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

June 28, 2019

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

Dear Senator Moreno:

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 one payment reform initiative under **Section 25.5-5-415 C.R.S**. This report will provide a brief background on the initiative, describe the payment methodology 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, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): 2019 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Legislative Council Library
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John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Interim Health Programs Office Director & Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

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

June 28, 2019

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

Dear Senator Fields:

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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If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): 2019 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Senator Brittany Pettersen, Vice-Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Faith Winter, Health and Human Services Committee
Legislative Council Library
State Library
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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

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

June 28, 2019

The Honorable Susan Lontine, Chair
Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

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 and Insurance 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 one payment reform initiative under **Section 25.5-5-415 C.R.S.** This report will provide a brief background on the initiative, describe the payment methodology 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/maq

Enclosure(s): 2019 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet P. Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Sonya Jaquez Lewis, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
Representative Perry Will, Health and Insurance Committee
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David DeNovellis, Legislative Liaison, HCPF

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

June 28, 2019

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 one payment reform initiative under **Section 25.5-5-415 C.R.S**. This report will provide a brief background on the initiative, describe the payment methodology 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, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

1570 Grant Street, Denver, CO 80203-1818 P 303.866.2993 F 303.866.4411
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KB/maq

Enclosure(s): 2019 Medicaid Payment Reform and Innovation Pilot Program Report

Cc: Representative Dafna Michaelson Jenet, Vice-Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Cathy Kipp, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, 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 June 30, 2019 to:

Joint Budget Committee

House Health, Insurance, and Environment 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 on a payment reform initiative operated by Rocky Mountain Health Plans (RMHP). The payment reform initiative called Rocky Mountain Health Plans Prime (RMHP Prime) is run within the Accountable Care Collaborative (ACC) but has a different payment methodology than the rest of the program. RMHP Prime started in September 2014 and continued through FY 2017-18.

Enrollment

RMHP operates the Region 1 Regional Care Collaborative Organization as part of the Department's ACC. RMHP Prime serves members in six counties: Garfield, Gunnison, Montrose, Mesa, Pitkin and Rio Blanco. In FY 2017-18, total monthly enrollment in Prime averaged 36,487 members. RMHP Prime primarily serves adult members, plus a small number of children with disabilities.

Financial Performance and Payments

The Department pays RMHP Prime a set monthly payment for enrolled members that covers a comprehensive set of physical health services. Total expenditures for members enrolled in RMHP Prime in FY 2017-18 were $198,446,756; this was an increase of $24,288,330. The reasons for the increased costs are listed below.

Amount of Increase	Reason for Increase
$10 million	Hepatitis C pharmaceutical treatments[1]
$8 million	Enrollment increase
$4.8 million	Rate increase of 2.7%
$1.3 million	Federally required Health Insurance Provider Fee payment[2]

RMHP offers primary care medical providers the opportunity to participate in its RMHP Prime payment reform program where a practice can receive a sub-capitated payment each month to cover a practice's services for all the members who are under the practice's care. In FY 2017–18, 46 practices participated in RMHP Prime's payment reform program

[1] Pharmaceutical treatments for Hepatitis C were paid directly by the Department for members enrolled in RMHP Prime. These treatments were not included as a covered service in Prime based on price volatility
[2] Section 9010 of the Affordable Care Act (ACA) created the Health Insurance Providers Fee as an excise tax on all health insurance providers. The Department withholds from the capitation an estimated amount of the fee that is likely to be attributed to Medicaid revenue. When the fee is actualized, the department reconciles the withhold and adjusts the net rates.

and received sub-capitated payments for an average monthly enrollment of 15,667 attributed members.

In addition to reporting on the overall program costs, this year, for the first year, the Department and its actuary compared the estimated costs of the population enrolled in RMHP Prime to estimates of what the population would have cost had they not enrolled in the program. The results of this analysis showed that RMHP Prime, as it currently operates, reduces the total cost of care for members by a small margin (less than two percent), or approximately $3 million, even after accounting for the additional administrative costs and increased investment in primary care made under RMHP Prime. The analysis indicates that the program was more successful in generating cost savings among individuals with disabilities and individuals older than 64 years of age, but experienced cost increases for Adults without Dependent Children. Of note, the Department used the most recent available data for the analysis, rather than data limited to the FY 2017-18 evaluation year. This allows the Department to also utilize the analysis for broader performance management The Department believes the analysis is still a reasonable representation of program performance for the FY 2017-18 evaluation period covered by this report as the operations of RMHP Prime has not changed significantly.

