Regional Accountable Entity Performance Pool Specification Document SFY 2023-2024

This document includes the details for calculations of Performance Pool Indicator Measures for the seven Regional Accountable Entities.

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Revision History		
Document Date	Version	Change Description
05/12/2023	V1	Final Performance Pool Document for SFY 23-24

Section 1: Introduction

Overview

The Performance Pool is comprised of set aside funding from the administrative per member per month amount as well as unearned money from the Key Performance Indicators (KPIs). These measures are intended to place greater emphasis on health outcomes and cost containment.

Purpose

The purpose of this document is to describe the methodologies used to calculate Performance Pool incentive payments for Regional Accountable Entities (RAEs) participating in the Accountable Care Collaborative (ACC) in State Fiscal Year (SFY) 23-24.

Scope

This document addresses only the methodology utilized to calculate the ACC Performance Pool Metrics.

Health First Colorado acknowledges that we are required to meet the goals and objectives in EPSDT in addition to CMS Core Metrics. ACC Performance Pool Metrics reflect our commitment to achieving high quality care for both programs.

Document Maintenance

This document will be reviewed annually at the start of the new State Fiscal Year and updated as necessary. This document contains a Revision History log on the Document Information page. When changes occur, the version number will be updated to the next increment as well as the revision date and change description. Unless otherwise noted, the author of the revision will be the document's author, as identified in the Document Identification table, which is also on the Document Information page.

Section 2: Data Requirements

Data Requirements

The Performance Pool Indicators are calculated for Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) participating in the Accountable Care Collaborative (ACC) program based on the members' utilization of services.

Background

Each Performance Pool Indicator calculation is based on the utilization of services by the population enrolled in the ACC. The following sections describe the differences in the methodologies used to calculate and evaluate these measures.

Note: Some Metrics are based on CMS Core Measure Technical Specifications. Telemedicine visits and services are included in calculations if specifications allow. See the CMS Core Measure Reporting Resources for more details.

Evaluation and Baseline Period

Each evaluation period is twelve rolling months of data based on service/eligibility dates allowing for three months of claims runout.

Evaluation Population

All members with full Medicaid are enrolled into the ACC program. All baseline and evaluation period populations will include all members with full Medicaid residing in each of the seven regions. The Performance Pool Population includes all members who are enrolled in the ACC program at the end of the evaluation period according to the ACC Snapshot.

Exclusions: Members who are enrolled in any physical health Medicaid managed care plan for more than three months during the evaluation period. Note: these members are identified by the managed care enrollment spans on the ACC Snapshot (MTH_ACC_CLNT_SNPSHT_V). Please note that retroactive enrollment changes are not captured in the ACC snapshot. There are instances where enrollment spans change, which cause misalignment between the current record of enrollment (CLNT_ENRL_FACT_V) and the ACC Snapshot. The ACC Snapshot is used for this exclusion.

Claims Selection Criteria

The following criteria are used to select the claims to calculate the measures:
- Both facility and professional claims
- Paid claims and Encounters (with three months runout)
- Only current records
- Last claim (after all adjustments have been taken)

Encounters:
- Dental Encounter Data
- Behavioral Health Encounter Data

Exclude:
- Deleted records
- MCO and CHP+ Encounter Data

Supplemental Data

The following data may be incorporated into appropriate measures where available and appropriate:

- Colorado Immunization Registry (CIIS)
- Clinical/EHR Data
- Laboratory Data
- Vital Records Data

Section 3: Baselines and Targets

Evaluation and Baseline Periods

Performance Period: July 1, 2023, through June 30, 2024
Baseline Period: July 1, 2021, through June 30, 2022

Calculation of Department Goals

Measures in the KPI Program that are using national standards have Department Stretch Goals typically based on the NCQA 90th percentile for all Medicaid Lines of Business, when available.

Gap Closure

The targets for indicators are based on a gap closure methodology. All indicators use a 10% gap closure methodology except for the Extended Care Coordination, which will use a variable gap closure percentage depending on the RAE's performance tier. Whenever possible, targets are set based on standard goals that RAEs should work toward over multiple years.

A rolling 12-month member count is used for most indicators except Indicators 1, 2, and 4.

