



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 1, 2013

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

Dear Senator Steadman:

Enclosed please find the legislative report to the Joint Budget Committee on the Department of Health Care Policy and Financing's School Health Services Program.

Legislative Request for Information 6 requires the Department to submit a report to the Joint Budget Committee, by November 1 of each year, on the services that receive reimbursement from the federal government under S.B. 97-101 public school health services program.

The report includes information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars distributed to each school under the program. The report also includes information on how many children were served by the program.

There are two programs under the Department's purview that provide funds for health services provided to students: The School-Based Center Program and the School Health Services Program. The School Health Services program provides health services as required in a child's Individualized Education Plan or Individualized Family Service Plan and the School Based Health Center Program provides primary care and mental health services. This report pertains to the School Health Services Program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, MaryKathryn Hurd, at MK.Hurd@state.co.us or 303-547-8494.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Susan E. Birch'.

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

SEB/sh

Enclosure(s)

CC:

- Representative Crisanta Duran, Vice-Chair, Joint Budget Committee**
- Representative Jenise May, Joint Budget Committee**
- Representative Cheri Gerou, Joint Budget Committee**
- Senator Mary Hodge, Joint Budget Committee**
- Senator Kent Lambert, Joint Budget Committee**
- John Ziegler, Staff Director, JBC**
- Kevin Neimond, JBC Staff**
- Eric Kurtz, JBC Analyst**
- Henry Sobanet, Director, Office of State Planning and Budgeting**
- Erick Scheminske, Deputy Director, Office of State Planning and Budgeting**
- Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting**
- Katherine Blair, Health Policy Advisor, Governor's Office**
- Legislative Council Library**
- State Library**
- Susan E. Birch, MBA, BSN, RN, Executive Director**
- John Bartholomew, Finance Office Director**
- Suzanne Brennan, Health Programs Office Director**
- Antoinette Taranto, Acting Client Services Eligibility & Enrollment Office Director**
- Lorez Meinhold, Community Partnerships Office Director**
- Tom Massey, Policy and Communications Office Director**
- MaryKathryn Hurd, Legislative Liaison**
- Rachel Reiter, Communications Director**



**COLORADO DEPARTMENT OF HEALTH CARE
POLICY AND FINANCING**

LEGISLATIVE REQUEST FOR INFORMATION # 2

ACCOUNTABLE CARE COLLABORATIVE

NOVEMBER 1, 2013

Executive Summary

The Accountable Care Collaborative completed its second year of operations in June 2013. Program results continue to be positive in terms of enrollment, cost savings, quality of care, client outcomes, and utilization of services. This report is submitted by the Department of Health Care Policy and Financing (the Department) in response to a request by the Joint Budget Committee for information on the following questions:

1. The number of Medicaid clients enrolled in the pilot program.

Over the past year, total ACC program enrollment has increased steadily each month:

- As of June 2013, total program enrollment was 352,236 members, including 222,862 children.
- Forty-seven percent of all Medicaid clients (729,074) were enrolled in the ACC program.

2. The current administrative fees and costs for the program.

The total program costs in FY 2012-13 were \$36,437,324. This cost includes the provision of care coordination services, network development, and practice support. Included in the figure are the following:

- The Regional Care Collaborative Organizations (RCCOs) were paid a total of \$27,417,161, of which \$688,672 (Quarters 1 and 2) was paid as an incentive based on demonstrated improvements on Key Performance Indicators (KPIs). The incentive payment for Quarter 3 (\$508,009) was paid in FY 2013-14 and that of Quarter 4 has yet to be calculated.
 - RCCO payments represent 3.34% of the total medical spend for the enrolled population.
- The Primary Care Medical Providers (PCMPs) were paid a total of \$6,020,164, of which \$489,035 (Quarters 1 and 2) was paid as an incentive for improvements on KPIs. The incentive payment for Quarter 3 (\$334,340) was paid in FY 2013-14 and that of Quarter 4 has yet to be calculated.
 - PCMP payments represent 0.73% of the total medical spend for the enrolled population.
- (B)The Statewide Data and Analytics Contractor (SDAC) was paid a total of \$3,000,000 in purchased services.

3. Performance results with an emphasis on fiscal impact.

Analysis of the program's performance demonstrates:

- 15-20% reduction for hospital readmissions and 25% reduction in high cost imaging services relative to a comparison population prior to program implementation;
- 22% reduction in hospital admissions among ACC members with COPD who have been enrolled in the program six months or more, compared to those not enrolled;
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%) relative to clients not enrolled in the ACC Program;

- Emergency room utilization by ACC enrollees increased 0.9 percentage points less than utilization by those not enrolled in the ACC program, or an increase of (1.9%) for ACC enrollees compared to an increase of (2.8%) for those not enrolled; and
- \$44 million gross, \$6 million net reduction in total cost of care (cost avoidance) for clients enrolled in the ACC Program.

Total Cost of Care:

In the previous year's report, the Department calculated a range of estimated gross program savings between \$9 million and \$30 million for FY 2011-12. The program continues to demonstrate success in cost containment and actual savings. In FY 2012-13, the ACC program analysis indicates \$44 million in gross savings or cost avoidance.

Introduction

The purpose of the Accountable Care Collaborative (ACC) Program is to transform the Medicaid program into a system of integrated care for clients and lower costs for the State of Colorado.

This annual report on the ACC program is submitted by the Department of Health Care Policy and Financing (the Department) in response to a request from the Joint Budget Committee for the following information:

- 1) the number of Medicaid clients enrolled in the program;
- 2) the current administrative fees and costs associated with the program; and
- 3) any performance results that demonstrate savings for the pilot program.

This report presents program performance information that demonstrates the continued success of the ACC program, the State of Colorado's commitment to the needs of its Medicaid population and its commitment to make its residents the healthiest in the nation. In addition to reduced costs, real member stories included in this report explain how the ACC program has positively impacted members' lives and helped improve their health.

The State of Health

In April 2013, the Office of the Governor released The State of Health, a transformative strategic plan to guide Colorado into the future as the healthiest state in the nation. The ACC program is both an integral piece of that plan and reflects actionable efforts that align with each of the four key focus areas.