Quality Performance

The Department incorporates quality measurement into its payment model for RMHP Prime by using four quality measures to adjust RMHP Prime's medical loss ratio. A medical loss ratio calculates how much money is spent on providing medical services compared to administrative services and profit. The more quality measures RMHP Prime meets, the more money RMHP Prime can allocate for administrative services and profit. For FY 2017–18, RMHP Prime met 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); screening for clinical depression and follow-up plan; and percentage of practices that completed a follow-up Patient Activation Measure (PAM®) assessment for members that had initial low activation scores.

The Department also uses the measures in the table below to compare health and cost outcomes of RMHP Prime members against a similar population of members enrolled in the statewide ACC.

FY 2017-18 Performance Comparison		
Performance Measure	**RMHP Prime**	**ACC**
Emergency Department Visits	898 visits per 1,000 members	812 visits per 1,000 members
Behavioral Health Penetration Rate	19.7%	19.3%
Hospital All-cause Readmission Rate	9.5%	10.3%
Members with 1+ visit to Primary Care Medical Provider	69.2%	62.7%

Provider Support and Member Experience

RMHP leverages its Accountable Care Collaborative Region 1 Practice Transformation Team to support practices in building capacity and better serving members. Such practice support builds strong relationships with providers and helps practices make the best use of its staff and resources for member care. RMHP offers practice transformation 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 seeks member feedback in several different ways. First, through the Voice of the Consumer project RMHP uses in-depth focus groups to assess and to respond to member experience. Second, RMHP uses a Member Experience and Advisory Committee to improve care and understand the needs of members. Finally, a CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey is used to get feedback on RMHP Prime member experience. The CAHPS® results reported that 68.7 percent of respondents rated their provider favorably (a 9 or 10 on a 1-to-10 scale) and 56.5 percent rated RMHP Prime favorably. In addition, 92.2 percent of members were pleased with how their providers communicated with them.

Evaluation

This year, with the comparison of the estimated costs of the population enrolled in RMHP Prime to estimates of what the population would have cost had they not enrolled in the program, the Department is better able to evaluate RMHP Prime. The Department's conclusion is that RMHP Prime is delivering similar performance to the statewide ACC, while providing some cost savings with higher rates of member experience and utilization of primary care. These indicate the value of continuing to operate RMHP Prime at the same

time as the Department pursues further performance improvements, such as emergency department utilization.

Without clear indication of substantial cost savings or improvement in quality, the Department does not see a reason at this time to expand RMHP Prime beyond its current scope. Additionally, the Department is not confident the model could be easily replicated as RMHP has played a unique role in the region for decades as a commercial health insurance plan and as a Department contractor for Child Health Plan Plus and Medicaid. That said, the Department will work with RMHP to leverage its work around primary care utilization and provider communications to strengthen these efforts within the broader ACC.

Looking Ahead

As part of the recent procurement of new vendors for the next iteration of the Accountable Care Collaborative, the Department is continuing RMHP Prime in Region 1 under the authority of C.R.S. Section 25.5-5-415. The new contract began on July 1, 2018.

The second phase of the Accountable Care Collaborative builds off the best practices learned from all Department programs, including RMHP Prime. The core innovation for Phase II has been joining the administration of physical and behavioral health under one regional entity, the Regional Accountable Entity (RAE). This combined administration is designed to promote the population's health and functioning, improve coordination of care, and improve the member experience by reducing system fragmentation and creating one point of accountability.

The Department also added new cost savings requirements for Phase II of the Accountable Care Collaborative contracts, which include:

- Return on program investment for the RAEs of between 1.5-2.0 to 1 during the first year of operations, with the return on investment increasing in subsequent years.
- Savings target of two percent (2%) or more below the fee-for-service equivalent for RMHP Prime.

