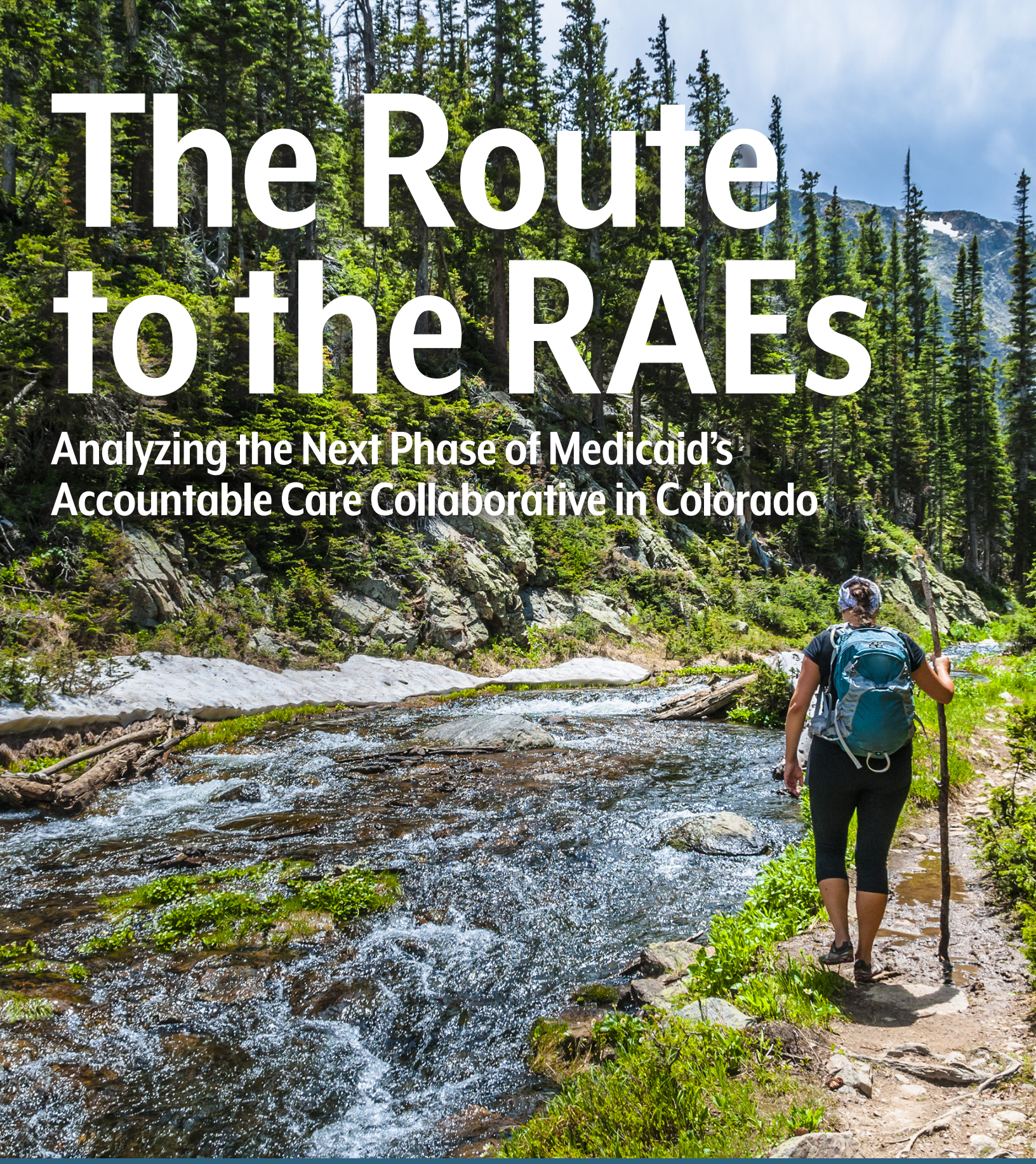
The Route to the RAEs

Analyzing the Next Phase of Medicaid's Accountable Care Collaborative in Colorado



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Colorado's Medicaid program is poised to take another step along the trail it blazed six years ago.

The state is preparing to implement the next phase of its Accountable Care Collaborative (ACC), a groundbreaking effort aimed at changing how care is delivered to Medicaid members as well as stemming the spending growth that saw Medicaid take up a bigger share of the state budget.

Any significant change to Medicaid will have huge implications for Colorado. Enrollment in the joint federal/state public coverage program now stands at about 1.4 million people — more than one of every five Coloradans. Over a million of those members are in the ACC, a number that is sure to increase during the next phase when ACC enrollment becomes mandatory.[1]

The ACC has, in many ways, been an experiment — a testing ground for new ideas. Phase One has shown promise, posting modest cost savings as well as incremental increases in the use of services that can improve health.[2] It has been identified as a feasible model for adoption by other states.

Phase Two, which is slated for 2018, outlines a broader range of policy changes and payment carrots and sticks that attempt to accelerate improvements in care and result in greater cost savings.

It is designed to influence, through contractually defined incentives and deterrents, the behaviors of the regional management entities created during Phase One as well as participating health care providers and Medicaid members themselves.

It takes steps toward sharing some of the state's financial risk with medical providers and the regional organizations. It moves toward a more flexible management structure with primary care providers. And it attempts to increase integration of physical and behavioral health care.