- ***Focus Area 1: Promoting prevention and wellness***
The ACC program offers outreach to members needing preventive and health promotion services. Population health data is utilized to identify client needs. Care management helps coordinate services to meet all members' health needs, ensure well checks, and promote healthy living.
- ***Focus Area 2: Expanding Coverage, access and capacity***
The ACC program is improving member access to primary care and specialty services and ensures the proper utilization of services: the right services, in the right place, at the right time.
- ***Focus Area 3: Improving health system integration and quality***
The ACC program is expanding the use of client-centered medical homes and promoting the availability of program level, population level, and client level data to support increased integration of services and quality of care.
- ***Focus Area 4: Enhancing value and strengthening sustainability***
The ACC program promotes innovative healthcare payment and delivery programs that contribute to achieving cost containment, savings, and long-term sustainability.

The Department strives to align all Medicaid initiatives with the State of Health, which in turn will support the overall success of the ACC program.

Program Background

The Department implemented the Accountable Care Collaborative (ACC) program in May 2011. The ACC is transforming the Colorado Medicaid program through an innovative payment and delivery system that has improved quality of care and lowered costs to the State. The program's focus is the needs of its members and leveraging local resources to deliver the best care to meet those needs. The four main goals of the ACC are to:

- 1) Ensure access to a focal point of care or medical home;
- 2) Coordinate medical and non-medical care and services;
- 3) Improve member and provider experiences; and
- 4) Provide the necessary data to support these goals and move them forward.

The ACC provides the Colorado Medicaid program with a client-centered, whole person care approach that both improves health outcomes and ensures better health futures and savings for Colorado's population. The program design includes a focus on clinically effective and cost effective utilization of services. The three (3) core components of the ACC program are:

- Seven (7) Regional Care Collaborative Organizations (RCCOs)
- Primary Care Medical Providers (PCMP)
- Statewide Data Analytics Contractor (SDAC)

Regional Care Collaborative Organizations (RCCOs)

The purpose of the RCCOs is to achieve both health and financial outcomes while ensuring comprehensive care coordination and a medical home level of care for every member. RCCOs leverage local infrastructure, relationships and community resources to foster partnerships and collaboration across the many systems that support Medicaid clients. The RCCOs' main responsibilities are:

- ***Medical management and care coordination:*** the RCCOs must ensure that every client receives an appropriate level of medical management and care coordination;
- ***Provider network development:*** developing a formal contracted network of primary care providers and an informal network of specialists and ancillary providers;
- ***Provider support:*** supporting PCMPs in providing efficient, high quality care by providing clinical tools, client materials, administrative support, practice redesign, etc.; and
- ***Accountability and reporting:*** the RCCOs are responsible for reporting to the state on the region's progress, and meeting programmatic and Departmental goals.

The RCCOs and their leadership play a vital role in the ACC and offer customized and local health care experience to the program. The ACC leverages personal human connections to build on the strengths of local and regional partners and to provide an integrated, outcome-focused, person- and family-centered system of care.

Primary Care Medical Providers (PCMPs)

The goal of the ACC is to have every member linked with a primary care medical provider (PCMP) as his or her central point of care, and the PCMPs are directly responsible for ensuring timely access to primary care for ACC members. PCMPs function as medical homes, a model that promotes comprehensive, coordinated, team-based, and client-centered care and enhances client experience and outcomes. PCMPs are also responsible for assessing members' non-medical needs and helping them to access wraparound services such as housing assistance, long-term services and supports, behavioral health care, child care, transportation, food assistance, and other community services. PCMPs may provide this support directly, or it may be provided by RCCO care coordinators.

The ACC has also shown significant success in engaging the provider community in Medicaid programs, ACC program developments, and the care of the Medicaid population. Statewide, over two-thirds (2/3) of all PCMPs actively exchange data with other providers and the RCCOs. In addition, nearly three-quarters (3/4) of all PCMPs engage in RCCO trainings and community meetings. As PCMPs become more familiar with the ACC, the Department expects these numbers to grow. Provider participation in quality improvement efforts directly benefits clients and helps build efficient service delivery.

Statewide Data and Analytics Contractor (SDAC)

The Statewide Data and Analytics Contractor provides the Department, RCCOs, and PCMPs with actionable data at both the population level and the client level. Population level data is used to evaluate and improve individual RCCOs, individual PCMPs, and the program overall. Client level data is used to support care management activities, and can help PCMPs identify high need clients. Data is provided via an online portal with secure, role-based access that is monitored by the RCCOs and the Department.

The SDAC tracks designated performance metrics called Key Performance Indicators (KPIs). KPIs are used to determine incentive payments for RCCOs and PCMPs, and will be revised as the ACC program evolves to support program goals. The SDAC also analyzes data for program monitoring and improvement efforts as part of the basic program design and mechanism for accountability.

The SDAC currently includes paid claims data and some behavioral health data. The Department is investigating opportunities to include additional quality metrics, clinical data, and data related to services provided by Single Entry Point (SEP) agencies, Community Centered Boards (CCBs), and Behavioral Health Organizations (BHOs). The inclusion of these additional datasets will allow a more accurate portrayal of the health needs and utilization patterns of each member.

Member Success Story: Michael

“Michael”, a 37-year old member with Type 2 diabetes, was unable to manage his own insulin and blood sugar levels, stating the tasks of self-care were difficult and overwhelming. As a result, Michael became a frequent visitor to his local emergency room. Even though he lived near the hospital, he would call an ambulance for transport. The increased frequency of Michael’s visits to the ER was brought to the attention of a RCCO care coordinator, who then reached out to assess Michael’s needs. Michael told the care coordinator that he did not have a primary care provider since his previous doctor had left town, and it was easier to go to the ER. Michael was quickly connected with a new provider, where he received diabetes education and a new glucometer. He was also encouraged to call the clinic rather than going to the ER. Since the intervention, Michael has not returned to the ER and has kept all of his scheduled appointments with his primary care provider.