For the Phase II contracts, the Department also incorporated the RMHP Prime quality-based medical loss ratio adjustments into the limited managed care capitation initiative being operated in Region 5 with Colorado Access and Denver Health Medicaid Choice. Additionally, the Department modified the Accountable Care Collaborative payments so the RAEs have the opportunity to create flexible, value-based administrative payments to best meet the needs and goals of their contracted Primary Care Medical Providers. This latter arrangement follows some of the lessons learned from the RMHP Prime payment reform program and other Department initiatives.

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 program underway as a result of this legislation.

Rocky Mountain Health Plans Prime (RMHP Prime) was run within the Accountable Care Collaborative (ACC) but has a different payment methodology than the rest of the program. RMHP Prime started in September 2014 and continued through FY 2017–18.

Enrollment

Rocky Mountain Health Plans (RMHP) operated the Region 1 Regional Care Collaborative Organization as part of the ACC from 2011 through FY 2017-18. In September 2014, RMHP implemented RMHP Prime to serve members in six counties in Region 1: Garfield, Gunnison, Montrose, Mesa, Pitkin and Rio Blanco. The majority of RMHP Prime members are adults. The only children enrolled in RMHP Prime are those with disabilities.

Eligible members are automatically enrolled in the program on an ongoing basis. Members who do 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 2017–18, monthly enrollment in Prime averaged 36,487 members, an increase from the monthly average of 34,892 the previous year.

Program Performance

Financial Performance and Payment Methodology

In FY 2017–18, total expenditures for members enrolled in the RMHP Prime program equaled $198,446,756. This was an increase of $24,288,330 million from the previous year’s expenditures of $174,158,426. The reasons for the increased costs are listed in Table 1.

Table 1. Detail of RMHP Prime Cost Increases for FY 2017-18

Amount of Increase	**Reason for Increase**
$10 million	Hepatitis C pharmaceutical treatments[3]
$8 million	Enrollment increase
$4.8 million	Rate increase of 2.7%
$1.3 million	Federally required Health Insurance Provider Fee payment[4]

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, offers primary care medical providers (PCMPs) the opportunity to participate in a payment reform program. The 46 participating PCMPS receive a single sub-capitation payment each month to cover the cost of all the practice's services for 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. An average of 15,667 members monthly were attributed to 46 practices participating in the RMHP Prime payment reform program during FY 2017-18.

Under RMHP Prime's payment reform program, PCMP practices have both *upside* and *downside* financial risk. If a PCMP practice's actual costs exceed the sub-capitation payment, RMHP Prime takes back 5 percent of the practice's 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.

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[3] Pharmaceutical treatments for Hepatitis C were paid directly by the Department for members enrolled in RMHP Prime. These treatments were not included as a covered service in Prime based on price volatility

[4] Section 9010 of the Affordable Care Act (ACA) created the Health Insurance Providers Fee as an excise tax on all health insurance providers. The Department withholds from the capitation an estimated amount of the fee that is likely to be attributed to Medicaid revenue. When the fee is actualized, the department reconciles the withhold and adjusts the net rates.

In addition to reporting on the overall program costs, this year, for the first time, the Department and its actuary compared the estimated costs of the population enrolled in RMHP Prime to estimates of what the population would have cost had they not enrolled in the program. The results of this analysis showed that RMHP Prime, as it currently operates, reduces total cost of care for members by a small margin. This savings remains even after accounting for the increased administrative costs and investments in primary care made under RMHP Prime. Reductions in higher cost services, such as hospitalizations, and limiting the exacerbation of conditions requiring more frequent utilization of lower cost services drive the offset that results in aggregate programmatic savings. The analysis also indicates that the program was more successful in generating cost savings among individuals with disabilities and individuals older than 64 years of age, but experienced cost increases for Adults without Dependent Children.

It is worth noting that there are inherent challenges in estimating what members would have cost had they not enrolled in the program. For example, to draw a meaningful conclusion from this type of analysis, it is important to find an appropriately comparable population to use as a proxy for the enrolled population and to account for regional differences in provider reimbursement rates. The Department's actuary used a population from Pueblo County, and risk adjusted (a process of adjusting expected expenditures for individuals based on their health status as indicated by historical claims data) the population to be comparable to the health status of those enrolled in RMHP Prime. The actuary also adjusted the price of services provided in Pueblo to be comparable to the price of services in the RMHP Prime region. A multitude of additional adjustments such as these are applied to the data to get to a reasonable approximation of costs had the members never been enrolled in RMHP Prime.