What's in a Name? ACC vs. ACO

Is the Accountable Care Collaborative the same thing as an Accountable Care Organization (ACO)? Over the past decade, the Medicare and commercial sectors have established ACOs to reduce costs while increasing quality. In general, ACOs embody three principles: they are led by providers that focus on primary care and ensure that a population of patients receive efficient care of high quality; payments are linked to improvements in the quality of care that also reduce cost; and improvement is made by measuring performance with data.[3]

There are both parallels and differences between ACOs and the ACC. Some point out that the ACC differs because ACOs are led by providers. Others say that the ACC goes beyond ACOs, because of its focus on medical homes and payment reform. Perhaps the best way to answer the question is that the ACC is akin to an ACO — sharing many of the same principles — yet is Colorado's unique approach to reforming Medicaid. [4]

Yet some of the state's biggest ideas for care integration have been scaled back, particularly those around behavioral health care. Efforts to pay for medical and behavioral health care in the same way were undone amid concerns that behavioral health services would become less available and cost more.

Meanwhile, the next iteration arrives amid new legislation requiring increased accountability and reporting on the ACC to the Colorado General Assembly.

So, what does Phase Two mean for Colorado? Are the changes in step with state and national trends? And do they go far enough — or provide the correct level of incentives and deterrents — to result in meaningful improvement?

To answer these questions, the Colorado Health Institute (CHI) spoke with stakeholders, analyzed results from Phase One and reviewed the draft and final Request for Proposals (RFP) for Phase Two from the Colorado Department of Health Care Policy and Financing (HCPF), which administers Medicaid. CHI also reviewed stakeholder responses to the draft RFP.[5]

We've identified five primary themes for Phase Two and analytical questions related to the policy and payment changes:

1. **Paying for Care: A Few Sticks, Many Carrots.** The way Medicaid pays health care providers remains largely unchanged. However, Phase Two – using contracts with regional entities – encourages greater quality and efficiency through approaches that reward better performance.

   Question: ***Are these the correct sticks and carrots to make meaningful change?***

2. **Integration Moves Ahead.** Phase Two will replace Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) with Regional Accountable Entities, or RAEs, in 2018. RAEs will be responsible for connecting Medicaid members with both primary care and behavioral health care. Primary care providers will be reimbursed for some behavioral health visits to encourage care integration. This initiative, however, has not been without detractors.

   Question: ***Will these steps result in increased or decreased access to behavioral health services for those who need them?***

3. **Welcome to the (Health) Neighborhood.** Phase Two takes small steps in acknowledging factors beyond clinical care that influence health. These factors include encouraging collaboration with such non-health care areas as education and housing; allowing greater flexibility in contracting with specialists and public health agencies; and developing plans that will improve the health of the Medicaid population.

   Question: ***These are issues that take years or generations to show results. Will state and local stakeholders be patient enough — and devote sufficient resources — to invest in the long haul?***

4. **Access to Care is Location, Location, Location — and Past Use.** On one hand, Phase Two pays more attention to geography, with additional guidelines designed to improve access to care based on the proximity of rural Medicaid members to their providers. On the other hand, Medicaid members will be connected to primary care based on where they've sought care in the past rather than where they live.

   Question: ***Will the new guidelines be disruptive to Medicaid members or improve the continuity of their care?***

5. **Doing It Up with Data.** New data systems and required performance metrics attempt to support RAEs and providers in new ways, with the goal of improving care efficiency.

   Question: ***Is it realistic for RAEs and providers to tackle so many performance metrics, and will the new data systems be sufficient to monitor progress?***

The steps outlined for Phase Two signal some big changes for the state's primary care and behavioral health care providers. At the same time, Phase Two represents an incremental approach. Some wish that Medicaid would travel even further down one path or another, toward more capitated managed care, some other model of paying for care, or a more intense focus on non-medical determinants of health.

Yet this approach is by design. Transforming such a large and complicated program carries enormous challenges, including maintaining continuity of health care for Medicaid members, among the state's most vulnerable residents. From the beginning, crafters of the ACC envisioned an iterative approach to moving the program forward.

Phase Two represents the next step along the trail toward greater substantive change.

The ACC's Journey: An Abbreviated Travelogue

Colorado's Medicaid program — renamed Health First Colorado — has been on a journey since 2011, when the ACC was launched. Here's a trail map.

Charting the Course

In 2011, the ACC brought many changes to Medicaid.

These changes were part of the ACC's ultimate vision: to improve the health of members while decreasing costs and improving the health care experience of patients and providers.

But how would it get there? HCPF developed the ACC – coordinating with federal regulators as well as Colorado stakeholders – to implement these three strategies:

1. Connect Medicaid members to a medical home, also known as a **Primary Care Medical Provider (PCMP)**, where they would receive regular primary and preventive care.
2. Establish a data system — called the **State Data and Analytics Contractor (SDAC)** — to support improvements in the quality and efficiency of care.
3. Establish seven **Regional Care Collaborative Organizations (RCCOs)**, responsible for coordinating care across primary care and specialty providers and managing the goals within their geographic regions. (See Figure 3.)

Using the Compass

So how far has the ACC moved toward its goals?

Notably, almost three of four Medicaid members are enrolled in the ACC (See Figure 1). HCPF estimates the ACC saved taxpayers approximately $62 million in the 2015-16 fiscal year — a modest amount given HCPF's total budget of $9 billion but a step in the right direction.[6]

Most of the savings were attributed to members with disabilities and adults covered by the Affordable Care Act's Medicaid expansion. (See Figure 2.) The ACC spent more money than expected on two groups — adults already eligible prior to the expansion and children. HCPF cites a variety of reasons these two groups did not achieve savings. For example, older adults requiring long-term services and supports — which are expensive — were counted in the pre-expansion group and offset the savings. Also, most children are healthy and do not require care coordination, even though each RCCO is paid the same amount for children as it is for other groups of members. HCPF points out, however, that spending for children's health is a worthwhile investment. It may reduce expensive chronic conditions — such as asthma and diabetes — down the road and improve a child's quality of life.

