

Supporting a Culture *of* Coverage

ACCOUNTABLE CARE COLLABORATIVE :: 2015 ANNUAL REPORT



COLORADO
Department of Health Care
Policy & Financing



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A year in review

I am pleased to present our Fiscal Year 2014-15 annual report for Colorado's foundational service delivery and payment reform program, the Accountable Care Collaborative (ACC).

Implemented in May 2011, the ACC began with one practice and roughly 500 people. The program has now grown to nearly 520 practices statewide with enrollment approaching 900,000 members.

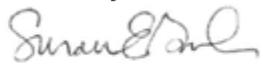
The ACC is designed to provide a person-centered approach to care. It connects members to medical and community resources, minimizing barriers to access. The goal is better health outcomes at lower costs. In coordination with our partners and stakeholders, we are creating a system that empowers our members and providers through increased accountability and ownership at a local level.

FY 2014-15 presented many challenges and opportunities for the ACC program. Medicaid expansion extended coverage to more Coloradans, creating a surge of new members. In addition, we launched several new initiatives. These included the ACC Medicare-Medicaid Program, which provides intensive care coordination services for full-benefit Medicare-Medicaid enrollees. The ACC Rocky Mountain Health Plans Prime program began using alternative payment arrangements to increase integrated care—behavioral health in primary care.

Furthering the innovative work of the ACC, Colorado was awarded the State Innovation Model grant in February 2015, providing federal funding for health delivery system transformation to better coordinate physical and behavioral health.

The ACC will continue to develop and reward integrated, person-centered care that improves quality of life for Colorado's Medicaid members while lowering costs for the state. I look forward to all that is to come and all we can achieve with our members, partners and stakeholders to make Colorado the healthiest state in the nation.

Sincerely,



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



*Susan E. Birch, Executive Director,
Department of Health Care Policy
and Financing*



About the Accountable Care Collaborative

When the Accountable Care Collaborative (ACC) launched in 2011, the Department's goal was not to simply deliver health care, but to improve the health of Medicaid members. Many factors contribute to health: personal health behaviors, access to medical care, good provider-member communication, a connected health system and access to resources to meet basic needs.

The ACC is designed to make incremental change on all of these fronts. It provides the usual Medicaid benefits with added supports to ensure that members get the right care, at the right time, in the right place. The ACC also takes wellness and non-medical needs into consideration, helping members overcome obstacles that have little to do with health care but everything to do with overall health.

This report looks at the progress made during the last year in each of the fundamental elements of the ACC: developing strong regional networks, connecting members to care, and supporting providers. It also describes how the ACC is innovating with data and payment models to drive change. Details about data and payment innovations are included in this report.

The primary goals of the ACC are to:

- ▶ Improve member health
- ▶ Improve member and provider experience
- ▶ Contain costs

The ACC fosters integration and collaboration across the spectrum of health care. It connects and supports providers to make collaboration possible, using the following framework:

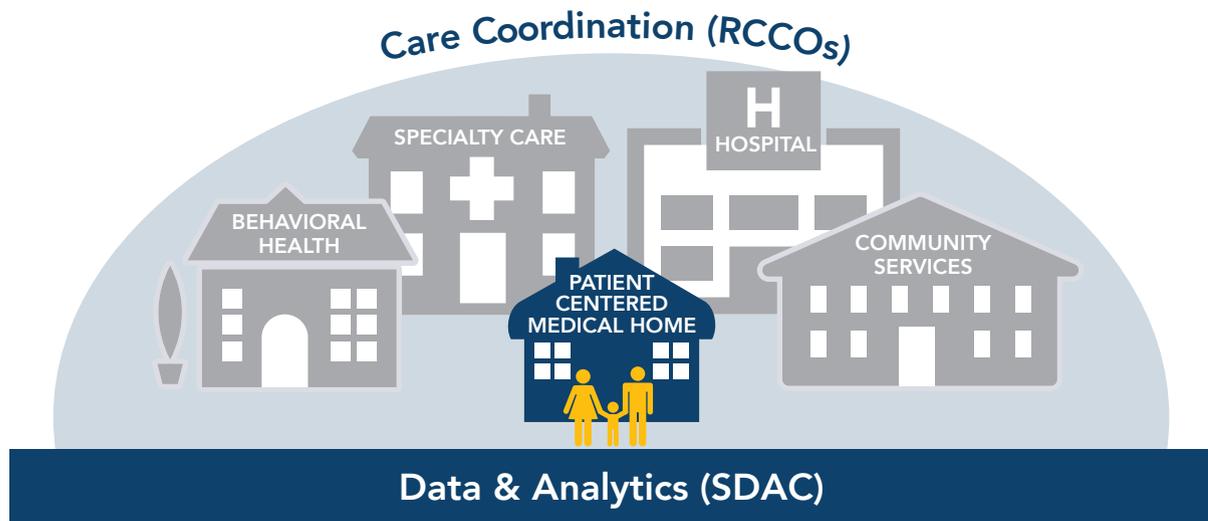
- ▶ Regional Care Collaborative Organizations (RCCOs): Seven organizations throughout the state that develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their population of members.