The Department would also note that the most recent available data was used for the analysis, rather than data limited to the FY 2017-18 evaluation year. This will allow the Department to utilize the analysis for broader performance management in addition to the insight provided for this report. While the timeframe is not aligned with the evaluation period of the report, the Department believes that because the underlying program has not changed significantly, the analysis is still a reasonable representation of RMHP Prime performance for the FY 2017-18 evaluation period covered by this report.

Medical Loss Ratio Metrics

Quality measures help the Department and RMHP monitor how well the RMHP Prime program is meeting the health needs of the population it serves. The Department has also incorporated quality measures into the RMHP Prime payment model by adjusting RMHP Prime's medical loss ratio based on the program's performance on four measures. A medical loss ratio calculates how much money is spent on providing medical services compared to administrative services and profit. The more quality measures RMHP Prime meets, the greater proportion of their payment they can allocate for administrative services and profit.

RMHP Prime's four measures align with quality measures used in other initiatives throughout the state and have established data sources. Three of the four FY 2017–18 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)
- Follow-up utilization of the Patient Activation Measure (PAM®)

The one change in measures was made in response to changing treatment practices among providers. The Department replaced the previous measure of antidepressant medication management for acute and continuation phases with the new measure of screening for clinical depression and follow-up plan. This new measure aligns with the State Innovation Model quality measures.

RMHP Prime met the benchmarks in all four measures.

Table 2. Quality Measures and Performance Targets for RMHP Prime

Quality Measure	Target(s)	FY 2017–18 Performance
Adult Body Mass Index (BMI) Assessment (HEDIS)	• Assessment completed for at least 93.5% of members	• 97.5% of adults were assessed
HbA1c Poor Control (>9.0%) (HEDIS)	• No more than 29.2% of members have an HbA1c above 9.0%	• 27.9% of members had HbA1c above 9.0%
Screening for Clinical Depression and Follow Up Plan	• 55.6% of members 12 years and older were screened for clinical depression on the date of the encounter AND, if positive, a follow-up was documented	• 64.9% of eligible members were screened for clinical depression and had follow-up documented if the screen was positive
Patient Activation Measure (PAM®)	• For practices actively using the PAM® tool, at least 30% of attributed members who had an initial PAM® level of 1 or 2 completed a follow up PAM® by the end of June 2018.	• 43.9% of members that had an initial PAM® level of 1 or 2 completed a follow up PAM® by the end of June 2018.

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

The first two 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 two 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

RMHP Prime met the benchmarks for these two HEDIS measures.

Screening for Clinical Depression and Follow Up Plan for RMHP Prime

For FY 2017–18, RMHP Prime was assessed on the percent of members 12 years and older that were screened for clinical depression using an age appropriate standardized depression screening tool and, if positive, a follow-up was documented. Screening members for depression and establishing follow-up plans for those who report indicators of depression is an important step toward integrating physical health and behavioral health in primary care settings. This measure is a National Quality Forum measure that is being used for Colorado’s State Innovation Model (SIM).

Performance on this measure was calculated based on data reported to the University of Colorado Health Systems' tool called SPLIT that is being used for SIM. RMHP Prime exceeded the 55.6 percent benchmark for FY 2017-18 and achieved a rate of 64.9 percent.

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 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. Over this year, RMHP Prime worked with these practices to use the Coaching for Activation portion of the PAM® to identify and work with members who had low levels of activation. During FY 2017-18, 43.9% of members who were rated at a low level of activation received the Coaching for Activation portion of the PAM® and completed a follow-up PAM®, exceeding the benchmark of 30%.

