and education with a member's level of health knowledge and readiness to change. The survey can also be used to help providers predict patterns of health and resource utilization.

It has been challenging for RMHP Prime practices to include the PAM® in their workflow. Some providers who have not yet adopted it wonder if the PAM® will be worth the time it takes to administer. However, those who adopt it see its value because they are able to identify and give extra support, including the use of a coach, to members who are not currently engaged in their care. As a result, these members are better able to do the things they must do to manage a condition at home.

By the end of FY 2015–16, 51 practice sites as well as the RMHP Care Management Department and Community Health Workers were using the PAM – an increase from 27 sites in FY 2014–15. In addition, RMHP has doubled the number of people trained to administer the assessment (from 127 to 257).

Emergency Department Use Among RMHP Prime Members

The Department also looks at emergency department use to understand how well the program is managing the health needs of its members and preventing high-cost services. The emergency department measure tracks 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 member months.

Members of RMHP Prime visited the emergency department at a rate of approximately 76.1 visits per thousand member months. This rate is higher than the average across all members in the Accountable Care Collaborative and regular Medicaid (57.6 visits per thousand member months). RMHP is taking steps to prevent unnecessary use of the emergency department. For example, RMHP Prime is working to coordinate behavioral health care with primary care and connect more people with needed behavioral health services before they have an emergency situation. Prime also uses community care teams to provide comprehensive assessment and care coordination for Prime members. Care coordinators connect members to needed services so they are less likely to need emergency care.

Members of the Accountable Care Collaborative Region 1, including RMHP Prime members, benefit from RMHP's Health Engagement Team, a pilot partnership between RMHP, Whole Health, LLC (a subsidiary of Mind Springs Health) and some primary care practices on the Western Slope. This initiative provides care management for individuals with a history of high emergency department utilization.

Access to Behavioral Health Services for RMHP Prime Members

RMHP Prime has made it a priority to get its members better access to needed behavioral health services. One way to measure access to these services is with the behavioral health organization penetration rate. This rate tells what percentage of the population served by a health plan actually receives behavioral health services. In FY 2015–16, the behavioral health penetration rate for Prime members was 20 percent, compared with less than 15 percent of all Medicaid members who use the Behavioral Health Organization in the same geographic area and with less than 15 percent of all Medicaid members.

RMHP Prime is making good use of the work that RMHP is doing through the Accountable Care Collaborative to improve access to behavioral health care through initiatives such as the State Innovation Model (SIM). This initiative supports practice transformation to improve integration of physical and behavioral health care. At the time of this report, 17 RMHP Prime practices have been selected to be SIM Cohort 1 practices. All of these practices received practice transformation support from the RMHP Practice Transformation team.

RMHP Prime is also utilizing another RMHP program called Colorado is Expanding Access to Rural Team-based Healthcare (CO – EARTH) to help small rural practices address behavioral health needs. The program offers training and support to help clinics improve their staff's ability to address behavioral health care, work with behavioral health clinicians in the community, bring behavioral clinicians on site or fully integrate behavioral health into the clinic. At the time of this report, 12 RMHP Prime practices were participating in the program.

3.4. Medical Loss Ratio for RMHP Prime

A medical loss ratio measures how much money a health plan spends on providing medical services compared to administrative services and profit. It is used to ensure that health plans are spending enough money on medical services. The standard ratio for most Medicaid and Medicare capitated plans is 85 percent.

For FY 2015–16, the Department set the medical loss ratio for Prime at 89 percent, meaning RMHP was expected to spend at least 89 percent of its revenue on medical services. However, RMHP Prime could reduce its expected ratio by one percentage point for each quality target it achieved. Because RMHP met all four of its quality targets, its medical loss ratio was reduced to 85 percent.

3.5. RMHP Prime Provider Participation and Satisfaction

In FY 2015–16, 51 practices participated in RMHP Prime and received global payments for attributed members. In addition to this payment, RMHP supports these providers as they adapt to the evolving health care landscape and transform their practices to meet the challenges of payment and delivery reform.

The Practice Transformation Team at RMHP works with its primary care practices to develop an active learning community. This group of engaged practices focuses on quality improvement and team-based, patient-centered primary care. The RMHP Practice Transformation Program offers learning opportunities at different levels of mastery that teach practices about quality improvement, care coordination across the medical neighborhood, and use of data to track health needs, service delivery and outcomes.

RMHP practices participate in a number of initiatives to improve or test new delivery and payment models, including RMHP Prime. The Practice Transformation Team creates learning collaboratives to help practices integrate all they have learned from RMHP Prime as well as initiatives like the Comprehensive Primary Care Initiative (CPCi), Comprehensive Primary Care Plus (CPC+), Transforming Clinical Practice Initiative (TCPI) and the Colorado State Innovation Model (SIM).

RMHP practices have noticed the effects of the new practice transformation and financial support. Below are some of their observations:

- “Our journey began with a private practice consisting of five providers, each practicing in their own silo with their own staff. Turning the clock to today, we have been able to maintain the continuity of care that patients expect, but in addition, we have recognized the power of care teams. In the end, practice transformation was the stepping stone that allowed us to improve ourselves as a practice first. As a result, our improvements are transferred into an improved patient experience.” – Roaring Fork Family Physicians
- “Some of the benefits I’ve seen as a result of our participation in practice transformation are measurable, while others are not as easily monitored. For

instance, I believe the current processes have pulled our team together into a more cohesive group. We've increased our staff awareness of what goes on with our patients, what responsibilities other staff members have to make our processes work and increased satisfaction when everyone participates and shares in different aspects of those processes." – Peach Valley Family Medical Center

- "For one of our patients with many complex needs, we opened up a conversation with the primary care provider, the behavioral health provider and the patient regarding the medical and non-medical components of chronic pain. We started to outline long-term treatment and a care plan to help her have less pain and increased function. The patient started crying and said that none of her care providers have ever done this before and showed care about her daily life." – MidValley Family Practice

3.6. RMHP Prime Member Engagement and Satisfaction

Member engagement is an important part of RMHP Prime's strategy. As described above, the program uses the Patient Activation Measure (PAM[®]) to assess how engaged members are likely to be in their care. RMHP Prime uses care coordinators and care managers to help members with low activation scores to overcome barriers and do their part to stay healthy.