Figure 1. The ACC at a Glance

1 Million

Enrollment in May 2017, 77 percent of the 1.4 million Medicaid beneficiaries

Net savings in fiscal year (FY) 2015-16, or .7 percent of HCPF's total $9 billion budget

- 2017 research published in the journal *JAMA Internal Medicine* compared the ACC with a similar model in Oregon that used a different payment method. The study found that while both states decreased Medicaid expenditures, Colorado performed as well or better at improving key metrics. The study concluded that Colorado's incremental approach "may represent a promising delivery system reform that may be more feasible for other states to adopt."[7]
- A 2016 evaluation of the ACC by the Colorado School of Public Health found that the ACC maintained the quality of care for Medicaid members while reducing health care expenditures. It also pointed to a number of areas of improvement, including the use of data and metrics to support the program, as well as engagement of Medicaid members about their care.[8]

Figure 2. The ACC Report Card: Grading Its Performance on Selected Metrics, FY 2015-16

\+ Progress Made - Room for improvement

Members with disabilities (all ages)	+	Savings: $126 million*
Adults covered by Medicaid expansion	+	Savings: $94 million*
Members enrolled in the ACC seven-11 months compared with those enrolled six months or less	+	Increase in follow-up care within 30 days of hospitalization; a greater increase among members dually enrolled in Medicare and Medicaid
	+	Decrease in use of high-cost imaging services like MRIs
	+	Increase in use of preventive services such as well-child visits, prenatal care and chlamydia screening
	+/-	Slight decrease in rate of emergency room visits; a greater decrease among members dually enrolled in Medicare and Medicaid
	+/-	Slight increase in depression screening, though still low at 4.0 percent
Children	+/-	Costs higher than expected by $48 million*
Adults eligible prior to the ACA expansion	-	Costs higher than expected by $90 million*
Parents reporting ability to get needed care for their child	-	Dropped from 83.7% to 78.9% between FY 14-15 and FY 15-16

* Summing the dollar figures in this table will result in a number larger than $62 million. This is because HCPF did not factor in the incentive payments made to RCCOs and providers in the administrative cost calculations for these four individual groups of Medicaid members.

HCPF also examined whether ACC members are using services known to benefit health — such as preventive services — or whether they are not using high-cost services, such as the emergency department, that may not be the most appropriate option for some types of care.

The promising news? Data show the use of preventive services such as well-child visits and follow-up visits after a hospitalization tended to be higher among ACC members who have been in the program for seven to 11 months compared with the control group — those enrolled six months or less.

Areas for improvement? Here's one example: Compared with newer enrollees, members enrolled in the ACC for seven to 11 months had higher rates of depression screenings. However, their rate of screening was at a modest four percent. In response, HCPF points out that depression screening in primary care is not a widespread practice yet, and that rates are expected to rise as RCCOs — and eventually the RAEs — educate primary care providers about best practices.

Looking Ahead

HCPF's changes to the ACC are monumental in some ways and incremental in others.

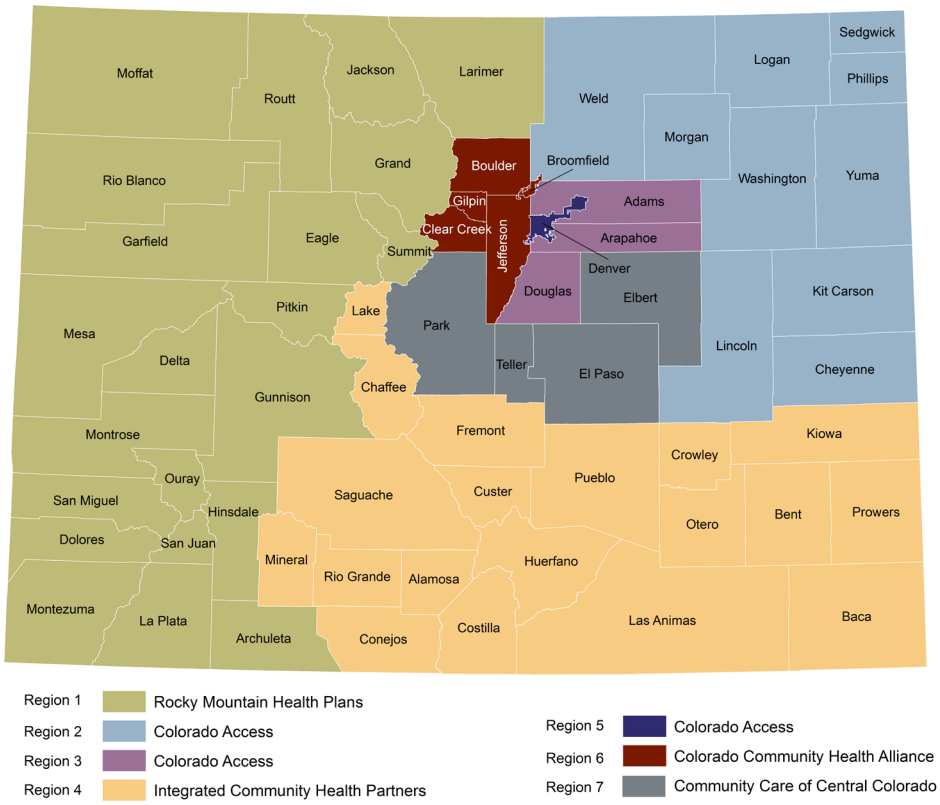
The headline for Phase Two is that two mainstays in Colorado Medicaid — the Behavioral Health Organizations (BHOs) and the Regional Care Collaborative Organizations (RCCOs) — are going away in 2018. They will be replaced by new regional organizations called Regional Accountable Entities or RAEs. The move signals a step closer to integrating primary and behavioral health care. It is premised on the idea that greater administrative integration will facilitate greater integration of care. The payment model, however, remains largely unchanged. (See Figure 3.)