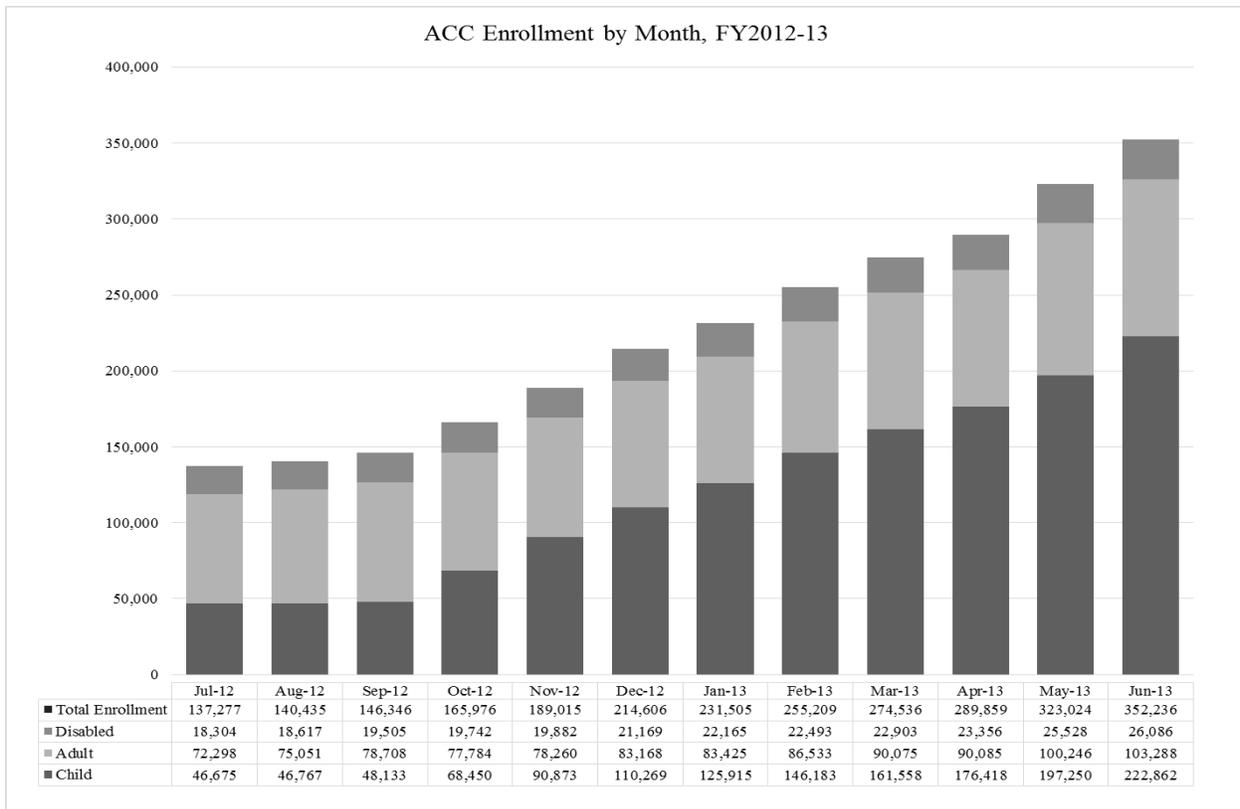
Medicaid Enrollment in the ACC Program

Medicaid Enrollment in the ACC Program

- ***As of June 2013, total program enrollment was 352,236 members, including 222,862 children.***
 - Compared to the previous year: As of June 2012, the total enrollment was 132,227, including 48,382 children
- ***At the end of FY 2012-13, 47% of all Medicaid clients were enrolled in the ACC program.***
 - Compared to the same period in the previous year: 20% of all Medicaid clients (651,122 June 2012 caseload) were enrolled in the ACC program.

Medicaid clients who are institutionalized or who are dually Medicare-Medicaid eligible are not being actively enrolled in the program at this time. However, if clients are institutionalized or become dually eligible after being enrolled in the ACC program, they may remain in the program. Clients may also voluntarily choose to enroll in the ACC program.

Over the past year, total ACC program enrollment has increased steadily each month, as shown in the chart below.



Administrative Costs

The total program costs in FY 2012-13 were \$36,437,324. These costs included the following:

- The Regional Care Collaborative Organizations (RCCOs) were paid a total of \$27,417,161, of which \$688,672 (Quarters 1 and 2) was paid as an incentive based on demonstrated improvements of Key Performance Indicators (KPIs). The incentive payment for Quarter 3 (\$508,009) was paid in FY 2013-14 and that of Quarter 4 has yet to be calculated.
 - RCCO payments represent 3.34% of the total medical spend for the enrolled population.
 - RCCOs are responsible for ensuring that clients receive coordinated, comprehensive, and holistic care. Additionally, RCCOs provide clinical tools and client materials, support practice redesign, build formal contracted networks of primary care medical providers, and report to the state on the progress of the region in meeting programmatic goals.
- The Primary Care Medical Providers (PCMPs) were paid a total of \$6,020,164, of which \$489,035 (Quarters 1 and 2) was paid as an incentive for improvements on KPIs. The incentive payment for Quarter 3 (\$334,340) was paid in FY 2013-14 and that of Quarter 4 has yet to be calculated.
 - PCMP payments represent 0.73% of the total medical spend for the enrolled population.
 - PCMPs function as medical homes or focal points of care for clients. PCMPs

promote team-based and client-centered comprehensive care that enhances both client experience and medical outcomes.

- The Statewide Data and Analytics Contractor (SDAC) was paid a total of \$3,000,000 in purchased services.
 - The SDAC is responsible for providing timely and actionable data to RCCOs, PCMPs, and the Department through a secure online portal, trainings, and reports. Data and analysis supplied by the SDAC is used to determine and address trends at the population level, as well as to focus care on individual client needs.

Impact of the ACC Program

Analysis of the program's performance demonstrates:

- 15-20% reduction for hospital readmissions and 25% reduction in high cost imaging services relative to a comparison population prior to program implementation;
- 22% reduction in hospital admissions among ACC members with COPD who have been enrolled in the program six months or more, compared to those not enrolled;
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%) relative to clients not enrolled in the ACC Program;
- Emergency Room utilization by ACC enrollees increased 0.9 percentage points less than utilization by those not enrolled in the ACC program, or an increase of (1.9%) for ACC enrollees compared to an increase of (2.8%) for those not enrolled; and
- \$44 million reduction in total cost of care for clients enrolled in the ACC Program.

Key Performance Indicator Trend Analysis

The Key Performance Indicator (KPI) metrics offer a high level representation of ACC program utilization performance. The three KPIs for FY 2012-13 were: 1) hospital readmissions within thirty (30) days of discharge, 2) emergency room visits, and 3) high cost imaging services. These KPIs were selected to measure initial program efforts to reduce cost and improve health outcomes. A fourth KPI measuring Well Child Visits was implemented on July 1, 2013, to measure the percentage of children who receive necessary preventive services and screenings. These four KPIs will be measured throughout FY 2013-14.

The ACC program seeks to reduce unnecessary utilization by providing care management support to members with chronic disease and/or other complex health care needs. In order to measure the scope of the reductions, the Department first calculates an expected value of utilization, or "benchmark", for each KPI. This expected value or benchmark is calculated by examining the utilization data of clients from before the program's implementation, and then adjusting for the health status and client mix of the current ACC population.