Quality Metrics

The Department also uses additional measures to compare health and cost outcomes of RMHP Prime members against a similar population of members enrolled in the statewide ACC. For a comparison population within the Accountable Care Collaborative, the Department reviewed all members not enrolled in a managed care organization (e.g. RMHP Prime or Denver Health Medicaid Choice) who were either an adult or a child with disabilities. Note, these rates are not risk adjusted. Additional details on each of the measures can be found in the narrative following table 3.

Table 3. FY 2017-18 Performance Comparison of RMHP Prime and the Statewide Accountable Care Collaborative

Performance Measure	RMHP Prime	ACC
Emergency Department Visits	898 visits per 1,000 members	812 visits per 1,000 members
Behavioral Health Penetration Rate	19.7%	19.3%
Hospital All-cause Readmission Rate	9.5%	10.3%
Members with 1+ visit to Primary Care Medical Provider	69.2%	62.7%

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 members.

Members of RMHP Prime visited the emergency department at a rate of 898 visits per thousand members during FY 2017-18, which is basically unchanged from last year's rate of 895 visits per thousand members. For FY 2017-18, the RMHP Prime rate is higher than the average across the same population of members in the ACC (812 visits per thousand members) and the same population of members in the ACC Region 1 administered by RMHP (723 visits per thousand members).

RMHP uses several approaches for preventing unnecessary use of the emergency department. One approach is improved coordination of 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 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 ACC 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.

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 integrate 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 explains what percentage of the population served by a health plan actually receives behavioral health services. In FY 2017–18, the behavioral health penetration rate for RMHP Prime members decreased to 19.7 percent from nearly 22 percent in FY 2016–17. This rate was slightly higher than the 19.3 rate for ACC members who received behavioral services through the behavioral health organizations.

RMHP works on several different levels to improve access to behavioral health care. RMHP has made behavioral health integration 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 uses another program called Colorado is Expanding Access to Rural Team-based Healthcare (CO–EARTH) to help small rural practices address behavioral health needs.

Finally, RMHP Prime 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.

Hospital All-cause Readmission Rate for RMHP Prime Members

As the Department continues to expand its cost-containment efforts, it has begun adding new measures to monitor the health of its programs. Unnecessary readmissions to a hospital can be costly and be an indicator of low-quality care and/or poor care coordination following the initial hospital discharge. It has become standard practice to monitor hospital

readmissions, particularly for health plans and accountable care organizations. To incentivize reductions in inappropriate hospitalizations, the Centers for Medicare and Medicaid Services expanded accountability for avoidable readmissions throughout its quality reporting and payment programs.

The Department has chosen to measure all readmissions to a hospital for any cause within 30 days of hospital discharge, with the exception of the following conditions: pregnancy; perinatal conditions; chemotherapy; rehabilitation; organ transplants; and planned procedures. RMHP Prime had a readmission rate of 9.5 percent, which was better than the 10.3 percent average readmission rate for the ACC.

Members with at Least 1 Visit to PCMP for RMHP Prime Members

The goals of the initial phase of the Accountable Care Collaborative were to ensure member access to comprehensive primary care and to a focal point of care, referred to as a Primary Care Medical Provider. Promoting utilization of a Primary Care Medical Provider supports preventive and well-care and is expected to reduce preventable specialty care, emergency department visits, and hospital admissions and readmissions.

One way the Department can assess whether members have access to and are utilizing comprehensive primary care is to calculate how many members who were enrolled for 12 continuous months received services from a Primary Care Medical Provider during that time period. For FY 2017-18, 69.2 percent of RMHP Prime members had at least one visit with a Primary Care Medical Provider. The RMHP Prime rate is higher than the average statewide ACC rate of 62.7 percent.

Provider Support

RMHP 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 gives providers the skills and support to work with other providers as part of a connected health neighborhood.

The Practice Transformation Team at RMHP fosters quality improvement in the delivery of team-based, patient-centered primary care. A multi-disciplinary team of Quality Improvement Advisors, Clinical Informaticists, and a Ph.D.-level Behavioral Health Advisor provide on-site coaching, training, and provision of resources. 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 use 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.

RMHP Prime uses practice transformation, care coordination and flexible financial payments to engage providers in meaningful operational and cultural change. During FY 2017-18, some of the most significant advances for RMHP Prime practices occurred around growing the workforce and expanding access to behavioral health services. For example, three separate practices were able to hire their first behavioral health practitioner based on the multiple lines of support from 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'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 ACC members, including RMHP Prime members.