Figure 3: The ABCs of the ACC

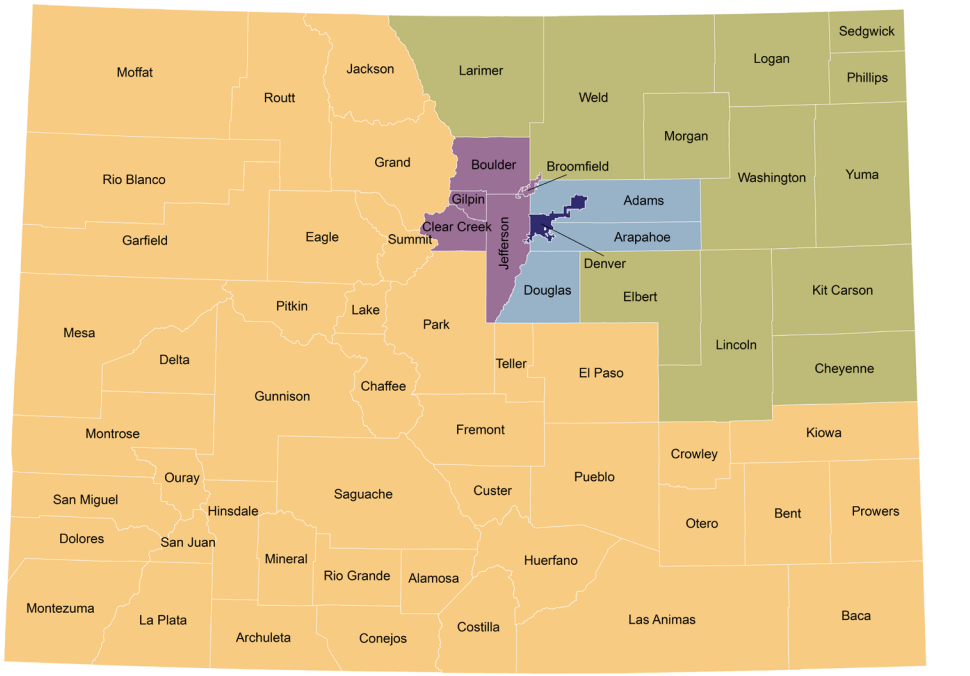
The program's key ingredients – and how they'll change in Phase Two.

Components of ACC Phase One:	Phase Two Changes:
Regional Care Collaborative Organizations (RCCOs) • Colorado is divided into seven RCCO regions (Map 1). • HCPF contracts with the RCCOs, ranging from community partnerships to insurance companies which are responsible for building networks of primary care medical providers (PCMPs) in their regions. • RCCOs connect members to a PCMP and ensure their care is coordinated, either doing that work themselves or by contracting with providers. • HCPF pays about $11 each month for each member — around $9 guaranteed and $2 withheld to pay when RCCOs and PCPMs meet performance criteria. These amounts vary by RCCO based on how many members are not yet connected with a PCMP and other factors. [9]	**Regional Accountable Entities (RAEs)** • Seven RAEs will replace RCCOs and BHOs (Map 3). • RAE boundaries will follow RCCO boundaries, except for Elbert County. • HCPF will contract with the RAEs, which will be responsible for both RCCO and BHO duties. RAEs must be licensed by the Division of Insurance. • HCPF will pay $15.50 each month for each member, withholding $4 to pay for improvement on key metrics and/or achieving additional goals. • At least 33 percent of the RAE's per member per month payment must be passed along to PCMPs.
Behavioral Health Organizations (BHOs) • Colorado is divided into five BHO regions (Map 2). • Under contract with HCPF, BHOs are managed care organizations that provide mental health, substance use disorder and other community-based services. • In FY 2014-15, BHOs served 166,394 members, about 15 percent of Medicaid members at that time.[10] • HCPF pays a per capita payment for behavioral health for each member in their region. This is often referred to as the behavioral health "carve-out" and averaged $38.61 per member per month in FY 2016-17.[11]	
Primary Care Medical Providers (PCMPs) • HCPF contracts with PCMPs to provide primary care. • Reimbursement is fee-for-service plus $3 per member per month. • An additional $1 per member per month is withheld to earn back for meeting performance goals.	**Primary Care Medical Providers (PCMPs)** • PCMPs will contract directly with the RAEs rather than HCPF, though they must still be enrolled with Medicaid to receive fee-for-service reimbursement. PCMPs may choose a $2 per member per month payment or other payment options. RAEs must distribute at least 33 percent of their per member per month payment to the PCMPs.
State Data and Analytics Contractor (SDAC) HCPF contracts with 3M, which analyzes claims data and provides analytical reports. HCPF, RCCOs and the PCMPs use the data to improve quality and monitor use of services. HCPF uses the data to determine RCCO and provider incentive payments.	**Business Intelligence and Data Management (BIDM) System** HCPF awarded the contract for this new data system to IBM Watson/Truven Health. BIDM will incorporate other data sources with HCPF claims. RAEs and PCMPs will use the data to improve quality and monitor progress.