The following charts present ACC performance for each KPI on a rolling 12-month basis, i.e. each bar represents an analysis of the data for that month and the previous eleven months. The charts report the percent difference of the actual KPI utilization from the expected number of visits. **As such, a negative percentage indicates positive performance in the ACC.** The

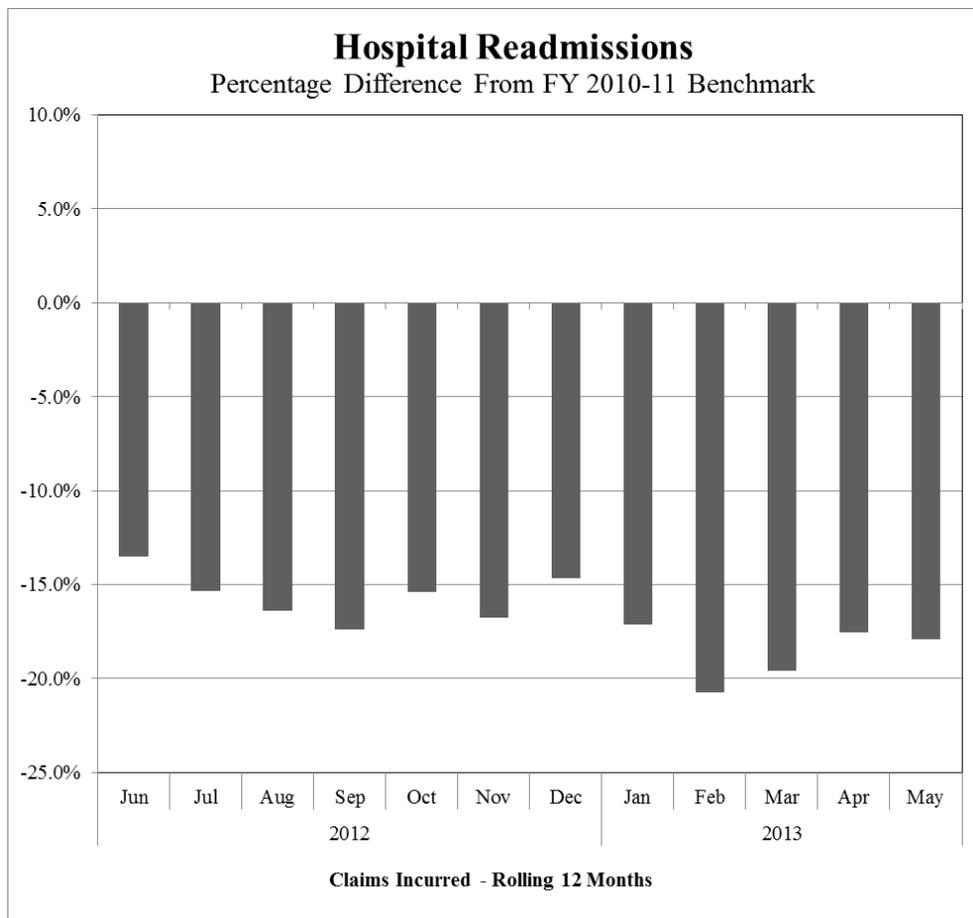
percent difference can be used as a proxy measurement for ACC performance, since program benchmarks were calculated using pre-ACC program data.

Hospital Readmissions

Re-hospitalization within thirty days of discharge is costly and can often be prevented through coordination between the inpatient and outpatient systems and comprehensive follow up care. This KPI measures the hospital readmissions that occur within thirty days of a member being discharged from an inpatient hospital stay.

Clients in the ACC Program have lower rates of inpatient hospital readmissions than those not enrolled in the program.

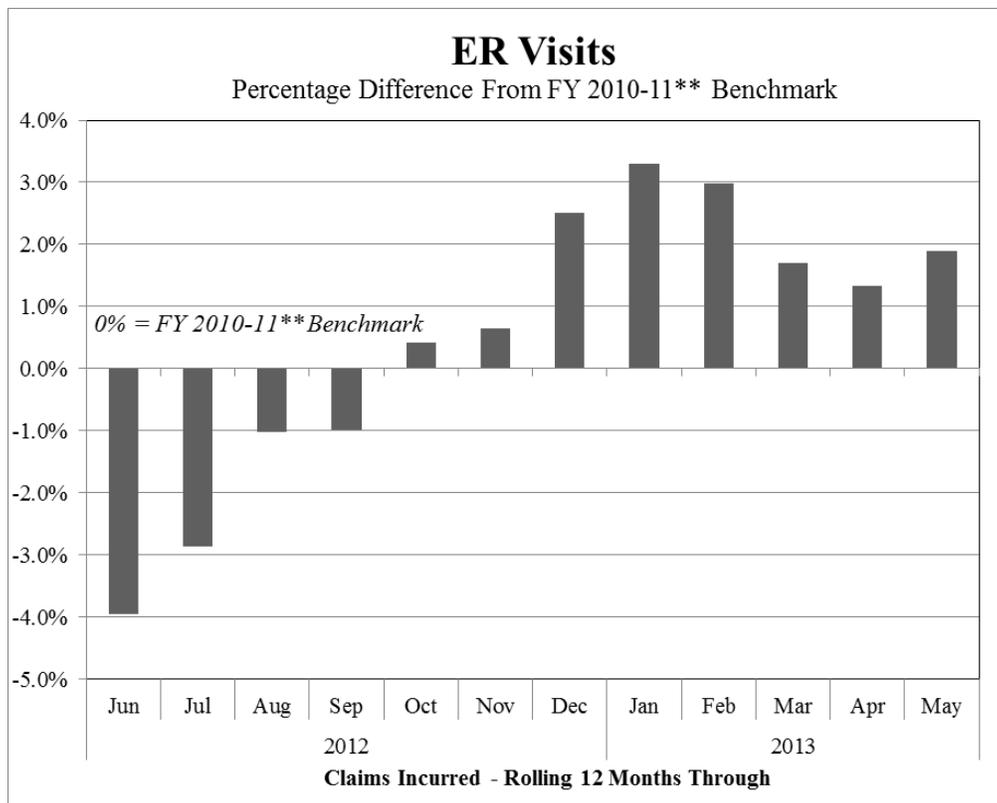
As mentioned above, each bar below represents 12 months of paid claims data. The first bar on the readmissions chart below, representing June 2012, indicates a 13% reduction in hospital readmissions compared to the expected number of visits or the benchmark. This improvement continued into FY 2012-13, as readmissions continued to decline to 15-20% below the expected benchmark.