RMHP 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 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:

- Following a car accident that left a man unable to walk or work, a community health outreach coordinator helped the man apply for social security disability benefits and find suitable housing for him, his youngest children, and his Great Dane. The community health outreach coordinator also coordinated ongoing health appointments for the man and helped him get medical equipment and the food and housing benefits he needs as he continues his recovery.
- A nurse care coordinator visits a woman at her home weekly to help her manage her health and complex medication regimen designed to treat a combination of illnesses, including arthritis, fibromyalgia, chronic obstructive pulmonary disease, and Meniere's disease. Following multiple falls and a stroke that impaired the woman's ability to speak clearly, she requested a care coordinator. The nurse care coordinator accompanies the woman to her health care visits, helps the woman communicate her needs and concerns to her providers, clearly documents the woman's care plan, and organizes her medications so she takes them correctly. The nurse care coordinator has been able to improve communication between the woman and her doctor and has supported the woman's adherence to her medications so that the doctor has been able to reduce the number of medications by about half. The care coordinator has also helped arrange physical and occupational therapy help at the woman's home to reduce the likelihood of falls.

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 2017–18 showed that 68.7 percent of respondents rated their provider favorably, and 56.5 percent rated RMHP Prime favorably. These results align with 2018 national CAHPS® survey results for adult Medicaid populations[5]. The favorable rating for RMHP Prime providers increased from 56 percent in FY 2016-17. In addition, for FY 2017-18, 82.5 percent of respondents reported receiving the care they needed, and 85.8 percent reported receiving that care in a timely and expedient way. 92.2 percent of respondents reported being pleased with how their providers communicated with them. This last measure is nearly twenty percentage points higher than the 2018 national average of 74 percent for adult Medicaid respondents.

RMHP uses in-depth focus groups to assess and to respond to member experience with the *Voice of the Consumer* project. RMHP listens to the experiences of members and uses this knowledge to design a coordinated delivery system that seamlessly links 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.

RMHP also uses a Member Experience and Advisory Committee to improve care and understand 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 has partnered with The Center for Independence (CFI) to provide sign language interpreting services for the those who are deaf in Mesa County and the surrounding area. Interpretive services are provided primarily to the health care provider community; however, the interpreter fulfills other community interpretive needs as time allows. The majority of respondents to a 2018 satisfaction survey regarding CFI's interpreting reported greater access to communication and improved quality of interpreting.

[5] 2018 Chartbook: What Consumers Say About Their Experiences with Their Health Plans and Medical Care. Agency for Healthcare Research and Quality, 2018 CAHPS Health Plan Survey Database. https://cahpsdatabase.ahrq.gov/files/2018CAHPSHealthPlanChartbook.pdf

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.

Department Assessment

This year the Department is better able to evaluate RMHP Prime utilizing the comparison of the estimated costs of the population enrolled in RMHP Prime to estimates of what the population would have cost had they not enrolled in the program. With this analysis, and the quality and outcome measures presented in this report, the Department has determined that RMHP Prime is delivering similar performance to the statewide Accountable Care Collaborative. It did perform better on the number of enrolled members that had at least one visit with a Primary Care Medical Provider during the reporting period, showing positive promotion of a medical home model of care. In addition, the 92.2 percent of members who responded to the CAHPS® who reported being pleased with their how their providers communicated with them is higher than the 74 percent national average of adult Medicaid respondents.

However, in contrast, RMHP Prime's emergency department utilization remained high for a second year in a row with little change. The Department will work with RMHP Prime to understand what might be contributing to this level of emergency department utilization and how they might better be able to lower utilization in the future.

The Department's conclusion is that RMHP Prime is delivering similar performance to the statewide ACC, while providing some cost savings and improving member experience with primary care and utilization of primary care. These indicate the value of continuing to operate RMHP Prime and to identify further areas to push on performance, particularly emergency department utilizations.