“The care coordination provided by the ACC: MMP truly makes a difference in the lives of our members. I have been a nurse for 34 years, working mostly with the most vulnerable populations – those living in poverty with mental illnesses and substance abuse issues – and this is the first time that I really think we are on the right track. And that is such a good feeling.”



– JOANNA MARTINSON, CARE COORDINATION DIRECTOR, NORTH COLORADO HEALTH ALLIANCE, RCCO 2

HOW THE ACC WORKS



Using Data

Data about health service utilization helps providers see which services are used too often, or not often enough.

- ▶ **Primary Care Medical Providers (PCMPs):** Primary care providers contracted with a RCCO serve as medical homes for Medicaid members.
- ▶ **Statewide Data and Analytics Contractor (SDAC):** A health information technology contractor that analyzes and reports on claims data to help the Department, RCCOs and PCMPs see patterns in how members are using health care services.

Enrollment in the ACC

As of June 2015, there were 899,596 Medicaid clients enrolled in the ACC. This is approximately 70 percent of all Colorado Medicaid clients—a 48 percent increase in membership since June 2014. Approximately 75 percent of enrolled clients are connected to a PCMP. The ACC is ready to take the next steps towards coordinating health care services and benefits, while continuing to emphasize the importance of a medical home through strategies like incentive payments and efficient enrollment processes.

Using Data in New Ways

Accountability is central to the ACC. The ACC is using existing data to learn about the needs of its members, how members use their health care services, and how the RCCOs and PCMPs can improve health outcomes and contain costs. The SDAC uses claims data to answer these questions.

Data is used for “hot-spotting”—finding geographic areas that have a higher utilization of certain services or a population with more complex medical needs. It is also used to identify individual members who have had many medical needs in the past, and need care coordination assistance and health management coaching.

The ACC also uses data to track RCCO and PCMP performance on Key Performance Indicators (KPIs), which can be proxies for better health outcomes and lower costs. The following are the KPIs that were used this year:

1. Emergency Room Visits.

Fewer emergency room visits are a good sign that the ACC is addressing problems before they become emergencies, and diverting members from the emergency room for routine care.

2. Well-Child Visits Ages 3-9.

This KPI measures the number of children ages 3–9 who receive their recommended annual well-child visit. These visits are key times for communication between caretakers and health providers. Caretakers learn about child development, vaccinations and safety, and have the opportunity to voice concerns about their child’s health or development.

3. Postpartum Care.

This is a measure of the percent of women who receive an outpatient postpartum exam following a live birth. Postpartum care provides an important opportunity for checking the physical and mental health of new mothers and for providing counseling on infant care and family planning.

The following page shows the KPI results this year. Data from FY 2014-15 indicate that as people spend more time in the ACC program, they are less likely to use the ER and more likely to receive evidence-based, recommended health services.

Paying for Value

Payment is a powerful way to set into motion changes to the health care system. The ACC uses a hybrid of several payment strategies to shift the health care system from its current focus on delivering a high volume of services to getting the most value possible and rewarding for outcomes. The program’s strategy is incremental; payments that reward providers for the wise use of services and good health outcomes are gradually added. This incremental strategy is intentional, a way to gradually strengthen and build Colorado’s health care infrastructure to adjust to a new way of thinking about care.