RMHP Prime's philosophy is that care coordinators should be located as close to the practice site as possible. Of the participating 51 Prime practices, 36 participate in at least one program that includes in-practice care coordination services. Other practices may have in-practice care coordinators even if they do not participate in one of the programs. Additionally, RMHP employs a staff of regional care coordinators that serve all of its Accountable Care Collaborative members, including Prime members.

RMHP Prime uses community health workers to help members remain knowledgeable about their health and engaged in their care. RMHP Prime has partnered with Whole Health LLC, which administers the Health Engagement Team project. With this project, RMHP Prime embeds behavioral health-trained community health workers in some of its primary care sites. This workforce supports RMHP Prime members who need extra support in maintaining their self-care and addressing social and behavioral factors that affect members' health. Community health workers screen for behavioral health needs, offer health education and coach members on taking care of their health. They also work specifically with RMHP Prime members who have had four or more emergency department

visits in the past 12 months, offering intensive care coordination with behavioral approaches such as shared care planning and motivational interviewing.

RMHP Prime solicits feedback on member experience of care through a CAHPS[®] survey (Consumer Assessment of Healthcare Providers and Systems). The results of the CAHPS[®] survey for FY 2015–16 showed that 81 percent rated their provider favorably, and 72 percent rated RMHP Prime favorably. More importantly, 85 percent members reported receiving the care they needed, and 82 percent of members said they received that care in a timely and expedient way. Finally, 94 percent of members were pleased with how their providers communicated with them.

Just as important as the survey numbers are the stories they represent. Below are some of the stories and feedback RMHP Prime has gotten from its members:

- “I couldn’t have done this without your help,” said a member who received medical, social, emotional and financial support while in Complex Case Management.
- The family of a child who needed oxygen services had a difficult time getting services from the oxygen provider. The medical assistant at the office called the care manager to ask for help, and the care manager was able to work with the family to fill out the right forms and get the child the oxygen he needed.
- One member with complex physical and behavioral health needs said she “feels much less anxious now” because she is working with a care manager, who checks in with her once or twice a week.

4. Lessons from the Payment Reform Initiatives

The payment reform initiatives described in this report have different features and, therefore, different lessons to offer.

RMHP Prime is comprehensive and delivers services to members through its network of providers on the primarily rural Western Slope. This initiative is demonstrating how flexible funding and greater accountability allows an organization like RMHP to support both providers and members in innovative ways. The program is strengthening the connections among providers in the area, which can be particularly challenging but critical in a rural area.

Access KP’s payment model is different because it features a single entity (Kaiser Permanente) that has contracted with the Regional Care Collaborative Organization

(Colorado Access) to manage much of the care for members, but not all of it. This program is demonstrating that both providers and members are accustomed to more traditional payment and delivery structures, so good communication and coordination is essential throughout the rollout process for everyone to learn how care will be delivered and billed.

The Department plans to integrate lessons learned into the design of the next phase of the Accountable Care Collaborative. Below are some of the lessons learned and how they have informed some of the features of the Accountable Care Collaborative's next iteration:

- **Both members and providers benefit from coordinated physical and behavioral health care.** RHMP Prime recognizes that many of its sickest members have both physical and behavioral health conditions that must be treated simultaneously if the member is to have a better health outcome. The program has, therefore, worked to create a payment and delivery structure that helps facilitate the integration of physical and behavioral health. This has benefited members, who have better access to the broader treatments and services they need, and providers, who have more access to member information and are working to collaborate to meet more of the members' needs than they ever could do alone. The Department plans to integrate the administration of physical and behavioral health in the next phase of the Accountable Care Collaborative by having a single administrative entity. What were previously Regional Care Collaborative Organizations and Behavioral Health Organizations will now be a Regional Accountable Entity, which will arrange and coordinate both behavioral and physical health care. In addition, new primary care payments will incentivize greater team-based care, integration of services and higher standards.
- **Practice support is essential, and flexible payment makes it possible.** Designing a good payment and delivery model is only half the work. Policymakers and payers must help practices translate the ideas into reality. Even a small change, such as doing a PAM[®] assessment, can disrupt the workflow of a practice. It can be difficult to learn and implement a new way to operate while continuing to provide necessary services, and practices need support and training to do this well. Moreover, without payment flexibility, many practices would be unable to implement their desired changes. RMHP has worked to simultaneously provide practice transformation assistance and flexible payments to practices in order to develop new care models that better address their members' needs. For the next phase of the Accountable Care Collaborative, the Department is looking at additional ways for regional entities to have more responsibility to financially and operationally support practices as they develop new models of care.

- **Care coordination works, especially for members with many health challenges.** Community health workers and care coordinators are an important part of the care team. Many of the things that affect health happen outside of the clinic walls, and care coordinators help members face and overcome the day-to-day obstacles to better health. In the next phase of the Accountable Care Collaborative, Regional Accountable Entities will have enhanced care coordination requirements for the whole population in their service area.

These payment reform programs are achieving their intended purpose: helping the Department understand how different models of payment and service delivery will work in reality. Each one is a laboratory that generates and tests new ideas that allow the Department to assess whether these activities may be scaled for use in the overall Accountable Care Collaborative program.