Emergency Room Utilization

Inappropriate use of the emergency room is a significant cost driver and a challenge for both public and private healthcare systems. While emergency room utilization has been increasing for Medicaid clients in general, ER utilization has increased more slowly for clients enrolled in the ACC than for clients who are eligible but not enrolled in the ACC. On average, clients enrolled in the ACC demonstrated 0.9 percentage points less utilization above benchmark levels when compared to clients not enrolled in the ACC.

Emergency room utilization is driven by client behavior and the health care market. Client strategies for accessing health care are often deeply ingrained and may be heavily influenced by social and geographic factors. Changing client behavior is necessarily a gradual process. Although the ACC program was implemented three years ago, enrollment has ramped up slowly. Many ACC clients have only been enrolled for a short period of time. Perhaps even more influential than individual client behavior is Colorado’s current health care market. Hospital systems in several regions around the state have recently opened urgent care and emergency room facilities. Current Medicaid billing practices don’t allow the Department to distinguish between visits occurring in those hospitals’ urgent care facilities versus those hospitals’ Emergency Departments.



** - FY2010-11 Benchmark adjusted for region-specific discrepancies in the baseline period

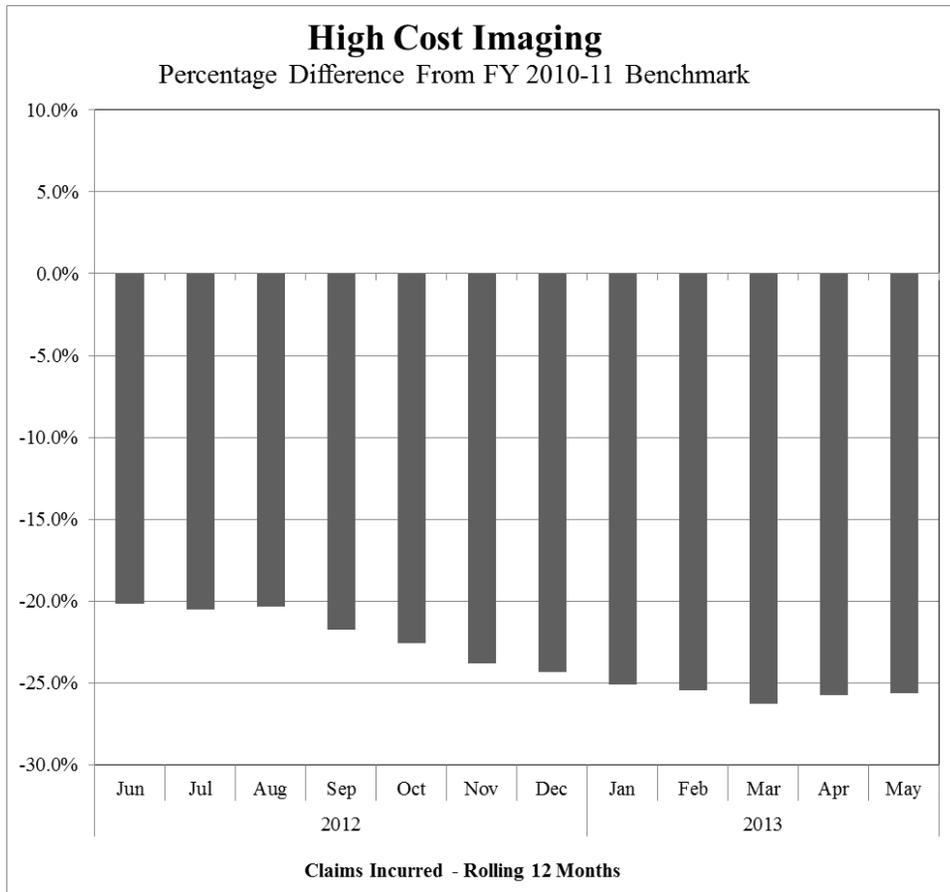
An evaluation of ER utilization suggests that some Colorado Medicaid clients may be utilizing the ER as a substitute for primary care services, as the ER is often perceived to be more accessible and convenient. The ACC has focused on providing more timely access to primary

care by extending PCMP hours and increasing overall appointment accessibility. PCMPs have also made significant efforts to promote the prevention and management of healthcare needs by engaging clients and families in familiar, more comfortable provider relationships and offering extended hours. Recently, the Department was awarded a technical assistance grant from the National Governors Association to study the behavior of clients who utilize excessive services. The goal is to find ways to alter the behavior of these “super-utilizers” while promoting interventions that increase quality and reduce cost.

While the ER visit results are not as positive as many of the data points in this report, they highlight one of the core benefits of the ACC program: increased transparency and ongoing program performance improvement. Increased access to data and analytics has not only allowed the Department to highlight successes but also identified areas where there is opportunity for improvement. ER utilization is one area in which the Department will allocate increased resources to better understand and address the increase.

High Cost Imaging

High-tech imaging tools, such as MRIs and CT scans, are commonly used diagnostic services that in recent years have developed into one of the fastest growing areas of medical spending. However, more cost effective alternatives are frequently available without compromising clinical efficacy and quality of care for clients. This high-cost imaging KPI exemplifies the Department’s efforts to move away from a volume-driven to a value-based system of care.