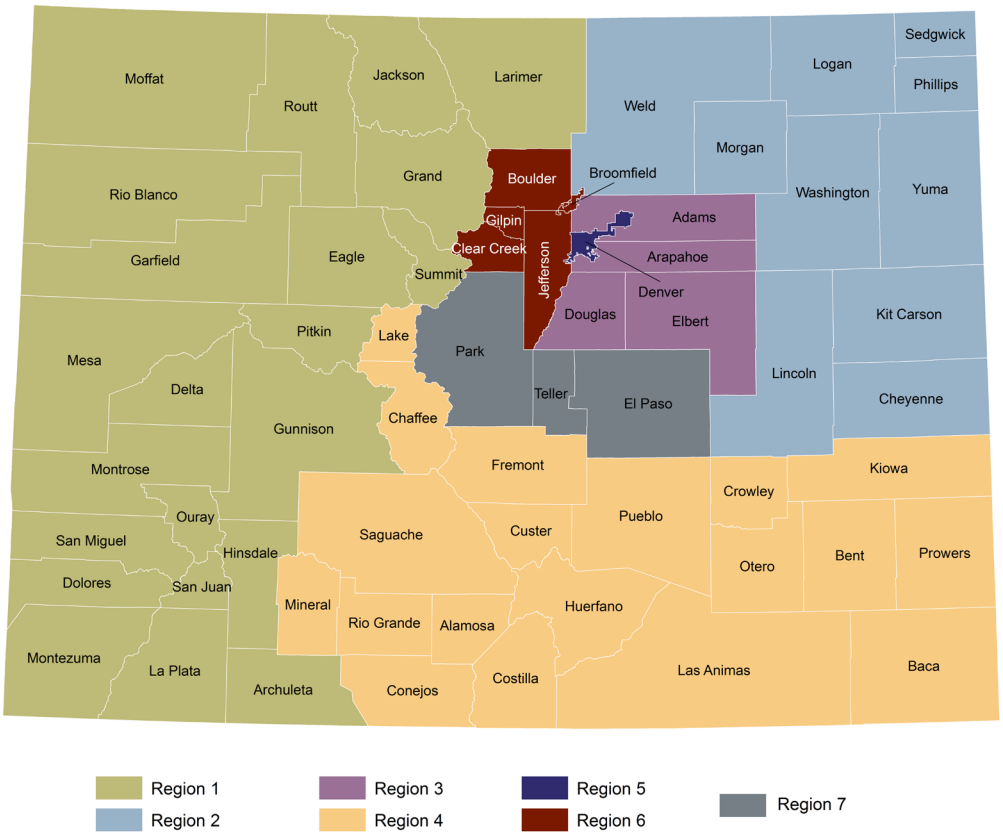
Map 1. Current Regional Care Collaborative Care Organizations (RCCOs)



Map 2. Current Behavioral Health Organizations (BHOs)



Map 3. Regional Accountable Entity (RAE) Regions in ACC Phase Two



The ACC in Lockstep with Other Programs

The ACC's Phase Two will be coordinated with several initiatives at HCPF:

- The State Innovation Model (SIM), a federal grant aiming to transform Colorado's delivery system by integrating primary and behavioral health care.
- The Primary Care Alternative Payment Methodology (APM), a HCPF initiative that gives primary care providers greater flexibility and incentives to improve the quality of care.
- The Hospital Transformation Program, under development with hospitals, to implement projects that reform the Medicaid delivery system.
- The Comprehensive Primary Care Plus (CPC+), a federal program that provides financial incentives to practices that manage patient care and improve access to preventive services.
- The ACC Medicare-Medicaid Program at HCPF, which has been enrolling Coloradans eligible for both Medicare and Medicaid in the ACC since 2014. The demonstration program will be ending in December 2017, though enrollees will remain in the ACC.
- The Colorado Opportunity Framework, an initiative aimed at addressing social determinants of health by working across state agencies and delivering evidence-based interventions that increase a person's economic self-sufficiency.

Phase Two Trail Markers

The path ahead for the ACC builds on the learnings from Phase One. For example, combining the administration and management of primary care and behavioral health is designed to encourage integration among providers.

This section delves into the five primary themes identified by the Colorado Health Institute.

1. Paying for Care: A Few Sticks, Many Carrots

Payment in health care is important because it's often how change is made in the delivery system. Colorado's Medicaid program relies on a mixture of payment methods. Most medical care is provided through a fee-for-service model, meaning that providers are paid by volume. The more procedures they perform and the more tests they run, the more they earn. Detractors say this creates a perverse incentive to provide unnecessary or expensive care. HCPF says that the checks and balances in the ACC — namely financial incentives and tracking performance with data — create a "managed fee-for-service" structure that encourages medical providers to provide high-value services.

The big exception to Colorado's predominantly fee-for-service Medicaid system is in behavioral health. Behavioral health organizations (BHOs) receive a capitated rate to provide a full array of behavioral health care services to each member in their region, regardless of whether the member uses services. In FY 2014-15, this equated to 166,394 Medicaid members — about 15 percent. The annual rates vary depending on eligibility category — from $19.67 per child to $139.32 per person with a disability. The average per-member rate in FY 2016-17 was $38.61.[12]

HCPF's original idea for Phase Two was to align primary care and behavioral health payments by doing away with the capitation system for behavioral health. However, behavioral health organizations and providers raised concerns that the new system would cost more and decrease access to needed services for those with severe mental illnesses. Specifically, their concerns focused on services offered in communities — such as support provided by trained peers — and stays in mental health hospitals. In the end, HCPF elected to retain much of the current capitation system, with some changes.

Incentives: How Much is Enough?

RAEs will receive $15.50 a month — including the $4 that HCPF will withhold described in Figure 3 — to provide care coordination and other services for each of their members in Phase Two. The primary reason that this is larger than the $11 per member per month that the RCCOs currently receive is that at least 33 percent must be passed along to primary care providers for serving as medical homes. In addition, it includes an increase of $1 in the monthly payment to account for the expanded scope of work required of the RAEs.