Each RAE will be responsible for closing gaps for specific measures during the performance year. Please see the example below.
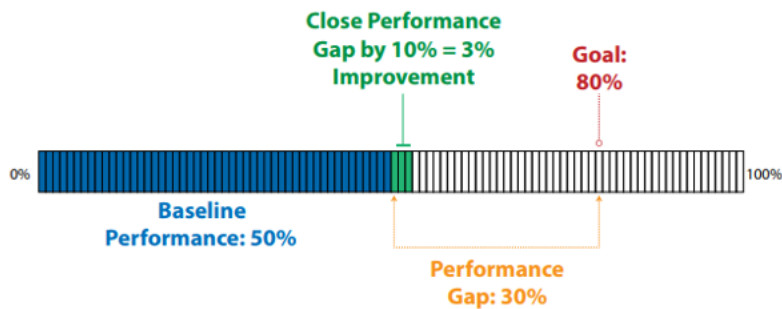
Baselines and Targets

Indicator 1: Extended Care Coordination		
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	77.87%	81.76%
2	58.55%	64.41%
3	19.57%	23.48%
4	19.56%	23.47%
5	25.87%	31.04%
6	36.22%	41.65%
7	38.24%	43.98%
HCPF	N/A	N/A
Indicator 2: Premature Birth Rate		
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	9.53%	8.58%
2	12.17%	10.95%
3	9.93%	8.94%
4	9.52%	8.57%
5	10.57%	9.51%
6	10.23%	9.21%
7	11.47%	10.32%
HCPF	11%	5.5%
Indicator 3: Behavioral Health Engagement for Members Releasing from State Prisons		
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	25.80%	24.70%
2	26.35%	24.70%
3	15.35%	24.70%
4	22.70%	24.70%
5	19.46%	24.70%
6	20.38%	24.70%
7	21.54%	24.70%
HCPF	21.53%	24.70%
Indicator 4: Asthma Medication Ratio		
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	48.21%	50.59%
2	46.48%	49.03%
3	46.50%	49.05%
4	41.29%	44.36%
5	44.80%	47.52%

6	48.03%	50.43%
7	48.87%	51.18%
HCPF	48%	72%

	Indicator 5: Antidepressant Medication Management - Acute	
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	68.45%	68.61%
2	63.56%	64.20%
3	68.39%	68.55%
4	64.95%	65.46%
5	61.89%	62.70%
6	70.23%	70.21%
7	66.91%	67.22%
HCPF	67%	70%

	Indicator 5: Antidepressant Medication Management - Continuation	
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	46.25%	47.23%
2	41.07%	42.56%
3	45.23%	46.31%
4	40.85%	42.37%
5	38.57%	40.31%
6	48.58%	49.32%
7	45.24%	46.32%
HCPF	46%	56%

	Indicator 6: Contraceptive Care for Postpartum Women	
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**
1	31.98%	34.17%
2	33.24%	35.30%
3	31.54%	33.77%
4	41.91%	43.10%
5	39.71%	41.12%
6	29.55%	31.98%
7	27.36%	30.01%
HCPF	22.4%	53.9%

Section 4: Payment Information

Payment Tiers

Each Performance Pool Metric is worth 1/6th of available Performance Pool Dollars.

Payment Schedule

The Department will calculate final performance for all indicators to determine payout based on the following timeframe:

- Indicator 1: Extended Care Coordination
    - Calculation Timeframe: December 2024
- Indicator 2: Premature Birth Rate
    - Calculation Timeframe: December 2024
- Indicator 3: Behavioral Health Engagement for Members Releasing from State Prisons
    - Calculation Timeframe: December 2024
- Indicators 4-6: Medication Adherence
    - Calculation Timeframe: December 2024

Once final performance is calculated, the Department will notify RAEs of their performance and their forthcoming payments in January 2025. The Department will make final payments by the end of January 2025. Final payments will come from SFY 2023 - 2024 Performance Pool funds. Payment Pool funds are comprised of $1.475 of the administrative PMPM plus any unearned Key Performance Indicator dollars.

Payout for Indicator 3 is based on whether RAEs collectively meet the performance target. One-sixth of Performance Pool dollars for each RAE will be set aside for this composite indicator, and if RAEs collectively hit the target, then each RAE will earn that amount.

The Department and RAEs will review data on a quarterly basis to assess whether RAEs are on track to reach performance targets for indicators. To support this review, the Department will provide RAEs performance data quarterly as a rolling 12 months for informational purposes throughout the year. Data will be uploaded to each RAE's Move It site or on the Colorado Data Analytics Portal.

Section 5: Performance Pool Indicators

Indicator 1: Extended Care Coordination

[Measure Steward - HCPF]

Measure Description
Percentage of members with complex needs who received extended care coordination within the performance period.

Due to varying definitions of members with complex needs by RAE, it is not advised to make performance comparisons across regions. The data are not comparable.

Measure Numerator
Number of unique members with complex needs who received extended care coordination.

