COLORADO
Department of Health Care Policy & Financing

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

April 16, 2018

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

Dear Representative Hamner:

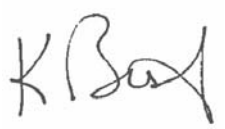
Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Medicaid Payment Reform and Innovation Pilot Program to the Joint Budget Committee.

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 implemented two payment reform initiatives under Section 25.5-5-415 C.R.S. This report will provide a brief background on 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 Interim Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,



Kim Bimestefer
Executive Director

KB/mpl

Enclosure(s): 2018 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Senator Kent Lambert, Vice-chair, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting
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Chris Underwood, Health Information Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Interim Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

April 16, 2018

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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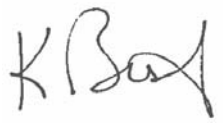

Kim Bimestefer
Executive Director

KB/mpl

Enclosure(s): 2018 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 16, 2018

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.

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

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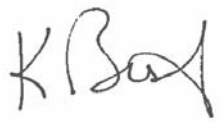

Kim Bimestefer
Executive Director

KB/mpl

Enclosure(s): 2018 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 Edie Hooton, Health, Insurance and Environment Committee
Representative Stephen Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment Committee
Representative Chris Kennedy, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
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David DeNovellis, Interim Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

April 16, 2018

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 implemented two payment reform initiatives under Section 25.5-5-415 C.R.S. This report will provide a brief background on the two initiatives, describe payment methodologies and quality measures, provide performance data, and discuss how program design impacts clients and providers.

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Sincerely,

Kim Bimestefer
Executive Director

KB/mpl

Enclosure(s): 2018 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Susan Beckman, 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 Joanne Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Susan Lontine, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
Representative Kim Ransom, Public Health Care and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Interim 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, 2018 to:

Joint Budget Committee

House Health, Insurance, and Environment Committee

House Public Health Care and Human Services Committee

Senate Health and 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 payment reform initiatives required under Section 25.5-5-415, C.R.S. (also known as House Bill 12-1281). The report provides an update for the initiatives underway as a result of this legislation: Rocky Mountain Health Plans Prime (RMHP Prime) and Access Kaiser Permanente (Access KP). Both programs were run within the Accountable Care Collaborative but have different payment methodologies than the rest of the program. RMHP Prime started in September 2014 and will continue through June 2018; in July, RMHP Prime will be implemented in next phase of the Accountable Care Collaborative as part of the Regional Accountable Entity contract for Region 1. Access KP ran from July 2016 to June 2017.

Rocky Mountain Health Plans Prime

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. RMHP Prime 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 2016–17, 56 practices participated in RMHP Prime and received payments for attributed members. During this time period, monthly enrollment in Prime averaged 34,893members. Expenditures for the program totaled $174,158,426 in FY 2016–17, which is a 12 percent decrease from FY 2015-16 expenditures.

For FY 2016–17, RMHP Prime met or exceeded its targets in three of the four quality measures for the program: body mass index (BMI) assessment for adults; HbA1c poor control (a measure of diabetes control); and percentage of practices using the Coaching for Activation portion of the Patient Activation Measure (PAM®) tool. The program did not meet its targets for antidepressant medication management for acute and continuation phases.

RMHP Prime members used the emergency department at a higher rate than members of the Accountable Care Collaborative as a whole, but the rate dropped slightly compared to

last year. RMHP Prime members accessed behavioral health care at a greater rate than the rest of the population that uses the behavioral health organization in that region (22 percent compared to 15.5 percent of the general population in the region).

RMHP Prime supports its practices so they can build capacity and better serve members. Such practice support builds strong relationships with providers and helps practices make the best use of their staff and resources for member care. Opportunities for practice transformation have been offered to all practices, but there has been uneven uptake of these opportunities depending on the readiness and ability of individual practices to integrate new approaches.

To better serve members, RMHP Prime seeks member feedback in several different ways. First, the program uses in-depth focus groups through the Voice of the Consumer project to assess and to respond to member experience trends. Second, RMHP Prime uses a Member Experience and Advisory Committee to improve care and to understand the needs of members. RMHP Prime listens to the experiences of members and uses this knowledge from both groups to design a coordinated delivery system that works to seamlessly link members to both health services and community resources that address social determinants of health.

