

## ACC Evaluation Year 1 Summary

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# **Project Summary: Mixed Methods**

## **Quantitative Analysis**

- HCPF Administrative Claims Data
- Sample Period: July, 2009 – June, 2014
- Currently adding data through June 2015

## **Qualitative Analysis**

- Interviews of Primary Care Medical Providers
- Open ended interviews using interview guide
- **Iterative process- Feedback loop into quantitative analysis**

# Quantitative Analysis

Analyzed spending comparing ACC enrollees & Control group

- Total spending on Inpatient, Outpatient and Pharmaceutical Utilization
- Spending by Type of Service
- By Cohort Year enrolled

Analyzed ACC enrollee-PCMP E&M visits

- Are clients visiting their attributed PCMP?

# Quantitative Analysis: Approach

## ACC enrolled & Control Group

- Pre and Post analysis by enrollment year
  - Cohort 1 enrolled in FY2011-12
  - Cohort 2 enrolled in FY2012-13
  - Control group individuals who did not enroll
- Pre-ACC period
  - 3-7 quarters of spending prior to ACC
- Interim Adjustment period (3 quarters):
  - Exclude data during quarter enrolled & quarter before and after enrollment.
- Post-ACC Period
  - Cohort 1: 8-12 quarters of data
  - Cohort 2: 4- 8 quarters of data

## **Analysis Sample, by ACC and Control Group**

	<b>Sample:</b>	<b>Standard Enrollees</b>		<b>Dual Enrollees</b>	
	<b>Group:</b>	<b>ACC</b>	<b>Control</b>	<b>ACC</b>	<b>Control</b>
<b>Cohort 1</b>					
	<b>Pre-period</b>	<b>83,640</b>	<b>246,261</b>	<b>14,911</b>	<b>19,249</b>
	<b>Post-period</b>	<b>94,258</b>	<b>101,645</b>	<b>17,206</b>	<b>8,399</b>
<b>Cohort 2</b>					
	<b>Pre-period</b>	<b>126,086</b>	<b>269,352</b>	<b>7,089</b>	<b>20,598</b>
	<b>Post-period</b>	<b>152,101</b>	<b>63,737</b>	<b>9,861</b>	<b>5,960</b>
<b>FY2013-14 and later enrollees: Truncated by sample period (preliminary)</b>					
	<b>Pre-period</b>	<b>101,003</b>	<b>197,995</b>	<b>6,673</b>	<b>16,816</b>
	<b>Post-period</b>	<b>94,136</b>	<b>45,327</b>	<b>5,019</b>	<b>4,831</b>

# Results: PMPM Spending, Standard Enrollees

Adjusted?	Cohort 1 (Began FY2011/2012)		Cohort 2 (Began FY2011/2013)	
	No	Yes	No	Yes
Total Spending				
Total	-\$44	-\$13.99**	-\$47	-\$16.43**
Inpatient	-\$18	-\$2.31*	-\$15	-\$8.13*
Outpatient	-\$19	-\$5.67**	-\$23	-\$6.49*
Pharmaceutical	-\$12	-\$5.53**	-\$34	\$3.10

## PMPM Spending, Standard Enrollees

- Cohort 1: Significant Reduction in Average Medical Spending
  - PMPM declines range from \$10 - \$18 (95% C.I.)
  - Relatively long follow-up period
  - Driven by declines in outpatient and pharma spending
- Cohort 2: Larger declines in Average Medical Spending
  - PMPM declines range from \$11 - \$21 (95% C.I.)
  - Shorter follow-up period than Cohort 1
  - Increase in Pharma spending offset by lowered inpatient spending
- Cohort 1 vs. Cohort 2: Suggestive of an initial increase in pharma utilization that is smoothed out over time.

### Results: PMPM Spending, Dual

- Cohort 1 Significant Decrease in PMPM Spending
  - PMPM decline of about -\$150
  - Declines in outpatient and pharma
- Cohort 2 No change in spending
  - PMPM change in spending not statistically significant
  - Shorter follow-up than Cohort 1.
  - Significantly smaller cohort
- Less confidence in estimate for duals because of sample size and enrollment issues. Pre-period trends of the ACC and control groups are not as consistently parallel as they are for the standard group

## PCMP Utilization

- Examined probability of client visiting attributed PCMP
  - Based on Evaluation and Management Visits
  - Unadjusted probability 0.67- 0.75
  - Slightly lower at FQHCs (~0.02 lower )
    - Could reflect the use of billing provider ID or “same day” visits with other provider
  - PCMP visits more likely if within 4.3 miles of PCMP (+0.01 to +0.03)
  - PCMP visits decline slightly over time (-0.02 to -0.03% per year)
- Based on E&M visits, ignores clients without E&M visits