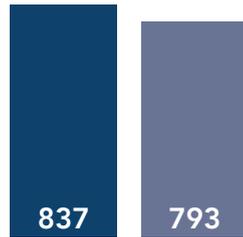
2015 KEY PERFORMANCE INDICATOR RESULTS*

■ 0-6 Months
■ 7-10 Months



EMERGENCY ROOM VISITS

Per 1,000 ACC clients per year

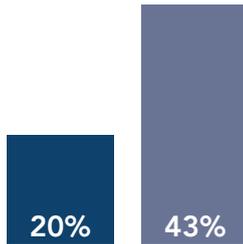


ER visits that do not result in a hospital admission decreased with the amount of time spent in the ACC program.



WELL-CHILD VISITS

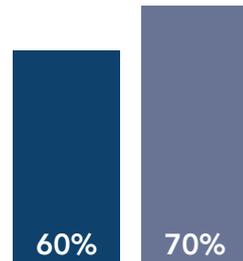
Children ages 3-9



The longer members are enrolled in the ACC, the more likely they are to receive well-child visits.



POSTPARTUM CARE



Postpartum care increased significantly with the amount of time spent in the ACC program.

BREAKDOWN OF ACC ENROLLEES



28%

are adults covered under the Affordable Care Act expansion



47%

are children without disabilities

Others enrolled include adults eligible prior to Medicaid expansion and individuals with disabilities.

48%



There was a 48 percent increase in enrollment in the ACC program since June 2014.

*For further information on these metrics, please see the Department's report to the Joint Budget Committee at <http://tinyurl.com/pbnubnu>.

The ACC pays for value by tying payment to its mission, goals and key strategies. This is done by linking enhanced payment for PCMPs and RCCOs to specific program objectives that have been shown to positively impact health outcomes. These pay-for-performance targets include elements designed to impact client health, reward providers for practicing at a high level, and transform the delivery system. They include:

- ▶ **Key Performance Indicators:** RCCOs and PCMPs receive incentive payments based on their region’s performance in certain key metrics. For FY 2014-15, these included:
 - o reducing the number of emergency room visits;
 - o increasing the number of children ages 3-9 who receive annual well-child checkups; and
 - o increasing the number of women who receive postpartum care after delivery.

- ▶ **Enhanced Primary Care Medical Provider Factors:** Beginning in July 2014, PCMPs who were validated as meeting five of nine enhanced practice factors were eligible to receive an additional 50 cents per-member-per-month (PMPM) payment. Factors include items such as performing behavioral health screenings, offering extended hours, tracking the status of and following up on specialty referrals, and developing person-centered care plans. For FY 2014-15, 265 practices were validated as enhanced PCMPs.
- ▶ **Performance Pool:** RCCOs are eligible to receive additional payment based on their relative performance in certain areas. For FY 2014-15, RCCOs were measured on their performance in increasing the number of follow-up care appointments for clients within 30 days of discharge from a hospital.

- ▶ **Adjusted RCCO Payment for Clients without a Medical Home:** RCCOs receive a reduced PMPM payment for each client who has remained unattributed to a medical home for six months or longer. The reduction is meant as an incentive for RCCOs to focus on finding a medical home for clients who have none. The number of clients linked to a PCMP increased by 10 percentage points during FY 2014-15.

During FY 2014–15, the Department estimates that the costs avoided through the ACC exceeded ACC administrative costs. Administrative costs include PMPM payments, SDAC payments and incentive payments to RCCOs and PCMPs for meeting KPIs. In FY 2014-15, the ACC achieved medical-expenses savings of **\$121,288,048**, with net savings totaling **\$37,682,795**, after accounting for all administrative expenses.

The ACC as a whole generated savings that exceeded its administrative costs this year.

The ACC achieved gross savings in medical costs of approximately \$121 million with net savings totaling approximately \$37 million after administrative expenses.



*Administrative costs include provider incentive payments for reaching performance targets on KPIs and enhanced primary care factors.

Community Partnerships Make Life-Saving Connections (RCCO 7)

Ruth had high hopes for her move from California to Colorado. She was getting out of an abusive relationship, and a friend in Colorado Springs offered her a place to stay at an affordable cost.

Ruth, 58, found out quickly that her friend was no such thing. She took Ruth's money and left her to live on the streets for four months.

Ruth ended up in the emergency room multiple times, owing to her diabetes, chronic obstructive pulmonary disease, and other health issues.

"I was really, really sick," she says. She was falling down several times a day and was in danger of losing part of her right foot.