Finally, RMHP Prime does a CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey to gather feedback on member experience. The CAHPS® results for RMHP Prime members in FY 2016–2017 showed that of the 1350 members who took the survey, 56 percent rated their provider favorably (a 9 or 10 on a 1-to-10 scale) and 52 percent rated RMHP Prime favorably. More importantly, 87 percent of members reported receiving the care they needed, and 85 percent of members said they received that care in a timely and expedient way. In addition, 89 percent of members were pleased with how their providers communicated with them. Members with complex conditions continue to benefit from care coordinators who help them overcome both medical and non-medical obstacles to health.

Access Kaiser Permanente

The Access KP pilot launched in July 2016 and concluded in June 2017. It was designed as a partnership between Colorado Access, Kaiser Permanente and the Department.

For this program, the Department paid 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, were covered

for members but were paid fee-for-service by the Department rather than by Colorado Access's subcontractor, Kaiser Permanente.

Access KP served Medicaid members in Adams, Arapahoe and Douglas counties (Accountable Care Collaborative Region 3) who have Kaiser Permanente as their primary care medical provider. Access KP had an average monthly enrollment of 22,316 in FY 2016–17. Expenditures for the program totaled $21,439,435 in FY 2016–17.

The program concluded on June 30, 2017, following notification from Kaiser Permanente that they would not renew their contract with Colorado Access for the contract period of July 1, 2017–June 30, 2018. Kaiser Permanente indicated they made this decision for several reasons, including:

- The operational challenges and costs associated with implementing a program with a payment structure split between a full-risk, partial benefit capitation payment, an administrative per-member-per-month payment for care coordination, and fee-for-service payments (Medicaid benefit plan services that Kaiser Permanente could provide in-network were paid through a capitation payment and the rest of the Medicaid benefits were paid fee-for-service);
- Kaiser Permanente's desire to focus on other payment reform strategies, including the Department's Alternative Payment Model (APM); and
- Challenges for providers in confirming plan enrollment in the Department's new eligibility portal.

Looking Ahead

This pilot payment reform initiative has provided some lessons and considerations for the Department as it continues to innovate for better care, particularly for the next phase of the Accountable Care Collaborative.

- **Care coordination continues to be a foundational service and need.** Care coordination is vitally important, especially for members who need multiple medical, behavioral health and social services. Care coordinators orient members to the system and help members connect their services and providers. In a fragmented health care system, care coordinators can help both members and providers work toward better health and well-being. As a result, care coordination can help with achieving better health and cost outcomes, such as reduced emergency department visits and better access to behavioral health care. For this reason, care coordination will continue to be a defining characteristic of the Accountable Care Collaborative in Phase II.

- **Successful behavioral health coordination requires engagement and effort at multiple levels.** RMHP Prime results indicate that the payment reform model has helped to coordinate behavioral and physical health and increase access to behavioral health services. Several different strategies contribute to this. The Department created a behavioral health metric to incentivize better behavioral health care. It also emphasizes care coordination and management to ensure that members with multiple complex conditions are getting the behavioral health care they need. Care coordinators and community health workers who are trained to work with members in need of behavioral health services serve as a critical link to needed services. Finally, RMHP Prime included behavioral health leadership into its governance structure. In Phase II of the Accountable Care Collaborative, the Department is putting the administrative functions for primary care and behavioral health under one entity to promote better coordination within and among physical and behavioral health systems.

- **System coordination starts with good program design and on-the-ground engagement.** The Department's goal is to create cohesive systems that meet the needs of members and providers while delivering value. Through these pilots, the Department has learned how important it is to have a strong payer and provider network that creates a coordinated system that includes all benefits. It is also important to get member experience feedback and help to build coalitions in the communities served by the program. When the benefits are limited or focused on a specific provider type, as was the case with Access KP, this level of coordination is difficult. Innovative collaboration is possible when the benefits are more comprehensive and a host of providers are participating, as was the case with RMHP Prime. By contracting with a single Regional Accountable Entity (RAE) in each region, the Department is encouraging benefit coordination and alignment, as well as engagement of local partners to create a health neighborhood. In addition, Phase II of the Accountable Care Collaborative will encourage member engagement and provider support to foster coordination from the ground up.

- **Program flexibility is critical for provider and system success.** RMHP Prime used novel payments to allow practices to try innovative interventions and fine-tune the capacity of their practices. While practice support resources are offered to all practices, the uptake of these resources varies and depends on the readiness and capacity of providers to fine-tune their operations and care models. As a result, improvements in health and cost outcomes may vary across the program. In Phase II of the Accountable Care Collaborative, the Department will create flexible, value-based payments that support non-traditional, coordinated and comprehensive models of care. The Department will work with its RAEs to

develop and implement models that support the broad range of providers and allow them to fine-tune their care models and better serve their members.