## Main Conclusions

- ACC led to savings among standard population that were persistent over time
- Very difficult to measure impact on Dual enrollees
- Newer enrollees had higher spending than established enrollees especially in outpatient settings on pharmaceuticals
  
- PCMP are visited **IF** enrollee has E&M visits
- Substantial number of enrollees had no E&M visits
  - Further investigation
  
- Analysis of quality and utilization measures inconclusive
  - Further investigation

## Qualitative Study

Representatives from the practices

Open ended interview guide

Preliminary results

Formal coding

- Coding comparison statistics

Final results next year

# Interview Guide

Decision to join the ACC

RCCO(s)

- Provider support
- SDAC and data analytics
- Financial incentives (PMPMs)

ACC impact on practice

- Practice transformation

Care Coordination

# Interview Guide

Key Performance Indicators (KPIs)

Expansion and dual eligible population

Non-ACC funding

- Supplemental Programs

Overall experience with the ACC

Suggestions for improvement

# Initial Sample

55 practices

## Criteria

- Size as determined by patient attribution
- Type
  - Pediatric, FQHC, urban/rural, etc.
- Geographic location
- RCCO

# Completed Interviews

Practice Size	Completed Interviews	Non-practice Interviews
<b>Small</b> <i>(150-415 enrollees)</i>	12	4
<b>Medium</b> <i>(416-5000 enrollees)</i>	23	
<b>Large</b> <i>(&gt; 5000 enrollees)</i>	6	
<b>Total</b>	41	4

# Declined Participation

<b>Practice Size</b>	<b>Declined Participation</b>
<b>Small</b> <i>(150-415 enrollees)</i>	4
<b>Medium</b> <i>(416-5000 enrollees)</i>	11
<b>Large</b> <i>(&gt; 5000 enrollees)</i>	0
<b>Total</b>	<b>15 (27% of 1<sup>st</sup> phase sample)</b>

# Preliminary Results

# General perceptions of the ACC

## General enthusiasm for the ACC

- Better results for patients
- Resources for PCMPs for care coordination
- Facilitated communication
- Many areas for improvement and continued growth
- Large, medium, and small practices

**“...I think in general it’s been a positive experience for us. And, I’m glad we did it. Initially, I was afraid that it was going to be very bureaucratic and bog down our system, and it pleasantly has not been that.”**

# Perceptions of the ACC cont.

## Large practices (>5,000)

- Generally positive perceptions of the ACC
- First step in needed healthcare reform
- ACC in line with their existing efforts
- ACC has not had a major impact as care coordination already a strong focus
- Some state that they would prefer to contract directly with the state

**”No, I don’t think it [ACC] has [had an impact on our practice]. I think...it’s another layer of bureaucracy. I don’t think that our providers or care coordinators would feel that they get a tremendous amount from the RCCOs...we were already doing this work and we have to document that a lot of what we do, in order to meet the requirements of the RCCOs but I think from [our] perspective we don’t see that we have added resources by being part of the RCCO.”**

# Perceptions of the ACC cont.

## Medium practices ( $\geq 450$ to $< 5,000$ patients)

- Potentially the greatest practice transformation impact from the ACC
- Greater enhancement of care coordination activities associated with the ACC
- Many medium sized practices receive outside grants to support practice transformation activities

**“And, it [ACC] just aligned very much with what [practice name] already offers in terms of the triple-aim, looking at some of our outcomes, costs and patient experience around how care coordination was offered...And so, it just opened an opportunity to actually get reimbursed and elevate some of that work and increase our resources and staffing.”**

# Perceptions of the ACC cont.

## Small practices (<450)

- Perceptions of the ACC varied greatly with the majority demonstrating lower levels of knowledge and reporting fewer changes associated with the ACC

**“I don’t think they’ve been out very much to follow up on us or see if we need additional help. I do know that they’re there, but I mean, they don’t routinely come out.”**

**“...I guess I would have to ask what those [key performance indicators] are. You know, I’m not real sure, to be perfectly honest.”**

# Perceptions of the ACC cont.

## Pediatrics practices

- Frequently stated that the ACC was not well aligned with pediatric populations

**“We have made that recommendation multiple times to the RCCO to say that you need to separate processes for adults and processes for children because they are not the same...”**

# Care Coordination

## Variations in conceptualization and operationalization

- Risk Stratification
- Disease or topic specific
- Care coordination teams
- Smaller clinics generally reported fewer care coordination activities
- Benefits of a standard definition?
  - Additional Guidance

“How do we define care coordination. I think we define care coordination in a very different way than other people do. I think that is a critical question that we as a healthcare system need to answer. What is care coordination and what does that definition look like... but care coordination is, at this point in healthcare, really kind of an ambiguous term that does not have clear definitions.”