Before being discharged from her final ER visit, Ruth's RCCO, Community Care of Central Colorado, helped her get admitted to Ascending to Health Respite Care (ATHRC), a program that provides supportive care and sheltering for homeless individuals who need assistance with their health care needs. There, Ruth entered the agency's shelter to recover from the pneumonia she had been battling and also to get her life back on the right track.

ATHRC helped Ruth gain control of a range of physical and behavioral health issues. Her blood sugar normalized, she improved her mobility, and she began to feel better about herself. She received help scheduling and attending her medical appointments, as well as help in taking her medications regularly.



"Ruth persevered and hung in there, and we were able to put the pieces together," says her caseworker. "It's really remarkable that she went from being homeless to being in a place where she takes care of herself."

Thanks to the coordinated work of Ruth's RCCO team, and the community partnerships they have developed, Ruth is thriving. She lives independently in one of the supportive housing units ATHRC oversees. She has reduced the number of daily insulin shots she needs. She can walk to the store. And she swims laps at the gym.

Ruth says her goals are to increase the distance she can walk and to reduce her pain by continuing to improve her health.

*"I wake up happy, and I go to bed happy,"
Ruth says. "I'm blessed."*



Developing a Regional Strategy

One fundamental building block of the ACC is strong regional networks of both medical and social services providers. Colorado's regions and communities are unique in geography, demographics and priorities. The ACC is designed to leverage regional strengths to create local networks to meet unique community needs.

Throughout the year, RCCOs collect stories from clients and providers that demonstrate the program's impact in a way that quantitative data cannot capture. These stories underscore the value of care coordination and community partnerships in getting people the care they need. The map on the back cover shows the RCCO regions highlighted in this report.

Coordinating Care

RCCO 5: Colorado Access

Denver Indian Health and Family Services (DIHFS) Operations Manager Johnny Worth says Medicaid expansion has provided medical security to many families within the American Indian and Alaska Native community throughout Colorado.

“In a community clinic setting such as ours, we seek to take care of the whole person, but we generally cannot do it all alone,” Worth says. “We must use referrals to other offices and services such as specialists or imaging.”

Worth says his RCCO Colorado Access has done a tremendous job finding providers taking new clients and working with them to gain access to that care. Providers feel confident in treatment planning and ensure that clients receive proper health care. DIHFS has also noticed a decrease in no-show rates for referred services due to the client buy-in the RCCO care coordinators have promoted.

“The RCCO has given our patients peace of mind, built trust in the medical system, allowed them to navigate the system properly, and overall, stay healthy,” Worth says.

Integrating Physical and Behavioral Health

Full integration of all health services is the long-term vision of the ACC. RCCOs throughout the state are moving toward this goal with

iterative changes through referral systems, care coordination and strategic partnerships.

RCCO 1: Rocky Mountain Health Plans

Pediatric Partners of the Southwest (PPSW), together with RCCO partner Rocky Mountain Health Plans, began an integrated behavioral health pilot program within the PPSW medical home in October 2014 with two behavioral health consultants. This program has evolved into a team-based care model, providing care coordination and support for all PPSW members related to behavioral health, normal development, school issues and developmental delay evaluation and referrals.

“Rocky’s financial support and guidance on data analytics has served as the key foundation of the program,” PPSW CEO M. Cecile Fraley, M.D. says. “Our providers embraced the team-based care model and within months were saying, ‘How did we ever practice without this?’ ”

Fraley says providers feel it produces better care and care coordination, and it allows them to rise to the top of their license.

“As the integrated behavioral health program begins its second year, we look forward to expanding,” Fraley says. Those plans include best-practice child-life support for procedures; educational talks; increased support for clients with chronic disease; a liaison for tele-psychiatry clients; and expanded data outcome measurements.

Using Data to Inform Care

RCCOs help providers collect accurate data so the statewide data and analytics contractor can use its expertise to inform decision-making within the ACC. Analysis of this data leads to care that can match trends and meet needs.

RCCO 4: Integrated Community Health Partners

In April Integrated Community Health Partners (IHP) began work on a well-child check tool kit to give to non-pediatrician providers so they feel more confident in completing well-child checks in a shorter period of time. This is part of the RCCO’s effort to make sure the well-child checks, a new Key Performance Indicator, are providing useful data and ultimately improving care.