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 House Bill 12-1281). The report provides an update for the programs underway as a result of this legislation.

This payment reform pilot includes two initiatives: Rocky Mountain Health Plans Prime (RMHP Prime) and Access Kaiser Permanente (Access KP). Both programs were run within the Accountable Care Collaborative but have different payment methodologies than the rest of the program. RMHP Prime started in September 2014 and will continue through FY 2017–18; in July, RMHP Prime will be implemented in next phase of the Accountable Care Collaborative as part of the Regional Accountable Entity contract for Region 1.

2. Rocky Mountain Health Plans Prime (RMHP Prime)

2.1. General Operations

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 2016–17, 56 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 2016–17, monthly enrollment in Prime averaged 34,893 members, compared to 35,356 per month the previous year. The majority of RMHP Prime members are adults. The only children enrolled in RMHP Prime are those with disabilities.

Program Costs and Payment Methodology for RMHP Prime

In FY 2016–17, expenditures for the Prime program totaled $174,158,426. This was less than the previous year's expenditures of $198,208,810 due largely to the continued decrease in the average monthly capitation payment. The main drivers of this downward trend in expenditures were improved rate-setting processes and a better understanding of

the populations covered under RMHP Prime, particularly those adults eligible through Medicaid expansion.

The Department pays RMHP Prime a set monthly fee in exchange for covering a comprehensive set of physical health services to its participating members. 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 well members and exclude sicker or older members.

Under RMHP Prime, participating Primary Care Medical Providers (PCMP) have both *upside* and *downside* financial risk. If a PCMP practice's actual costs exceed the global payment, RMHP Prime takes back 5 percent of the practice's global payment for that month. However, if a PCMP practice's expenditures were lower than expected and the practices 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.

2.2. Quality Metrics for RMHP Prime

Quality measures help the Department and RMHP Prime monitor how well the program is meeting the health needs of the populations it serves. The FY 2016–17 quality measures for RMHP Prime are similar to 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 the Coaching for Activation tool of the Patient Activation Measure (PAM®)

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.

RMHP Prime met the benchmarks in three of the four measures: BMI assessment for adults, HbA1c poor control, and implementation of the Coaching for Activation tool of the PAM®. The program did not meet the benchmark for antidepressant medication management.

Table 1. Quality Measures and Performance Targets for RMHP Prime

Quality Measure	Target(s)	FY 2016–17 Performance
Adult Body Mass Index (BMI) Assessment (HEDIS)	• Assessment completed for at least 91.28% of members	• 93.02% of adults were assessed
HbA1c Poor Control (>9.0%) (HEDIS)	• No more than 29.68% of members have an HbA1c above 9.0%	• 28.45% of members had HbA1c above 9.0%
Antidepressant Medication Management (HEDIS)	• At least 59.35% of members with major depression remain on medication for at least 3 months (acute phase) • At least 42.29% of members diagnosed with major depression remain on medication for at least 6 months (continuation phase)	• 56.03% remained on the medication for at least 3 months • 36.21% remained on the medication for at least 6 months
Patient Activation Measure (PAM®)	• At least 85% of practices actively using the PAM® tool will demonstrate use of the Coaching for Activation portion of the tool	• 89.47% (34 of 38) of practices that use the PAM® tool demonstrated use of the Coaching for Activation portion of the tool

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 met the benchmarks for the first two HEDIS measures (BMI assessment and HbA1c control). The program did not meet the benchmark for the third HEDIS measure (antidepressant medication management), largely due to changing treatment practices among providers. As behavioral health has become better coordinated across the program,

providers now have greater access to alternative forms of treatment and therapy. As a result, providers have shifted away from medication-centric therapies, and RMHP Prime has seen a decline in the use of antidepressant medication.

The Department has been working with RMHP Prime to develop alternative measures that account for these changing practices, assess behavioral health coordination and, most importantly, foster clinical practices that holistically manage behavioral health conditions. For the final contract year of FY 2017–18, RMHP Prime will be assessed for its overall depression screening rates, as measured by the Patient Health Questionnaire®. This tool helps providers manage and triage behavioral health issues that arise during a clinical visit and is a better measure of basic efforts to coordinate behavioral health.

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 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.