Are these amounts enough to make significant change?

Research on the exact amount of financial incentive necessary is inconclusive. Programs vary in how they are set up, managed and what they aim to achieve. However, analyses of existing research points to one conclusion: the bigger the incentive, the better the outcome.[13]

In addition, a Joint Budget Committee staffer, in a memo to lawmakers during the 2017 legislative session, raised other questions about Colorado's performance payments, asking whether they would:

- Increase overall expenditures;
- Be too hard to achieve and cause providers to lose money;
- Be too small to influence provider behavior;
- Change too frequently to provide meaningful incentives;
- Encourage fraudulent reporting of performance and lead to bad data.[14]

As a result, Phase Two does not represent a dramatic departure when it comes to payment. Medical providers will still bill Medicaid on a fee-for-service basis, and behavioral health will be based on a capitated rate.

Bigger changes come in the form of financial incentives to encourage increased access to care, value and efficiency.

Figure 4. Payment Incentives in the ACC Phase Two

CARROTS

Several incentives focus on positive reinforcement. In other words, they only have a financial upside. This approach will financially reward RAEs and primary care providers for activities or achievements that are high value or beneficial for the health of members.

For the RAEs:

- $4 will be withheld from each RAE's per member per month payment of $15.50 and be put into a pay-for-performance pool. RAEs can earn payments from the pool by showing improvement on key metrics or achieving other goals to be established by HCPF, such as participating in new state or national initiatives.
- When RAEs achieve key performance targets, they can earn an additional incentive of up to five percent of their behavioral health capitation rate — which averaged $38.61 per member per month in FY 2016-17[15] — for achieving key performance targets.

For the PCMPs:

- Under the new Primary Care Alternative Payment Methodology (APM), PCMPs will have the opportunity to earn financial incentives for improving the quality of the care they provide. These practices will receive a higher reimbursement rate for a set of primary care services when they meet certain criteria and demonstrate a high degree of performance in areas such as cost containment, chronic care management and preventive visits.[16]

For both RAEs and providers:

- RAEs will receive a single per member per month administrative payment of $11.50 — after HCPF withholds $4 — and will contract directly with providers. The RAEs must give PCMPs the option to receive at least $2 per member per month. Allowing RAEs to contract directly with PCMPs gives them the flexibility to establish their own incentive programs with primary care providers.

A MIXTURE OF CARROTS & STICKS

These approaches reward RAEs and providers when they perform at or better than a particular standard, but carry penalties or financial losses if they fail to meet that standard.

For the RAEs:

- The per member rate at which RAEs will be paid for behavioral health will be set based on federal guidelines and certified by an actuary. The actuary conducts an analysis of how much the services for the RAE's members are anticipated to cost. RAEs must meet standards set by HCPF to be paid at this rate. If the RAE fails to meet these standards, it will be paid at a lower rate — at most 1.5 percent less — in the second year. If it achieves identified goals, it will be paid up to 1.5 percent more than the original rate.
- Each RAE must show that it is spending at least 85 percent of its capitation payment on behavioral health services and 15 percent or less on administrative costs. This calculation is called a medical loss ratio (MLR). If the RAE does not meet or exceed the 85 percent target, it will reimburse HCPF.
- Bidders for RAE Region One (the Western Slope) and Region Five (Denver) may submit a supplementary proposal for a capitated payment reform initiative. The intent is to preserve the continuity of care for members currently enrolled in capitated managed care programs in these regions. HCPF will decide whether to implement a proposed payment reform initiative after the RAE contracts are awarded.

For the PCMPs:

- HCPF is developing a payment track within the Primary Care APM for qualified primary care providers to take on additional financial risk for caring for patients. Instead of being paid fee-for-service, these providers will be paid on a per member per month basis, regardless of how many of their members use health services. A core set of primary care services would still be reimbursed fee-for-service under this option. Participating practices must meet higher quality standards to be paid in this fashion. The details of this option are still being worked out, but the goal is to give providers a predictable revenue stream and greater flexibility while incentivizing them to operate efficiently. For example, a practice could make follow-up phone calls to patients rather than scheduling a follow-up appointment.

Most of these incentives are "carrots" — promised reimbursement or rewards — while a few represent a mixed "carrot and stick" approach of shifting financial risk from the state to the RAEs and providers. (See Figure 4.)

2. Integration Forges Ahead

Integrating primary care and behavioral health care is one of the big ideas in the practice of medicine. Efforts focused on integration — such as the state's State Innovation Model (SIM) — are trying to improve efficiency and patient health.

Phase Two of the ACC attempts to move this integration forward.

At the administrative level, consolidating the missions and responsibilities of RCCOs and BHOs signals a move away from their silos.

On the front lines, HCPF will reimburse primary care practices for up to six sessions of behavioral health evaluation and/or psychotherapy in Phase Two. HCPF will not require that providers submit a diagnosis of mental illness or other behavioral health condition in order to be reimbursed for these six visits.

Many advocates and primary care providers think this new fee-for-service reimbursement will improve access to behavioral health services. They see the six visits as an opportunity to seamlessly involve a behavioral health professional in clinical operations — from planning a patient's care with other clinicians to using a common medical records system. They also argue that some patients may be more inclined to get needed behavioral health care within the familiar setting of a primary care office, rather than feel stigmatized by visiting a mental health provider.

In addition, child health advocates applaud HCPF's decision against requiring a "covered diagnosis" for reimbursement. They see this as increasing access to children's behavioral health care, given that young children often do not have a diagnosable condition and providers may be reluctant to label a child as mentally ill.