# Care Coordination

## **Integration of care coordination in the practice believed to be more effective**

- Within practice care coordinators require minimum scale of patients
- Virtually all practices with more developed care coordination models receive outside funding in addition to PMPMs or have size and scale

“And then, we hired a lot of care managers and developed a pretty robust care management system within our EHR. And so, the patients were getting a lot more care after we took over.”

“And, we felt that we have had experience before where entities have come in and tried to do care management for our patients, but externally. And, that didn't work well. So, we were very committed to making sure that...If there was case management or care coordination to be provided to patients that we would be the entity doing that.”

# Per-Member-Per-Month (PMPM)

Practices state that the PMPM helps but is not sufficient to support practice transformation activities

Significant practice transformation and care coordination activities supported by...

- Large scale of Medicaid enrollees
- Outside funding

“...there’s been additional case management staff that has come in since the ACC Program, additional nursing staff that has been added to the model and...That might be it. And, those things were added, some in response to the ACC Program, but some just in response to...This is the model of our care team, and this is how we render care, and it was felt necessary to add those positions.”

“...but in terms of care management... I think those... that really is the ACC dollars that go to our care management program...I mean, the question is, is [X] [care coordinators] enough?”

# Key Performance Indicators

Variation in perceptions of KPIs

- Opinion that ED visits are out of practices control

Regional calculation of KPI performance decreases the incentive for individual practice effort

Tailor KPIs to practice type

“...it certainly has been my, as well as everyone else’s, consistent feedback to HCPF is what are you doing about engaging the Eds in a conversation about managing how they’re recruiting people to come to the ED?...the problem is, you know, they’re putting up EDs fricking all...there’s a new one on every corner of the damn county. And so, you know, they certainly are not slowing down in their recruitment.”

# Statewide Data Analytics Contractor

Potential of data analytics recognized but SDAC viewed skeptically

- Attribution in SDAC inconsistent with practice internal data
- SDAC data claims based (2-3 month after event)

Larger practices - greater sophistication with data analytics

- Struggle with making SDAC actionable

Some of clinics supplement SDAC to make it usable

“So, a couple things I would say is that the difficulty with the data is, of course, it claims data. So, it’s not always actionable data, or it’s data... However you manipulate the claims information, because it’s old information, unless it’s overlaid with the information from the medical record, it’s hard to drive action on it because it just frustrates case managers who are reaching out for supposed gaps in care that don’t exist...Unless it’s really overlaid with our own data, it’s difficult to make that actionable, I would say.”

“Well, it’s [combining SDAC data with EHR] a manual process, unfortunately. So, it’s dumped into a business intelligence tool, and then we’ll pull something like our high utilizers or pull patients who look like they might have had a gap in care. And then we’ll—at the same time—run reports on their record so that the business intelligence tool is mining information from the medical record to show the last visit and to show whether or not a patient was up to date on certain standards of care...we’re looking for a solution where there’s something that somehow can combine a little more elegantly and easily information and make it actionable in a way that a case manager could use it without a whole lot of...”

## Data Driven QI

Majority of clinics are using their own EHR and care coordination systems for data analytics and care coordination

- Some practices rely solely on their RCCO to facilitate SDAC data analysis to guide QI

Real-time access to hospital data

- Few practices have access to Health Information Exchange (CORHIO and QHN)
- Some RCCOs facilitate real-time ED visit data: inconsistent and ad-hoc
- Some practices have relationships with hospitals: inconsistent and work-intensive

“Well, obviously, here within the organization, it’s super easy to get information. From the other hospital that’s local, [hospital’s name], they’re pretty good about sending us information. Or, if we call and request it, then they get that to us. As far as timely response, I think it’s a matter of who’s working that day, you know? And, if it’s a...if it’s on the top of their list of something to be done or not...I think there’s always room for improvement in that regard as well.”

“For example, I still don’t fully understand how somebody determines what an individual clinical risk group score is. I understand on a sort of basic definition level what that is but I think TREO and 3M, they haven’t fully revealed what a clinical risk group score means, and there is a lot of other really important data elements in the SDAC, but I think they can get sort of clouded or diluted in just the sheer quantity of data that is available there, which I think is sort of a catch 22.”

“It is really, really great because there is so much more data available to us now than there ever has been historically. However, with all of that data comes some confusion with what do we really look at, what does the department care about, what do the RCCO’s care about, and what do we care about?”

# Patient Education

Understanding the medical home

Patients as partners in their care

Expansion population

- High utilizers
- Pent-up demand
- Demanding patients

# Interactions with RCCOs

Practices that operate in multiple RCCOs report differences and preferences

- Focus of ongoing qualitative work

“Well, I think that they’re [specific RCCO]...They’ve been the ones most willing to try different models, adjust the things that aren’t working, proactively approach us and say, “Hey, is there something else we can do to support you guys?” You know, they’re the ones most intent on pushing the ball forward to achieve the goals. I think the other ACCs [RCCOs], at least, the other ones that we deal with, are much more cautious in holding their... You know, kind of holding their money tight and not very willing to let it out.”