Given that the PAM® is a new tool to most providers, RMHP Prime has elected to implement the tool in stages. During the first two contract periods, RMHP Prime focused on getting practices to implement the basic features of the tool within their clinical workflows. During the third contract period, RMHP Prime focused on getting practices to use the Coaching for Activation portion of the tool. By the end of FY 2016–17, 89.47 percent (34 of 38) of practices that had implemented the PAM® were using the Coaching for Activation portion of the tool, exceeding the benchmark of 85 percent. Over the final year of its contract, RMHP Prime will work with these practices to use the Coaching for Activation portion of the PAM® to identify and work with members who have low levels of activation.

2.3. Health and Cost Outcomes

Emergency Department Use Among RMHP Prime Members

The Department looks at emergency department use to understand how well the program is managing the health needs of its members, preventing high-cost services, and shifting utilization to preventative care settings, like primary care. 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 74.8 visits per thousand member months. This rate is higher than the average across all members in the Accountable Care Collaborative (58.5 visits per thousand member months) but less than last year's RMHP Prime emergency department visit rate (76.1 visits per thousand member months). This higher rate of emergency department visits among RMHP Prime is due in part to its higher percentage of enrolled members who have a disability or who were eligible as a result of Medicaid expansion.

RMHP Prime has several approaches for preventing unnecessary use of the emergency department. The program coordinates behavioral health care with primary care, allowing RMHP Prime to connect more people with needed behavioral health services before they have an emergency situation. RMHP Prime also uses practice transformation to increase the capacity of primary care practices to meet the needs of members with complex conditions.

Another strategy RMHP uses is the Health Engagement Team Program. This program provides care management for members with a history of high emergency department utilization. All Accountable Care Collaborative members in Region 1, including RMHP Prime members, have access to this program, which is a pilot partnership between RMHP, two mental health organizations and 12 primary care practices on the Western Slope. This program embeds community health workers in primary care practices to coordinate care and connect members with needed medical care, behavioral health and social services. For RMHP members who participate in this program, emergency department visits were reduced by 41 percent.

Access to Behavioral Health Services for RMHP Prime Members

One of the goals of RMHP Prime is to improve access to needed behavioral health services and better coordinate those services with medical care. By ensuring that members get the behavioral health services they need, the Department can avoid costly crisis care and emergency department visits. In addition, addressing behavioral health can often improve treatment outcomes of chronic diseases, since these often occur together.

One way to measure access to behavioral health services is the behavioral health *penetration rate*. This rate tells what percentage of the population served by a health plan actually receives behavioral health services. In FY 2016–17, the behavioral health penetration rate for Prime members increased to nearly 22 percent from 20 percent in FY 2015–16.

The behavioral health penetration rate was also greater for RMHP Prime members than for Medicaid members served by other health plans during FY 2016–17. The behavioral health penetration rate for Medicaid members who received behavioral services through the behavioral health organization, the primary behavioral health plan, in the same geographic area was 15 percent. The statewide rate for all behavioral health plans was 15.5 percent. This suggests that Prime and its model may increase access to needed behavioral health services.

RMHP Prime works on several different levels to improve access to behavioral health care. RMHP has made behavioral health coordination a key component of its practice transformation efforts. RMHP's practice transformation program has added a Ph.D.-level clinical psychologist to coach practices on successfully integrating behavioral health services into their workflow.

Additionally, RMHP Prime uses another 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, 7 RMHP Prime practices are participating in CO-EARTH.

Finally, RMHP maintains strong partnerships with behavioral health providers and others in the community who can connect members to behavioral health services. An integrated executive committee provides strategic and operational oversight of the program. This committee includes two key community mental health centers within RMHP Prime's counties. The committee meets quarterly and works to develop and advance shared principles of an integrated delivery system.

2.4. RMHP Prime Provider Support and Engagement

RMHP Prime supports and works with its providers to help them adapt to the evolving health care landscape and meet the challenges of payment and delivery reform. By supporting providers, RMHP Prime gives providers the skills and support to work with other providers as part of a connected health neighborhood.

Provider Transformation Support

The Practice Transformation Team at RMHP works with its primary care practices to develop an active learning community. This group includes 30 RMHP Prime practices that focus on quality improvement and team-based, patient-centered primary care. To support the unique needs of rural practices, RMHP offers specific practice transformation opportunities like CO-EARTH to develop skills and build infrastructure. The Practice Transformation Team also creates learning collaboratives to help practices integrate what they are learning from other initiatives such as Comprehensive Primary Care Initiative (CPCi), Comprehensive Primary Care Plus (CPC+), Transforming Clinical Practice Initiative (TCPI) and the Colorado State Innovation Model (SIM).