Meanwhile, behavioral health providers have their own concerns. They question whether there will be a sufficient behavioral health workforce to support efforts to integrate care.

In addition, BHOs currently are paid a capitated rate to provide behavioral health services. In turn, the BHOs pay community mental health centers a capitated rate for services they provide. The behavioral health providers point out that the capitation gives mental health centers greater flexibility to provide an array of services. They also argue that it promotes efficiency by giving providers more financial skin in the game. They fear that RAEs will receive the capitated payment but pay community mental health centers on a fee-for-service basis, which could limit services to those that are billable and could weaken the motivation to be efficient. The RFP contains a provision directing RAEs from using the capitated payments to support the RAE's physical health responsibilities.

3. Welcome to the (Health) Neighborhood

HCPF considers the health of Medicaid's members — and their caregivers, when appropriate — to be the focus of the ACC. Phase Two highlights three areas where health and health care can be improved:

With Other Providers: Primary care and behavioral health settings aren't the only places where members receive care, so RAEs will be expected to engage other providers in the Health Neighborhood. These include hospitals, specialists, long-term services and supports (LTSS), substance use disorder providers, oral health providers and public health agencies.

Activities outlined in the RFP include:

- Increasing the number of specialists serving members.
- Promoting the use of electronic consultations — also known as e-consults — between primary care providers and specialists.
- Facilitating data sharing among providers in the Health Neighborhood.
- Incorporating patient navigators, peers, promotores and other lay health workers within care teams.
- Supporting providers using telehealth.

In the Community: A small section of the Phase Two proposal takes on a big topic: non-medical factors that affect health. These factors — also called the social determinants of health — include economic opportunity, housing, educational attainment, environmental conditions and childcare. Phase Two encourages RAEs to identify health disparities in their communities and collaborate with schools, school

districts and community organizations working on the social determinants.

Across all Medicaid Members: In its broadest sense, the term population health is used to describe the health outcomes of a group of people. In Phase Two, each RAE must develop a Population Health Management Plan to improve the health of all members, such as mailing out diabetes prevention materials or texting birth control reminders. Every year, the RAE must ensure that each of its members receive at least two interventions identified in the plan.

4. Access to Care is Location, Location, Location

Colorado is a state of cities and towns, sprawling plains and mountain passes. One of the guiding principles of the ACC is that regional entities can best address the health needs of members within their borders. Phase Two acknowledges the importance of geography in ensuring access to needed health care.

People often cross city and county borders — or their RAE borders — when seeking health care. RAEs will be encouraged to develop networks of providers not only within their borders but statewide. In addition, Phase Two will expand travel time and distance standards established in Phase One to ensure that members living in frontier areas of the state have reasonable geographic access to a provider.

Another significant change in Phase Two is that members will be assigned a PCMP — and the provider's corresponding RAE — based on where they've receive care in the past instead of where they live. This change is intended to keep members connected with their regular primary care provider. Stakeholders have acknowledged the good intentions behind these changes but question whether they will be disruptive to the continuity of some members' care.

5. Doing It Up with Data

From the outset, data have been one of the key components of the ACC. Phase Two contains new data sources and data collection activities. For example, HCPF will now collect a Health Needs Survey when a person enrolls in Medicaid. RAEs will use the data — covering topics from a person's health goals to their chronic conditions — for outreach and care coordination activities with clients.

In addition, the ability of RCCOs and PCMPs to earn many of the financial incentives is determined by improvement on a set of metrics called key performance indicators (KPIs). The KPIs are intended to serve as a check and balance to ensure that patients are still getting appropriate and preventive care. Phase Two expands the list of KPIs from three to eight. In the future, HCPF may require that RAEs address a ninth KPI in addition to working on the eight KPIs in this list:

- Total cost of care
- Emergency department visits for conditions that could be prevented with primary care
- Wellness visits
- Members receiving behavioral health services
- Prenatal care
- Dental visits
- Rates of overweight and obesity
- Use of electronic consultations and agreements with specialists

The KPIs are not the only metrics that RAEs will work to improve. Phase Two also aims to measure how satisfied members are with their health care experiences, using a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). It requires monitoring numerous behavioral health metrics, including suicide risk assessments, hospital readmissions, diabetes screenings for individuals with schizophrenia or bipolar disorder and engagement in alcohol and other drug dependence treatment. And HCPF has proposed public reporting of a variety of performance measures by each RAE region. These metrics — still under development — range from use of appropriate asthma medications to teen pregnancy rates.[17]

Some stakeholders have raised questions about whether it is realistic to expect RAEs and providers to improve on so many measures. In addition, tracking performance requires sophisticated data systems. There are questions about whether the available data will enable RAEs to assess progress.

The current data system — called the SDAC — relies primarily on claims submitted to HCPF. But because providers are allowed to bill within months of providing a service, there's a time lag. The lag is usually about three months between the date the

patient received a service and when the service can be reported in claims data. Phase Two replaces the SDAC with the Business Intelligence and Data Management (BIDM) system. Although the time lag will persist, the BIDM will augment the claims data with HCPF's eligibility, long-term services and supports (LTSS) and pharmacy benefit data systems. The BIDM will allow RAEs to generate ad hoc reports, with the hope that they will use multiple data sources to monitor and improve care.

The Path Ahead

The roll-out of the ACC Phase Two comes at a time of significant Medicaid policy discussions at the state and national levels.

Leaders in Congress and the Trump administration have emphasized reducing Medicaid spending and creating greater flexibility for the states. One proposal calls for financing state Medicaid programs with a set amount of per capita funding. Will the ACC's incremental gains set the pace for expectations of operating Medicaid with greater efficiency?