Without clear indication of significant cost savings or improvement in quality, the Department does not see a reason at this time to expand RMHP Prime beyond its current scope. Additionally, the Department is not confident the model could be easily replicated as RMHP has played a unique role in the region for decades as a commercial health insurance plan and as a Department contractor for Child Health Plan Plus and Medicaid. That said, the Department will work with RMHP to leverage its work around primary care utilization and provider communications to strengthen these efforts within the broader ACC.

Looking Ahead

As part of the recent procurement of new vendors for the next iteration of the ACC, the Department is continuing to operate RMHP Prime in Region 1 under the authority of C.R.S. Section 25.5-5-415. The new ACC contracts began on July 1, 2018.

Accountable Care Collaborative Phase II

The core innovation for the ACC has been joining the administration of physical and behavioral health under one regional entity, the Regional Accountable Entity. This combined administration is designed to promote the population's health and functioning, improve coordination of care, and improve the member experience by reducing system fragmentation and creating one point of accountability.

The second phase of the ACC incorporates many lessons learned from the Department's programs, including from RMHP Prime.

- *Payment flexibility is critical for provider and system success.* In Phase II of the Accountable Care Collaborative, the Regional Accountable Entities are responsible for creating flexible, value-based administrative payments that best meet the needs and goals of their contracted Primary Care Medical Providers to fund coordinated, comprehensive models of care. The Department will work with its Regional Accountable Entities to develop and implement models that support the broad range of providers and allow them to better serve their members. The Department is utilizing lessons learned from RMHP Prime's payment reform program and other Department initiatives to guide these activities.
- *Use of Quality Measures to Determine Medical Loss Ratio.* The use of quality measures to determine how much money RMHP must spend on providing medical services compared to administrative services and profit has been a powerful vehicle to incorporate value-based payment into a traditional managed care payment

arrangement. The Department has incorporated this same approach into the Denver Health Medicaid Choice contract. By aligning quality measures between the two physical health managed care programs, the Department will be better able to compare performance.

New cost savings requirements for Phase II of the ACC include:

- Return on program investment for the RAEs of between 1.5-2.0 to 1 during the first year of operations, with the return on investment increasing in subsequent years.
- Savings target of two percent (2%) or more below the fee-for-service equivalent for RMHP Prime.

Alternative Payment Models

The Department is transforming payment design within the rest of the ACC with the goal of rewarding improved quality of care while containing costs. One way the Department is doing this is to use differential payment structures to change the way it pays providers. There are two different payment reform models. Under the Primary Care Alternative Payment Model (APM), Primary Care Medical Providers can earn higher reimbursement when designated as meeting specific criteria or performing on quality metrics. To be eligible to participate in the APM, Primary Care Medical Providers must have more than $30,000 in annual billing associated with the code set designed for the APM. Primary Care Medical Providers who fall below this threshold will be excluded from the APM and will not see a change in their rates. Primary Care Medical Providers who are eligible but choose not to participate will see a decrease in their rates. This allows the program to make a sustainable investment into primary care while rewarding performance and increasing provider accountability.

Federally Qualified Health Centers (FQHCs) will be eligible for two new value-based payments: value based encounter payments and prospective per-member per-month payments. The value-based encounter payments will tie four percent of payments to quality and is similar to the model used for the APM. The Department is also pursuing a limited pilot payment model for per-member per-month payments to FQHCs.

Cost Control and Quality Improvement Office

The Department created a Cost Control and Quality Improvement Office on July 1, 2018, established by Senate Bill 18-266 with unanimous support. This office will lead the strategic development of a targeted, consistent, and comprehensive cost control approach across all programs, including the ACC and payment reform initiatives such as RMHP Prime. Initiatives for FY 2018-19 are focused on: pharmacy; home health (including prior authorization requirements); hospital costs; identifying and reducing "potentially avoidable

costs"; better informing Regional Accountable Entities of high cost, vulnerable members for increased care coordination and management; instituting analytics that help stratify the population in order to improve care coordination; and reducing fraud, waste and abuse including new medical claim system technology to prevent overpayments. Details are available in the Department's report released on November 1, 2018. As part of this work, there is a specific ACC Cost Collaborative in which the Department and Regional Accountable Entities work together to find opportunities for cost containment and institute cost control best-practices.