The RMHP Practice Transformation Program offers clinical guidelines and patient resources for specific medical conditions like diabetes, high blood pressure and depression. It also offers extensive learning opportunities about topics such as motivational interviewing, patient self-management and activation, quality improvement, care coordination across the health neighborhood, and data used to track needs and outcomes. Some examples of training include:

- **Bridges Out of Poverty.** Based in part on Dr. Ruby K. Payne's myth-shattering *A Framework for Understanding Poverty*, Bridges reaches out to millions of service providers and businesses whose daily work connects them with people in poverty.
- **Disability Competent Care Training.** These trainings on disability-competent care are facilitated by the Colorado Cross-Disability Coalition (CCDC), using a case study model. Trainings are offered in person and by webinar. In addition, a pediatric-focused training is offered to pediatric providers.

Provider Engagement

RMHP Prime uses practice transformation, care coordination and flexible financial payments to engage providers in meaningful operational and cultural change. Mountain Family and River Valley Family Health Centers are examples of this three-pronged approach to cultural change.

While it started with a strong foundation, Mountain Family Health Centers used RMHP as a significant opportunity to shift toward value-based operations. It was an early adopter of RMHP Prime's practice transformation, flexible payment and care coordination model. The practice hired care coordination staff and embedded them in primary care teams in order to service members with complex needs at the point of care.

River Valley Family Health Center's participation followed a different path, starting with practice transformation and assuming minimal risk with flexible payments. As the practice

matured and worked collaboratively with RMHP Prime, it was able to expand practice transformation, care coordination and flexible payments to create more holistic care models within its clinics.

Both practices have assumed more risk and accountability for both resources and results during the pilot, which is creating a cultural shift. “Principles of accountability drive our collaboration and agreement with Rocky,” said Ross Brooks, CEO of Mountain Family Health Centers. “We are transparent about our care model and accountable to deliver results based on it. That has helped create a values-based culture at our clinics.” RMHP plans to continue using these principles to drive system change in its broader health community.

2.5. RMHP Prime Member Experience

Member engagement is an important part of RMHP Prime’s strategy. As described above, the program uses the Patient Activation Measure (PAM®) to assess the level of a member’s engagement 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.

Care Coordination to Improve Member Experience

Care coordination continues to be a key strategy for improving the experience of members, particularly those with complex medical conditions or those requiring social services. RMHP Prime’s philosophy is that care coordinators should be located as close to the practice site as possible. Some practices have in-practice care coordination services, while others rely on the staff of RMHP regional care coordinators that serve all of Region 1’s 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. The Health Engagement Team Project, 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.

Below are some examples of how RMHP Prime's approach to care coordination has made a difference for members:

- A care coordinator helped a member make the transition from incarceration to the community. The care coordinator worked with the parole office to find the member temporary housing until the member's health needs could be assessed. The care coordinator arranged a conference with the county human services department, the health clinic and the Department of Corrections. As a result, the member was placed in a long-term care facility that met his ongoing needs for care until he was ready to transition to the community. He now lives in his own apartment.
- A care coordinator met with a member who was dealing with serious pain problems and had been discharged from several local practices that could no longer work with him. The care coordinator built trust with the member, helped him to find doctors he could trust and advocated for him as he looked for a surgeon to do a necessary shoulder surgery. The care coordinator helped the member overcome years of antagonism and broken trust with medical providers so he could get the care he needed. The member now has a strong relationship with a primary care provider and is able to manage his medical care independently.
- A member with end-stage liver disease was in a challenging living situation, dependent on her boyfriend because of her disease. The care coordinator, community health worker and behavioral health provider worked with her to help her apply for housing, food assistance and Social Security benefits. This gave her the independence and resources she needed to take care of her health, and her hospitalizations have decreased as a result.

Member Feedback

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 2016–17 showed that of the 1350 members who took the survey, 56 percent rated their provider favorably, and 52 percent rated RMHP Prime favorably. More importantly, 87 percent of members reported receiving the care they needed, and 85 percent of members said they received that care in a timely and expedient way. In addition, 89 percent of members were pleased with how their providers communicated with them[1].

[1]This year, the Department changed its CAHPS reporting methodologies for its health plans. It now reports only "top-box" scores of 9 and 10 from CAHPS surveys. Previously, it had used scores of 8, 9, and 10. Using only scores 9 and 10, the favorable ratings from FY 2015–16 are as follows: personal provider (68%), health plan (55%), needed care (85%), timely care (82%), and provider communication (94%).