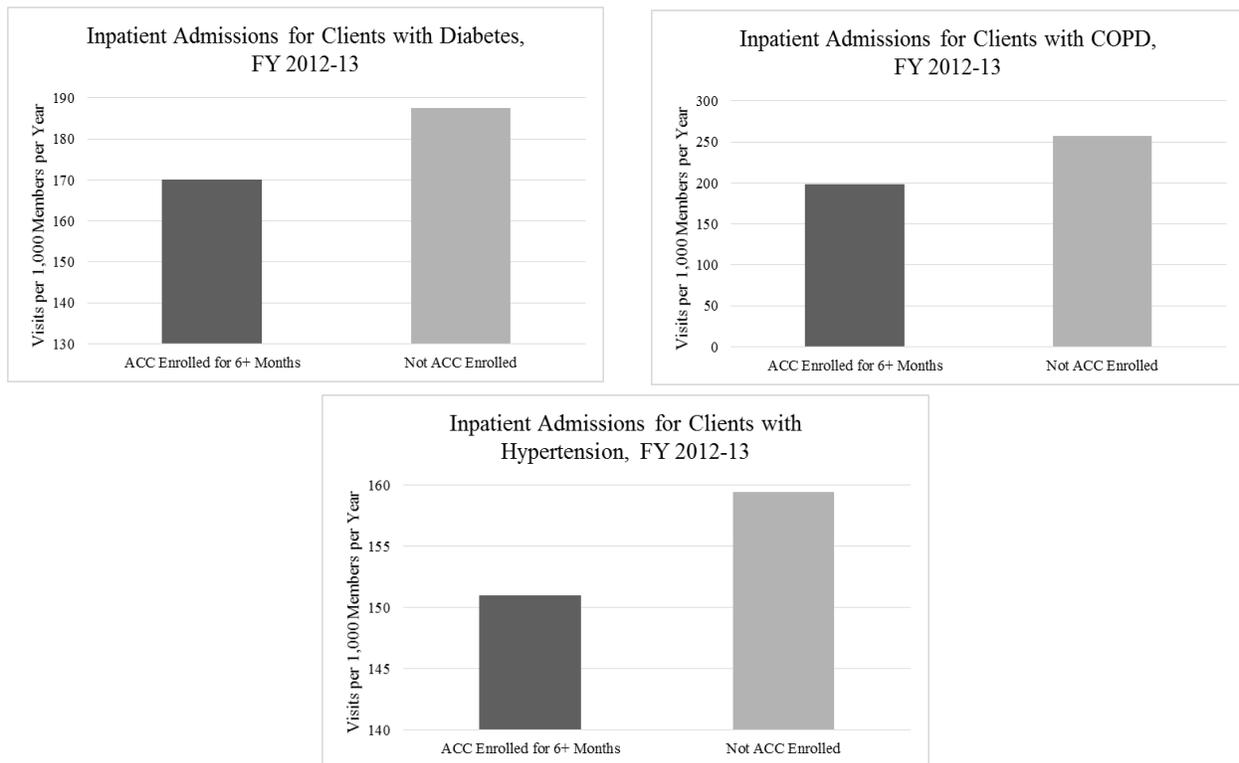


Much like hospital readmissions, enrollment in the ACC is correlated with reductions in the utilization of high cost imaging services. Initial high cost imaging service utilization was reduced 20% compared to benchmark after one year. This trend has continued to improve as high cost imaging utilization is now approximately 25% below the expected benchmark.

Chronic Disease Management

Chronic diseases such as hypertension, diabetes, and chronic obstructive pulmonary disease (COPD) have historically been significant drivers of cost in the health care system and a major cause of death and disability. In order to improve client outcomes over time, as well as manage costs, PCMPs are charged with coordinating member care and tracking the progression of any chronic disease(s) with which a client is diagnosed. Pro-active care coordination and active monitoring of chronic diseases provide members with more timely interventions that can, in turn, prevent conditions from worsening and requiring more costly and intensive interventions down the road.

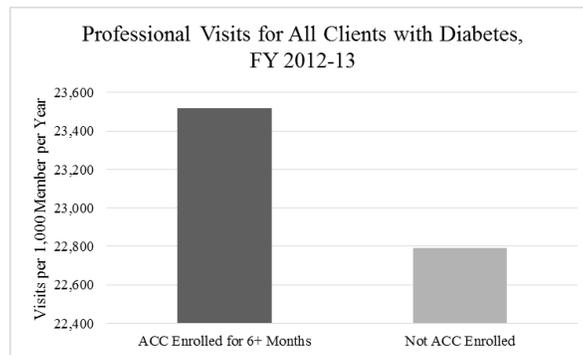
An examination of hospital admissions for diabetes, hypertension and COPD illustrates that ACC enrolled clients have lower rates of hospital admission for these disease than clients not enrolled in the ACC:



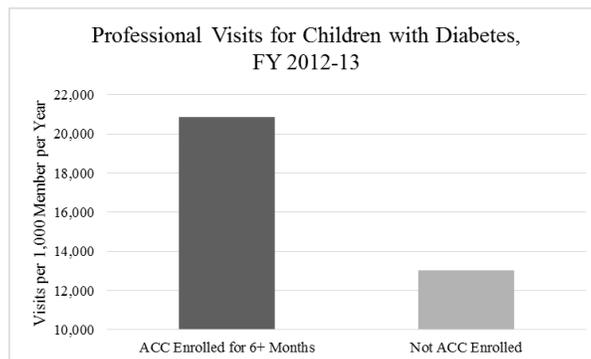
ACC members with COPD who have been enrolled in the program for 6 months or more were admitted to the hospital **22% less often than those not enrolled**. This pattern is similar for members with diabetes, who demonstrated a **9% reduction in hospital admissions**, and **members with hypertension, who demonstrated a 5% reduction in admissions**. The

correlation between ACC enrollment and lower inpatient admission rates for enrollees with chronic conditions supports the assertion that the ACC is successful in providing coordinated care with a focus on clinically appropriate and cost-effective utilization of services.

Beyond the initial cost savings of the program, the ACC has also invested in long term health outcomes. By investing in lower cost medical visits and services that serve a preventive function, the ACC is able to provide appropriate disease management that reduces future, more costly interventions. An examination of metrics related to outpatient medical visits and services for members with diabetes shows that clients in the ACC are more often provided with lower cost, more effective services as compared to clients not in the ACC.



For the ACC’s child population, the correlation between ACC enrollment and effective service utilization is even more pronounced. This is an important finding, as children who receive appropriate diabetes management at an early age benefit from improved health outcomes and reduced costs long-term.



In addition to cost savings and improvement in appropriate utilization of medical services, real member stories included in this report demonstrate how the ACC program has improved member health and impacted their lives for the better.

For example, improved health and well-being can improve a child’s school attendance and help him reach his potential in the classroom. A parent who previously spent time taking care of a sick child may more reliably keep a job and provide for her family’s needs. These types of improvements in life and livelihood are realistic expectations of better health; therefore, the impact presented in this report should be treated as the minimum of what the program achieved.

Member Success Story: Mr. F

ACC member “Mr. F” was having trouble maintaining a primary care relationship due to behavioral problems and angry outbursts at staff. Mr. F had frequent visits to the emergency room, a number of recent inpatient stays, and required medication monitoring. A case manager with one of the RCCOs, Colorado Access, reached out to Mr. F and learned that he was grieving the recent loss of his partner. The case manager worked closely to provide him with education and resources to address his anxiety and anger which had been disruptive to his medical care. The case manager then connected Mr. F with a new PCMP. Since being in care with the new clinic, Mr. F has reported being satisfied with the new relationship and is demonstrating a new willingness to engage in mental health care. Since connecting with his new PCMP and mental health provider, Mr. F has had no emergency room visits or inpatient hospitalizations.