Extended care coordination activities include the following:
- Unique Members identified as complex on day one of the performance period under a new definition are expected to have a robust care plan developed within the first 120 days.
- Unique Members identified as complex at any time after day one of the performance period are expected to have a robust care plan developed within 90 days of the member being identified as complex.
- Unique Members who were identified as complex under the old definition and remain in the complex population under the new definition who have an active care plan DO NOT require development of a new care plan. These members are expected to have bi-directional contact with the care coordinator in the 90 days prior to day one of the new definition.
- All members engaged in Extended Care Coordination are expected to have, at minimum, quarterly bidirectional contact with the member by the care coordinator.

A robust care plan must adhere to best practices which are reflected in the RAE contract Section 11.3. Utilization of health care services cannot be counted as part of quarterly monitoring activities.

The following members can be counted in the numerator of the metric, but must be reported separately:
- Members who are "**unreachable**" can be counted in the numerator as long as they received at least three outreach attempts with two different modalities based on what is deemed by the care coordination team to be most effective for successful engagement and keeping in mind any limits to the availability of contact information. Members who are unreachable must have an attempted outreach every 6 months after the initial attempt is made.
- Members who **opt out** of extended care coordination can be counted in the numerator. RAEs must have in place a documented opt out process for members. Members who opt out must have an attempted outreach every 6 months after the initial attempt is made in order to be counted in the numerator.

- Members who have been in extended care coordination, have **met their goals,** and no longer need or want support must also have an attempted outreach every 6 months to continue to be counted in the numerator.
- Members can only be counted in either the opt out category or the met their goals category, not both.

If a member's lead care coordinator is a case management entity or another organization, the member can still be counted in the numerator if the RAE care coordinator has an up-to-date care plan on file and meets the quarterly bidirectional contact requirement by a member of the care team.

Measure Denominator
Number of members with complex needs identified at any time during the performance period. This includes Members who were previously identified as complex and remain in the complex population at the beginning of the performance period. There is no continuous enrollment requirement. The look back period will be 27 months long.

Department Goal
100%

RAE Target Methodology
Variable gap closure to HCPF target based on baseline performance.
0-25% performance: 20% gap closure
26-50% performance: 15% gap closure
51-75% performance: 10% gap closure
75-100% performance: 5% gap closure

Measurement Period
July 1, 2023 – September 30, 2024
Rolling 12 Months Reported Quarterly

Data Source
Department monthly risk stratification lists for members with complex needs (Denominator)
Note: The Department will flag members for both the $25,000+ definition and the 4+ chronic condition definition.
RAE complex lists for members with complex needs if the RAE has chosen to use their own definition (Denominator)
RAE provided extended care coordination data (Numerator)

Measure Calculation
This measure will be calculated by the RAEs.

Measure Reporting Additional Details
RAEs are responsible for providing access to care coordination for all members who need it. Members who have more complex needs may require more intense levels of care coordination, also referred to as extended care coordination. This is not the only intervention for complex

members, but it is a core RAE function that can support members in achieving their physical health, behavioral health, and social needs.

The four or more chronic conditions must be based off the Department approved list which includes the following: maternity, diabetes, hypertension, chronic heart failure/cardiovascular disease, asthma, COPD, anxiety, depression, chronic pain, and SUD. RAEs have access to definitions for each condition listed above; however, if additional information is sought, contact Department staff.

For members in the denominator who drop off the complex list within the first three months of appearing on the complex list, RAEs can still count them in the numerator if the member has either an assessment or, at a minimum, one outreach attempt associated with them. The Department recognizes the list of complex members will fluctuate and does not want to disincentivize providing care coordination services to members who are more likely to experience churn.

When churning members return as "complex" but had a care plan previously, the RAE should update the care plan within the first 90 days to ensure it is current and active. It is up to the discretion of the care coordinator and member if a new care plan must be created.

The Department may initiate an audit of this measure once the performance period is complete (details forthcoming). RAEs must participate in the audit by providing necessary extended care coordination documentation for complex members. Payment of this measure is contingent on complete participation in this audit. However, payment is not contingent on audit performance.

RAEs will deliver an attestation form and data workbook by November 15, 2024 that confirms the submission of accurate data per the specifications outlined in this document.

HCPF will use the quarterly complex care coordination report that is required in the RAE contract to evaluate performance on a quarterly basis. The Department recognizes that there will not be precise alignment between this report and the ECC measure.

Indicator 2: Premature Birth Rate

[Measure Steward - HCPF]

Measure Description
Number of premature births (< 37 weeks) per total live births within the performance period

Measure Numerator
Number of premature births (< 37 weeks) within the performance period

Measure Denominator
Number of total live births within the performance period

Department Goal

5.5% This is a [March of Dimes goal](#).

RAE Target Methodology
10% Gap Closure to Department Goal

Measurement Period
July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source
All RAE claims, Encounter systems, FFS Claims, CDPHE Vital Statistics Birth Certificate (Gestational Age, Live Births) and Pharmacy data.