RMHP Prime uses in-depth focus groups to assess and to respond to member experience with the *Voice of the Consumer* project. RMHP Prime listens to the experiences of members and uses this knowledge to design a coordinated delivery system that works to seamlessly link members to both health services and community resources that address social determinants of health. Within its counties, RMHP Prime has developed strong partnerships with over 20 providers and community-based agencies to conduct this work. Not only do these partnerships serve as a focal point for local clinical and community leadership, they help build consensus within communities to create and evaluate member-driven system changes.

For example, RMHP Prime has developed three key areas of intervention through this work to meet the needs of its Spanish-speaking population. The first focuses on engaging new community partners such as churches. The second focuses on working with key practices to assess and improve their cultural competency. The third focuses on increasing the use of preventive services and engaging members in wellness activities such as health promotion classes.

RMHP Prime also uses a Member Experience and Advisory Committee to improve care and understand of the needs of members. The Committee has focused on understanding the experiences of members who live with sensory impairments such as deafness and helping providers adopt best practices to serve and care for this population. As a result of this work, RMHP Prime is adding a Deaf Services Coordinator who will recruit interpreters and expand deaf services in the region.

2.6. Challenges

RMHP Prime includes a group of diverse practices across a vast geographic area. The practices differ widely in the challenges they face, the resources they have, and their readiness to adopt and participate in innovative financial and practice transformation activities. While practice transformation, flexible payments and coordination resources are offered to all practices, the uptake of these resources varies by practice capacity and readiness. As a result, improvements in health and cost outcomes may vary across the program. In this and future pilots, the Department will need to work with its programs to develop and implement policies and operations that support the broad range of practices and ensure that both operational and financial interventions are customized to help practices fine-tune their care models and better serve their members.

3. Access KP

3.1. General Operations: Enrollment and Cost

During FY 2016–17, Access KP served Medicaid members in Adams, Arapahoe and Douglas counties (Accountable Care Collaborative Region 3) who have Kaiser Permanente as their primary care medical provider. Access KP had an average monthly enrollment of 22,316 in FY 2016–17. Almost half of those enrolled are adults without a disability, and almost half are children without a disability. Only a small number of members had a disability.

Members who were already receiving care from Kaiser Permanente were 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 were able to opt out during their annual open enrollment period as well. After this initial enrollment, only Medicaid members who selected Access KP were enrolled into the program.

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

The Department paid Colorado Access a capitated per-member-per-month fee to cover most primary care and some specialty care services for its members. The services covered under the capitation payment included any non-pharmacy and non-laboratory medical service codes that Kaiser Permanente had billed to the Department in the previous three years. Medicaid benefits not covered under the monthly capitation fee, such as inpatient hospital stays, pharmacy and laboratory services were still covered for members but were paid fee-for-service by the Department rather than by Kaiser Permanente. In this hybrid payment model, Colorado Access was financially responsible and its contractor, Kaiser Permanente, delivered the care for about 2,000 primary care and specialty care treatment codes.

In addition to the limited benefit, full-risk capitated portion of this program, Colorado Access was paid an administrative PMPM amount to provide care coordination support that spanned the entire Medicaid benefit plan for Access KP members. The Department was financially responsible for all other care.

This model used 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.

3.2. Access KP Pilot Closure

The program concluded on June 30, 2017, following notification from Kaiser Permanente that they would not renew their contract with Colorado Access for the contract period of July 1, 2017 – June 30, 2018. Kaiser Permanente indicated they made this decision for several reasons, including:

- The operational challenges and costs associated with implementing a program with a payment structure split between a full-risk, partial benefit capitation payment, an administrative per-member-per-month payment for care coordination, and fee-for-service payments (Medicaid benefit plan services that Kaiser Permanente could provide in network were paid through a capitation payment and the rest of the Medicaid benefits were paid fee-for-service);
- Kaiser Permanente's desire to focus on other payment reform strategies, including the Department's Alternative Payment Model (APM); and
- Challenges for providers in confirming plan enrollment in the Department's new eligibility portal.

As indicated above, one of the primary challenges was related to the confusion among providers about the partially capitated benefit plan program design and how it would affect them. The Department anticipated this confusion and planned communication and training efforts accordingly. The Department developed a strategic, targeted outreach to non-Kaiser Permanente practices that data identified as practices that KP-attributed members had received services from historically. The Department hosted webinars, created fact sheets, put messages in the provider bulletin and created a website specifically to inform non-Kaiser Permanente providers about the Access KP program. Despite these efforts to reach out to providers proactively, confusion persisted among non-Kaiser Permanente providers, who continued to provide primary care services for Access KP members without first receiving prior authorization. This led to frustration and confusion when these services were reimbursed by neither the Department nor Kaiser Permanente. This problem was exacerbated by the launch of the Department's new eligibility portal, with many providers indicating it was difficult to ascertain a client's enrollment in the program and distinguish between RCCO and Access KP enrollments.