Total Cost of Care

In FY 2012-13, the ACC program achieved an estimated \$44 million in gross savings.

To estimate a total cost of care impact, the Department compares actual expenditure for ACC enrolled clients to a forecast of expenditure for these same clients using only data from periods prior to the implementation of the program. The forecast is essentially a model of expenditure for ACC enrolled clients under the assumption that the program was never implemented, or a counterfactual model. The difference between actual expenditures and forecasted expenditures in the counterfactual model is measured as program performance. Additional detail regarding this methodology can be found in the appendix.

To develop the counterfactual model, the Department used baseline cost data from before the implementation of the ACC and applied an actuarially determined growth rate to account for medical inflation. This model estimated gross savings of approximately \$64 million.

In the Department’s FY 2013-14 S-1: “Medical Services Premiums” request, the Department estimated \$30.60 PMPM gross savings per client enrolled in the ACC; for FY 2012-13, this would produce a \$44 million total gross savings estimate for FY 2012-13. The budgetary figure was based directly on savings identified in the prior year’s ACC annual report. Although the counterfactual modeling methodology supports stating a higher level of savings in FY 2012-13, because every model has a degree of uncertainty and the Department would not want to overstate savings, the Department believes the budget estimate of \$44 million is a reasonable estimate of program performance. This is equivalent to approximately \$6 million net cost avoidance in FY 2012-13 after accounting for program administrative costs.

Conclusion

Program data on costs and utilization, stories of improved client experience, and enhanced provider engagement in program activities all represent ACC program successes. As the Department, the RCCOs, providers, and the community continue to gather experience and lessons learned, the program will build upon this collective experience and continue to improve.

The ACC program is the platform through which future program improvements and reform efforts will be implemented. Better health and lower costs in health care will enhance Coloradan lives, and effectively contribute to improvements in the state's social and economic environment. These early results and successes indicate a positive trend of enduring improvements and a future health system that achieves the promise of the State of Health, making Colorado truly the healthiest state in the nation.

Appendix A

Technical Documentation for Total Cost of Care

The Department's total cost of care estimate was calculated using a *counterfactual estimation* technique, which calculates the impact of the ACC compared to a hypothetical scenario in which the ACC program was not implemented. This method is widely used throughout the health care industry to estimate the impact of care management programs on the total cost of care. Because ACC enrollment has captured a large proportion of the Medicaid population, no comparable alternate population exists to compare results. Therefore, the counterfactual estimation technique is the most useful and appropriate method to calculate savings from the program.

Limitations

The counterfactual methodology requires an accounting of various client groups' utilization patterns, expected changes to those patterns, and the application of risk adjustment to accurately compare distinct sub-populations. The counterfactual method does not account for factors that remain unchanged over time, such as client preferences, that may contribute to variations in cost and utilization within the enrolled and non-enrolled groups. It is possible that differences in pre-period costs were incorrectly calculated to be savings.

It is important to note that this counterfactual estimation technique differs from the method the Department anticipates using for the ACC Shared Savings initiative, although the two methods are similar in some ways. In estimating the impact of the ACC on the total cost of care, the Department is comparing actual observed performance to a hypothetical baseline that would only exist without the ACC. The Shared Savings Initiative, however, will attempt to measure improvements at the RCCO level, as compared to the broader performance of the ACC.

Comparable Cohorts

In order to accurately estimate the impact of the ACC on total cost of care, the enrolled population is divided into distinct groups with similar characteristics and health needs and, therefore, similar costs. This subdivision allows more finely-tuned hypothetical growth rates to be applied to the benchmark cost for each group. Groups were defined in the following way:

- 1) Clients are grouped into three distinct categories based on their age and disability risk score:
 - Non-Disabled Children
 - Non-Disabled Adults
 - Disabled Adults and Children
- 2) Clients are separated into the seven RCCO regions based on their county of residence. Each of the three eligibility types above is separated into seven distinct groups, one for each region.
- 3) Clients are separated into groups based on the month they were enrolled in the ACC program. Clients are enrolled on the first of each month. The months between July 2012 and June 2013 (FY 2012-13) are considered for this analysis. For each of the 21 distinct

groups above (3 eligibility and 7 regions within each eligibility type), clients are separated into enrolled or non-enrolled groups for each of the 12 months during FY 2012-13. Only enrolled clients are included in the risk-adjusted actual costs presented below.

Risk Adjustment

Risk adjustment allows for the comparison of different groups of clients by normalizing for differences in health status. A risk score is a measurement of the relative health status of a group of clients compared to the health status of the entire population. The risk score for the entire population is set to 1.0 and is based on the average cost of the entire population. The risk score for a particular group of clients is then established by summing the total cost PMPM for the group and dividing by the total cost PMPM for the entire population. Once risk has been normalized, it is possible to fairly compare which group was more expensive on average.

The risk adjustment methodology used to control for differences in health status is Clinical Risk Groups (CRGs) developed by 3M. This methodology groups clients into similar sub-populations based on diagnosis codes and procedure codes. Further refinement of each group is accomplished by considering the relative severity of illness and risk of mortality for each of the members in a given sub-population. Risk scores are calculated using three years of historical claims data. Scores are calculated separately for disabled and non-disabled populations.

Growth Rates

Counterfactual estimation relies heavily on the use of accurate growth rates (measurements of changes in cost and utilization of medical services over time) to estimate a benchmark in the absence of a comparison population. Using claims data from FY 2010-11 and FY 2011-12, the Department's actuary estimated population-level and RCCO-level growth rates for the entire ACC-eligible Colorado Medicaid population. The actuary normalized the data using the CRG methodology described above, adjusted the data to account for services that were incurred but not reported (IBNR), and subtracted out program changes not related to the ACC. This analysis allowed the actuary to estimate rates of change for each population by RCCO. These estimates indicate that medical expenditures for the entire ACC-eligible population would have grown approximately 3.91% in FY 2011-12 and 2.27% in FY 2012-13 in the absence of the ACC.

These growth rates may initially seem to contradict growth rates presented in per capita trends shown the Department's budget request for Medical Services Premiums (see, for example, the Department's November 1, 2013 Budget Request R-1, Exhibit C). Cash-based actual per capita costs are projected to significantly decrease for many of the eligibility types that the ACC impacts. There are numerous reasons for the differences between the Department's projections based on actual growth rates and the actuary's estimated growth rates. Most importantly, the Department's estimated growth rates take into account estimated effects of the ACC, while the actuary's do not.