Measure Calculation
This measure will be calculated by the Department.

Measure Reporting Additional Details
The Department will provide the most up to date dataset to the RAEs on a quarterly basis that includes member-level data. This includes member-level birth certificate data from CDPHE.

Managed care members are excluded from this measure.

Premature births are determined based on birth certificate data from CDPHE. The statewide match rate of birth certificate data to Medicaid data are approximately 83% currently.

There is an approximately 5-month lag time. Data may not be fully complete for up to a year. See [Performance Pool Premature Birth Rate SQL Code.sql](#) document on the RAE SharePoint site

Indicator 3: Behavioral Health Engagement for Members Releasing from State Prison

[Measure Steward - HCPF]

Measure Description
Percentage of members releasing from a Department of Corrections (DOC) facility with at least one billed behavioral health capitated service or short-term behavioral health visit within fourteen (14) days.

Measure Numerator
Number of members who had at least one billed behavioral health capitated service or short-term behavioral health visit within fourteen (14) days of being released from a DOC facility.

Measure Denominator
Number of members who were released from a DOC facility and who are eligible for Medicaid.

Department Goal
84.61% This target represents the portion of releasing individuals with a P code of 2 or higher which indicates an immediate behavioral health need. However, any individual who was released from DOC and received a behavioral health service within 14 days will be counted toward the final performance.

RAE Target Methodology
5% Gap Closure to Department Goal

Measurement Period
July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source
All RAE claims, RAE Flat Files, Encounter systems, FFS Claims, Daily DOC Roster.

Measure Calculation
This measure will be calculated by the Department.

Measure Reporting Additional Details
This fulfills the requirements of SB222 and demonstrates inter-agency collaboration.
Given challenges with the DOC Roster, RAEs will be measured as a collective group and earn incentive money only if the collective group meets its target. If the target is met, then RAEs will earn a shared payment. If the target is not met, no RAE will receive a payment. This target was developed to align with the Department's Wildly Important Goal for justice-involved members.

Managed care members will be included to promote a more inclusive approach to managing care for individuals releasing from state prisons.

The Department will exclude members who return to DOC within the 14-day period from the denominator.

Day 1 of 14 starts on the day after release. Members should be counted based on the month of release. RAEs will have until July 14th for follow up for individuals released on June 30th.

The Department will also exclude members who lose Medicaid eligibility within the 14-day period from the denominator.

Should a member show multiple releases in the 14-day period, the Department will use the most recent release date.

Indicator 4: Asthma Medication Ratio

[Core Measure – Measure Steward - NCQA]

Measure Description
The percentage of members ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Measurement Period
July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source
All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Description
This measure will be calculated by the Department.

Measure Reporting Details
Please see Appendix B for links to detailed measure information and value sets.

Indicator 5: Antidepressant Medication Management

[Core Measure – Measure Steward - NCQA]

Measure Description

Two Rates are Reported:

Percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

- Effective *Acute* Phase Treatment. Percentage of beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective *Continuation* Phase Treatment. Percentage of beneficiaries who remained on an antidepressant medication for at least 180 days (6 months)

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 6: Contraceptive Care for Postpartum Women

[Core Measure – Measure Steward - NCQA]

Measure Description
Among women ages 15 through 44 who had a live birth, the percentage that is provided:

> 1. A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.
> 2. A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.

Payment to be based on Most/Moderately effective form of contraception within 60 days, total.

Measurement Period
July 1, 2023 – June 30, 2024
Rolling 12 months reported quarterly

Data Source
All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Description
This measure will be calculated by the Department.

Measure Reporting Details
Please see Appendix B for links to detailed measure information and value sets.

Appendices

Appendix A: Quarterly Data Sharing

Schedule for Sharing Quarterly Data

Timeframes for metrics run by HCPF through Care Analyzer:			
Performance Period*	90 Day Runout Period Ends	HCPF Detailed Data Availability	RAE Detailed Data Availability
Jan 1 – Dec 31	30-Mar	30-Apr	15-May
Apr 1 – Mar 31	30-Jun	31-Jul	15-Aug
Jul 1 - Jun 30	30-Sep	31-Oct	15-Nov
Oct 1 – Sept 30	31-Dec	31-Jan	15-Feb
*Most recent 12 months of available data. This is updated every 3 months.			

Appendix B: CMS Core Measure Technical Specifications

Important information regarding Indicators 2, 4-6:
The following measures are defined using the 2023 CMS Core Measure Set Technical Specifications and Value Set Directories. You can find the Reporting Resources at the links below for each of the following measures.

2023 CMS Adult Core Measure Set Reporting Resources
2023 CMS Child Core Measure Set Reporting Resources