Access KP members were notified of their disenrollment in mid-June, and dis-enrolled from the Access KP pilot in July. Members continued to be covered by Health First Colorado during July and were able to continue accessing services with their Kaiser Permanente provider. They were re-enrolled into the Accountable Care Collaborative program by August 1, 2017, and attributed to Kaiser Permanente as their Primary Care Medical Provider (PCMP). Access KP members were able to remain with their current Kaiser Permanente provider if they chose to do so.

3.3. Quality Metrics for Access KP

Quality measures help the Department and Access KP to monitor how well the program is meeting the health needs of the populations it serves. The following were the quality metrics for Access KP in FY 2016–17:

- Well-child visits among children ages 3–9
- Postpartum care

Five percent of the medical services capitation payment was withheld to incentivize performance on the well-child visit and postpartum care incentive metrics. These measures were chosen because they have established data sources and align with the Accountable Care Collaborative quality measures and measures used in other initiatives throughout the state.

Access KP exceeded the benchmark for postpartum care by a large margin, but did not meet the benchmark for well-child visits. Without either additional years performance to show consistency over time, or expanded program enrollment numbers to compensate for small population size, the Department cannot attribute the significant difference over the baseline to program design. The baselines were set using data from all Medicaid members enrolled in Region 3 of the Accountable Care Collaborative (about 2.5 million member months), but performance was calculated using data from only Region 3 members who were enrolled in the Access KP program (about 270,000 member months). Variability and random fluctuations in measurement are common with a population of this small size.

Table 2. Quality Measures and Performance Targets for Access KP[2]

Quality Measure	Target(s)	FY 2016–17 Performance
Well-child visits among children ages 3–9	• Tier 1 target: 60% • Tier 2 target: 80%	• 18.3%
Postpartum Care	• Tier 1 target: 1% improvement over the baseline of 25.07% • Tier 2 target: 3% improvement over the baseline of 25.07%	• 40%. This is a 61% improvement over the baseline

3.4. Health and Cost Outcomes

In addition to quality measures, the Department used health and cost outcome measures to evaluate the performance of Access KP. One dollar of the administrative per-member-per-month fee was withheld to incentivize performance on the emergency department admission and inpatient admission metrics. Colorado Access could earn the withheld funds by reaching tiered performance targets. Emergency department use and inpatient admissions were chosen as measures because they can be indicative of effective care coordination and how well the program preventing high-cost services by managing the health needs of members.

The emergency department measure tracks the number of emergency room visits per the number of members attributed to Kaiser Permanente. The inpatient admissions measure tracks the number of inpatient hospitalizations per the number of members attributed to Kaiser Permanente. Both measures showed an improvement during the pilot. However, in order to set an actuarily sound capitation rate and baseline scores for this program the Department used data from clients that were attributed to Kaiser Permanente statewide. However, the incentive payment calculations were limited to the performance of the enrolled population. This difference in population size is seen in the denominators of the metrics: the baseline year had a of about 2.5 million member months compared to the performance year of about 270,000 member months. A smaller denominator increases the

[2] To establish sound baseline rates for this program, the Department used data from all Medicaid members who were enrolled in Region 3 of the Accountable Care Collaborative. However, to calculate incentive payments, the Department measured performance using data from members enrolled in the Access KP program. Therefore, the baseline year had a much larger client count than the program performance calculation. The performance year had a smaller denominator, which increases the variability of the calculation and reduces confidence in using the performance results to measure the effects of the program.

variability of the overall calculation and reduces the confidence that actual performance is not due to random fluctuations.

Table 3. Health and Cost Outcome Measures and Performance Targets for Access KP[3]

Quality Measure	Target(s)	FY 2016–17 Performance
Emergency Room Visits	• Tier 1 target:1% improvement over baseline of 14% • Tier 2 target: 3% improvement over baseline of 14%	• 2%. This is an 84% improvement over the baseline. Note that for this measure a decline from the baseline of 14% represents improvement.
Inpatient Admission	• Tier 1 target:1% improvement over baseline of 0.85% • Tier 2 target: 3% improvement over baseline of 0.85%	• 0.62%. This is a 27% improvement over the baseline. Note that for this measure a decline from the baseline of 0.62% represents improvement.