Appendix B Program Background

The Department implemented the Accountable Care Collaborative (ACC) Program in May 2011 as the predominant Medicaid system reform. The ACC Program represents a committed effort to transform the Medicaid Program into an integrated system of better care for all its members and to lower costs for the State of Colorado.

In the early 2000s, a number of managed care plans withdrew from Medicaid, leaving 80% of the Colorado Medicaid population in a fee-for-service payment system. Fee-for-service reimbursement has been shown to be an inefficient and ineffective payment method for health care. After seeing an increase in the number of Medicaid enrollees and the resulting rising costs, the Department took the initiative to develop a plan for achieving greater efficiency.

The Department developed a Colorado-specific solution, the ACC Program, in collaboration with stakeholders. In 2009, the legislature passed a budget action authorizing the Medicaid Value-Based Care Coordination Initiative, now known as the ACC Program. Stakeholders have been vital to the design, implementation, and ongoing evolution of the ACC Program, and ongoing stakeholder engagement is continuously achieved through a robust advisory committee process.

Higher quality and lower cost health care can be accomplished, but changing a system as large as the state's Medicaid Program necessitates progressive evolution rather than overnight metamorphosis. The Department has outlined four goals for the ACC Program. The program will:

- 1) Ensure access to a focal point of care or medical home;
- 2) Coordinate medical care and non-medical care;
- 3) Improve member and provider experiences; and
- 4) Provide the necessary data to support these goals.

The ACC Program is a short-term solution to improving care and reducing costs as well as a long-term investment in better health futures and savings for Colorado's population. The program design includes an immediate focus on cost- and clinically-effective utilization of services. Coordination of care and an enhanced emphasis on wellness and prevention is expected to result in better health and reduced costs across the lifespan of current members.

Program Design

The three core components of the ACC Program include:

- Regional Care Collaborative Organizations (RCCOs), to ensure cost and quality outcomes for their Medicaid members;
- Primary Care Medical Providers (PCMPs), to serve as the focal point of care for each member;
- Statewide Data and Analytics Contractor (SDAC), to provide actionable data at both the population and client level.

Regional Care Collaborative Organizations

For the purpose of the ACC Program, the state is geographically divided into seven regions, each having one Regional Care Collaborative Organization (RCCO) responsible for all of the ACC members in that region. The program was designed this way to promote collaboration and avoid a scenario in which multiple entities compete for Medicaid clients. The seven RCCO contracts were awarded in late 2010 and early 2011 through a competitive procurement process.

The RCCOs' four main responsibilities are:

- **Medical Management and Care Coordination:** The RCCOs must ensure that every client receives an appropriate level of medical management and care coordination. This links to the program goal of ensuring a positive provider experience as well as a positive member experience. RCCOs can assist providers with addressing the non-medical needs of their clients that they may not have the in-house capacity to address.
- **Network Development:** Develop a formal contracted network of primary care providers and an informal network of specialists and ancillary providers. This addresses the core program goal of ensuring access to primary care.
- **Provider Support:** Support the PCMPs in providing efficient, high quality care through activities such as providing clinical tools, client materials, administrative support, practice redesign, etc. This responsibility ties to the core program goal of ensuring a positive provider experience.
- **Accountability and Reporting:** the RCCOs are responsible for reporting to the state on the region's progress.

Primary Care Medical Providers

The role of PCMPs is to serve as a focal point of care or medical home for ACC clients. Every member should be linked with a PCMP as his or her central point of care. PCMPs are directly responsible for ensuring timely access to primary care, one of the core goals of the ACC program. Currently, PCMPs must be a physician, advanced practice nurse, or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology. This primary relationship is essential to building an integrated care system. The system must grow around the client, and establishing a strong connection to the system will ensure that right services may appropriately form around the client's needs.

Clients in the ACC Program are enrolled with both a RCCO and a PCMP in the Medicaid Management Information System (MMIS). Clients are assigned to a PCMP at the time of enrollment if they have a clear pattern of use with that provider. Clients with a clear pattern of use with a provider who is not in the ACC Program are not enrolled, so existing provider/client relationships are not broken. Clients with no claims history with a provider are only enrolled in the RCCO, and the RCCO is responsible for connecting them with a PCMP. Approximately 75% of enrolled clients are linked with a PCMP. This prospective enrollment allows providers to know who they are responsible for and to implement proactive strategies for ensuring that clients are receiving the care that they need.

Medicaid providers contracted as PCMPs have been integral to developing and improving the ACC Program. The Department continues to receive feedback from the practice level around the positive impacts to members, especially those with high needs and non-medical needs that affect health outcomes. These successes continue to generate positive enthusiasm, engagement, and commitment to the improvement and realization of a better Medicaid program.

Statewide Data and Analytics Contractor

The Statewide Data and Analytics Contractor (SDAC) is responsible for providing the Department, RCCOs, and PCMPs with actionable data at both the population and client level. Population level data is used to evaluate and improve the program, individual RCCOs, and individual PCMPs. Client level data supports care management activities. The data is provided to the Department, RCCOs, and PCMPs via an online portal with secure, role-based access. Currently, only paid claims data are included. The online Web portal was launched in January of 2012.

The SDAC tracks program Key Performance Indicators (KPIs). The KPIs for FY12-13 were:

- ER visits;
- Inpatient hospital readmissions; and
- High-cost imaging services.

These KPI metrics were identified because they strongly correlate with the total cost of care, can be measured using existing claims data, and represent opportunity for providers to impact care delivery. In addition, appropriate utilization of these services may be influenced through care coordination and care management practices. Both the PCMPs and the RCCOs have access to a Web portal that details the KPIs of their enrolled members. They are able to monitor and improve their own performance and identify members who may need additional assistance.

The KPI metrics are tracked for each RCCO and PCMP. The metrics are calculated based on the clients attributed to each RCCO and PCMP. The Department is able to compare RCCOs and PCMPs by comparing their KPI metrics. Beginning in FY 2012-13, one dollar of the administrative PMPM is being withheld from both the RCCOs and PCMPs. Both entities are eligible to earn the dollar back by meeting utilization reduction targets for each KPI.

The SDAC is responsible for dissemination of best practices across the ACC Program. By scheduling regular training sessions with RCCOs and PCMPs, the SDAC can share methods of using data to create actionable care plans for ACC clients.