# Fee for Service nature of ACC

Continued payment system transformation

Challenge of moving away from FFS

Possible tiered system

# Conclusions and Next Steps

Enthusiasm and Support for ACC

Formal coding for the qualitative data

Additional wave of qualitative interviews

Data saturation

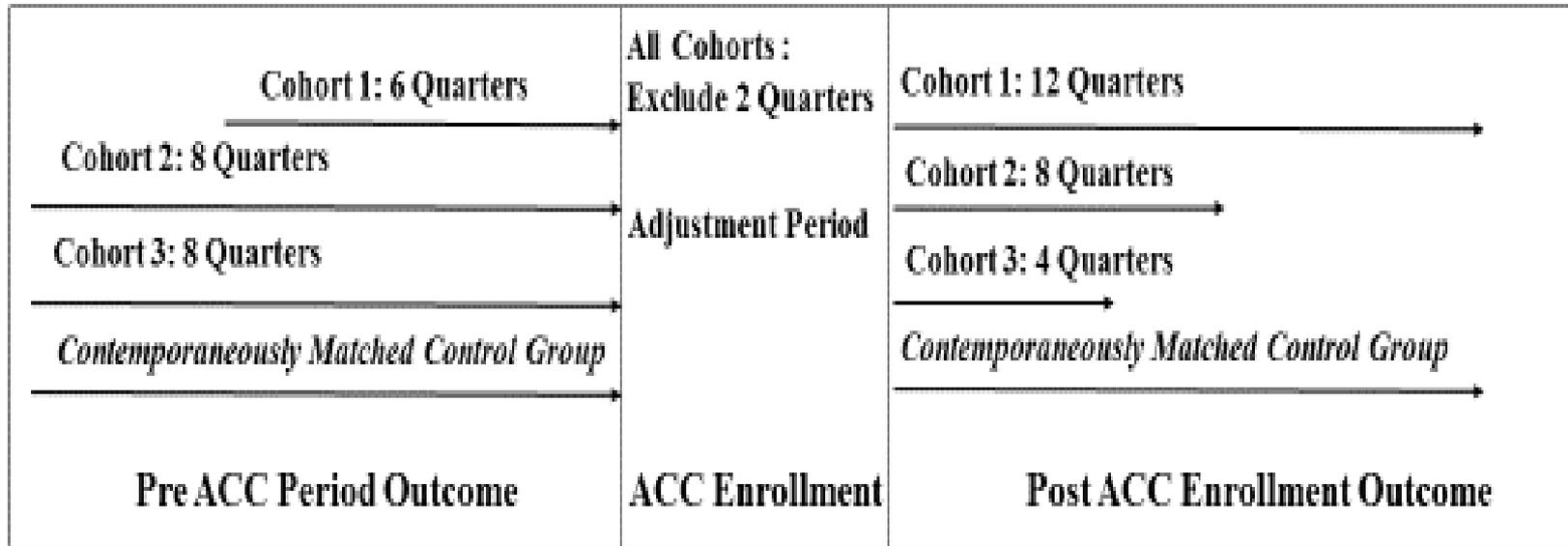
Additional topics for examination

Integration of Quantitative and Qualitative findings

# Appendix slides

The following slides provide details that weren't discussed during the presentation but are provided for interested persons.

# Figure for Quantitative Design



Pre ACC Difference between Cohort and Control Group

$$\Delta^{Pre} = \overline{Outcome}_{Pre}^{ACC} - \overline{Outcome}_{Pre}^{Control}$$

Post ACC Difference between Cohort and Control Group

$$\Delta^{Post} = \overline{Outcome}_{Post}^{ACC} - \overline{Outcome}_{Post}^{Control}$$

$$\text{Difference in Differences Estimate} = \Delta^{Post} - \Delta^{Pre}$$

## Controlling for Selection into ACC

- Attribution Process
  - Replicated attribution based on prior 12 month E&M visits for *all* ACC eligible beneficiaries
  - Assigned a fixed effect based on “pseudo” attributed provider
    - Controls for selection related to enrollee —primary care relationship (future PCMP)
- Propensity score weighting
  - Model probability of ACC enrollment using “pseudo” attributed physician and beneficiary characteristics
    - Provider type and Patient language, race, age
  - Weight regressions using inverse probability weights from propensity score
  - Control for selection on observable characteristics

## Spending Specification

- “Two-part model”
  - Controls for prevalence of \$0 spending (i.e. no utilization)
  - Part 1: Probability of any utilization with Logit specification
  - Part 2: Spending conditional on any utilization
- Separate estimates for Standard and Dual enrollees
- Separate Estimates by Cohort
- Adjust for comprehensive set of risk-adjusters and patient characteristics