It is further difficult to draw conclusions about program design based on these data because Kaiser Permanente made no changes to their usual way of delivering primary care for this pilot. Kaiser Permanente did not provide alternate guidance to their providers to provide care for Access KP enrollees differently from Medicaid enrollees who were being covered by Kaiser Permanente under the fee-for-service structure.

4. Looking Ahead

All current pilot payment reform initiatives will be completed by June 2018, at which point any remaining interventions that continue from RMHP Prime will be rolled into the Accountable Care Collaborative Phase II. The two pilot projects under this payment reform initiative have provided some lessons and considerations for the Department as it continues to innovate for better care, more efficient delivery and lower costs through Phase II of the Accountable Care Collaborative, which begins in July 2018. Phase II will have a specific focus on the following objectives:

- Joining physical and behavioral health under one accountable entity

[3] To establish sound baseline rates for this program, the Department used data from all Medicaid members who were enrolled in Region 3 of the Accountable Care Collaborative. However, to calculate incentive payments, the Department measured performance using data from members enrolled in the Access KP program. Therefore, the baseline year had a much larger client count than the program performance calculation. The performance year had a smaller denominator, which increases the variability of the calculation and reduces confidence in using the performance results to measure the effects of the program.

- Strengthening coordination of services by advancing team-based care and health neighborhoods
- Promoting member choice and engagement
- Paying providers for the increased value they deliver
- Ensuring greater accountability and transparency

Below are some lessons learned from this pilot that have implications for these objectives.

- **Care coordination continues to be a foundational service and need.** Care coordination is vitally important, especially for members who need multiple medical, behavioral health and social services. Care coordinators orient members to the system and help members connect their services and providers. In a fragmented health care system, care coordinators can help both members and providers work toward better health and wellbeing. As a result, care coordination can help with achieving better health and cost outcomes, such as reduced emergency department visits, better access to behavioral health care and more member engagement. For this reason, care coordination will continue to be a defining characteristic of the Accountable Care Collaborative in Phase II.
- **Successful behavioral health coordination requires engagement and effort at multiple levels.** RMHP Prime results indicate that the payment reform model has helped to coordinate behavioral and physical health and increase access to behavioral health services. Several different strategies contribute to this. The Department created a behavioral health metric to incentivize better behavioral health care. It also emphasizes care coordination and management to ensure that members with multiple complex conditions are getting the behavioral health care they need. Care coordinators and community health workers who are trained to work with members in need of behavioral health services serve as a critical link to needed services. Finally, RMHP Prime included behavioral health leadership into its governance structure. In Phase II of the Accountable Care Collaborative, the Department is putting the administrative functions for primary care and behavioral health under one entity to promote better coordination within and among physical and behavioral health systems.
- **System coordination starts with good program design and on-the-ground engagement.** The Department's goal is to create cohesive systems that meet the needs of members and providers while delivering value. Through these pilots, the Department has learned how important it is to have a strong payer and provider network that creates a coordinated system that includes all benefits. It is also

important to get member experience feedback and help to build coalitions in the communities served by the program. When the benefits are limited or focused on a specific provider type, as was the case with Access KP, this level of coordination is difficult. Innovative collaboration is possible when the benefits are more comprehensive and a host of providers are participating, as was the case with RMHP Prime. By contracting with a single Regional Accountable Entity (RAE) in each region, the Department is encouraging benefit coordination and alignment, as well as engagement of local partners to create a health neighborhood. In addition, Phase II of the Accountable Care Collaborative will encourage member engagement and provider support to foster coordination from the ground up.

- **Program flexibility is critical for provider and system success.** RMHP Prime used novel payments to allow practices to try innovative interventions and fine-tune the capacity of their practices. While practice support resources are offered to all practices, the uptake of these resources varies and depends on the readiness and capacity of providers to fine-tune their operations and care models. As a result, improvements in health and cost outcomes may vary across the program. In Phase II of the Accountable Care Collaborative, the Department will create flexible, value-based payments that support non-traditional, coordinated and comprehensive models of care. The Department will work with its RAEs to develop and implement models that support the broad range of providers and allow them to fine-tune their care models and better serve their members.

The payment reform pilots have been invaluable for testing interventions, strategies and methods that the Department can use or adjust for the next phase of the Accountable Care Collaborative. These pilots move the Department closer to creating a cohesive system that delivers value, meets the needs of Colorado, and can be scaled to work within each of the state's unique regions.