At the state level, Colorado's legislature passed a bill in 2017 that adds a new level of accountability to the ACC. Colorado's Joint Budget Committee (JBC) has called for greater legislative oversight of the ACC, given the significance of the ACC in Colorado's Medicaid program. The legislation (HB17-1353):

- Authorizes HCPF to implement the ACC and its performance payments to providers.
- Defines the goals of the ACC.
- Expands HCPF's legislative reporting requirements. HCPF must now provide information on implementing performance payments, such as the whether the payments require a budget request, the evidence behind the payment strategy and how stakeholders were engaged in making decisions about the payments.[18]

As this legislation is implemented, one big question emerges: Will new oversight help or hinder HCPF's ability to make changes to the ACC in the future?

CHI will continue to monitor national and state policy developments, providing analysis of how new and proposed changes would impact Colorado and the ACC.

Conclusion

The ACC has been an exercise in iteration. Many of the concepts on the table must be operationalized. The bid to become a RAE is likely to be highly competitive and may elicit new partnerships and innovative ideas. And Phase Two itself, by design, will evolve over time.

Nevertheless, the next phase represents a mile marker on Colorado's Medicaid journey. While some changes are big — such as combining RCCOs and BHOs — other key components of Phase One will continue, including the focus on primary care, coordination across providers and regional management.

The most important question, however, is how Medicaid members will be impacted. Many stakeholders cite the increased engagement of consumers and communities as the crowning achievement of Phase One. Will this level of engagement continue?

For many of Colorado's most vulnerable, Medicaid represents their path into the health care system. Consequences of Phase Two changes — both intended and unintended — should be closely monitored. Rigorous evaluation should be planned. And the health and well-being of Coloradans should always be the destination.

CHI Members Who Contributed to This Report

- Jeff Bontrager, lead author
- Brian Clark
- Chrissy Esposito
- Cliff Foster
- Deborah Goeken
- Tamara Keeney
- Michele Lueck

Endnotes

[1] HCPF (2017). June 2017 Medical Premiums Expenditure and Caseload Report, http://bit.ly/2nFwml5. Also based on CHI analysis of the 2015 Colorado Health Access Survey (CHAS).

[2] HCPF (2016). ACC FY 2015-16 Legislative Request for Information #3. Nov. 1, 2016. http://bit.ly/2o458bq.

[3] McClellan, M., et al. (2010). A National Strategy to Put Accountable Care into Practice. *Health Affairs* 29, no. 5. May 2010.

[4] Kaiser Commission on Medicaid and the Uninsured (2012). Emerging Medicaid Accountable Care Organizations: The Role of Managed Care. May 2012. http://bit.ly/2o2zIB4 National Academy for State Health Policy (2013). *Colorado – ACO*. Dec. 21, 2013. http://bit.ly/2pjBQWv

[5] The primary source of changes in Phase Two of the ACC discussed in HCPF's *Request for Proposals: Regional Accountable Entity for the Accountable Care Collaborative* (Released May 11, 2017). The RFP and the stakeholder comments from the draft RFP (released Nov. 4, 2016) are available at http://bit.ly/2oLMvHG.

[6] Unless otherwise specified, these sources were used for data in this section: ACC enrollment and total Medicaid enrollment data are from HCPF (2017). *June 2017 Medical Premiums Expenditure and Caseload Report*, http://bit.ly/2nFwml5. HCPF total budget is from Colorado Joint Budget Committee, *FY 2016-17 Appropriations Report* (HCPF FY15-16 Appropriation of $9,112,384,274). http://bit.ly/2oP69TI. Outcome measures are based on HCPF (2016). *ACC FY 2015-16 Legislative Request for Information #3*. Nov. 1, 2016. http://bit.ly/2o458bq.

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[9] ACC staff provided the Phase One PMPM amounts and reviewed this description. The source of Phase Two PMPM amounts is the RAE Request for Proposals (May 11, 2017).

[10] Calculated by the Colorado Behavioral Healthcare Council from FY2015-16 *Validation of Performance Measure* reports for each BHO covering FY2014-15. http://bit.ly/2oBTyRk.

[11] This rate is the estimated weighted average rates for FY2016-17. Source: HCPF FY 2017-18 budget request, *Exhibit GG – Medicaid Behavioral Health Capitation Rate Trends and Forecasts*. http://bit.ly/2n0D2Z1

[12] Ibid.

[13] Damberg, C., et al. (2014). *Measuring Success in Health Care Value-Based Purchasing Programs*. Published by the RAND Corporation. Mendelson, A. (2017). The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review. *Annals of Internal Medicine*, 166. No. 5. Mar. 7, 2017.

[14] Kurtz, E. (2017). *Health Care Policy and Financing additional figure setting issues.* Memo to the Joint Budget Committee. Mar. 8, 2017. http://bit.ly/2tfTjwl

[15] HCPF FY 2017-18 budget request, *Exhibit GG – Medicaid Behavioral Health Capitation Rate Trends and Forecasts*. http://bit.ly/2n0D2Z1

[16] While the Primary Care Alternative Payment Methodology (APM) is a separate effort focused on providers, key components of its launch are coordinated with ACC Phase Two. The RFP outlines how RAEs will support participating providers.

[17] HCPF (2017). *Regional Accountable Entity Request for Proposals. Appendix U: Performance Measures.* (May 11, 2017). http://bit.ly/2oLMvHG.

[18] Colorado General Assembly (2017). HB17-1353, Implement Medicaid Delivery & Payment Initiatives. http://bit.ly/2ox2l5c

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303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200
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