Earlier this year IHP began site visits to its health centers to help them review their well-child checks data collection and brainstorm solutions to any challenges they were facing in this area.

IHP also began providing monthly feedback and suggestions to each care coordination group to help them identify children who haven’t yet had a well-child check. IHP continues to work with its providers to make the most of well-child checks on both a client and system-wide level.



Connecting Members to Care

The ACC's care delivery model works more effectively when all members have a medical home. For members with particularly complex health needs, a care coordinator supports the medical home in helping these members get the right services.

When the ACC launched, the first priority was to connect members to a medical home—a focal point of care. Ready access to consistent, high-quality primary care is a basic foundation from which the ACC can grow to add and integrate services.

Medicaid Expansion

In January 2013, Governor John Hickenlooper announced that effective January 1, 2014, Colorado would expand Medicaid coverage to more Coloradans. Our state General Assembly passed legislation to expand Medicaid to 133 percent of the federal poverty level during the 2013 legislative session. The federal government covers 100 percent of the costs of the expansion through 2017, then matching funds taper down to cover 90 percent of costs by 2020.

As with performance for the entire population, expansion clients with a longer duration in the ACC generally had higher

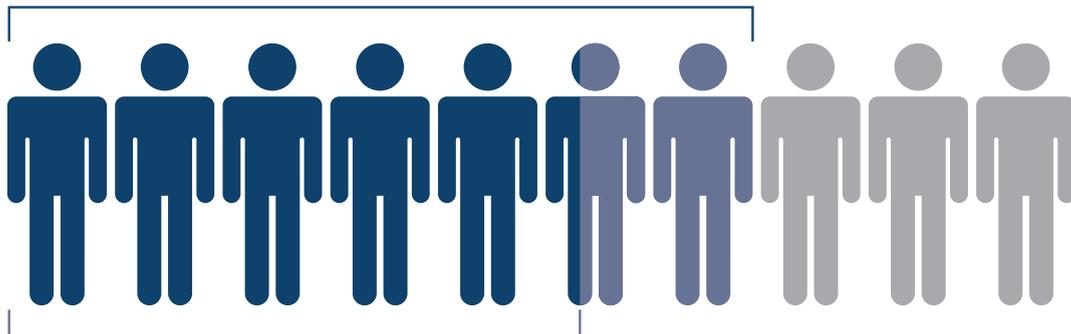
utilization of services that can improve health. Expansion clients also showed a general increase in the use of all health services as they spent more time enrolled in the ACC program, even some services that may not contribute to overall improved health and lower costs.

One possible explanation for this is that those clients enrolled in the ACC for a longer period of time were among the first expansion clients to enroll, and individuals who sought out Medicaid coverage immediately after the expansion may be sicker or have more health care needs than those who waited several months before signing up for coverage.



2014 PERCENT OF MEDICAID CLIENTS ENROLLED IN ACC

70% of Medicaid clients are members of the ACC



76% of those enrolled are connected to a medical home



As of June 2015, 249,885 expansion adults – 70 percent of the total Affordable Care Act Medicaid expansion population – were enrolled in the ACC. During FY 2014-15, there was an increase in the percentage of ACC enrollees attributed to a PCMP of roughly 10 percentage points. For the expansion population, this increase was even greater – approximately 20 percentage points. Increased assignment to PCMPs and elements of care coordination in the expansion population may result in a decline in the use of services that may not contribute to overall improved health after the first full year of enrollment.

New Care Coordination and Payment Reform Initiatives

In FY 2014-15, the ACC program launched two new initiatives, the ACC: MMP and ACC: RMHP Prime.

The Accountable Care Collaborative: Medicare-Medicaid (ACC:MMP) Program

The Department, together with the federal Centers for Medicare and Medicaid Services, implemented this initiative, which integrates and coordinates physical, behavioral, and social health needs for people who are Medicare and Medicaid enrolled. Colorado was one of 15 states to implement this type of program.

Before this initiative, approximately 32,000 Coloradans were full-benefit Medicare-Medicaid enrollees but were not in an integrated system of care. Clients who participate in this initiative keep all their Medicare and Medicaid benefits and services. They also have the right to keep the same doctors and other health care providers.

The system serving Medicare-Medicaid enrollees is at times fragmented, which can result in unnecessary and duplicative services. The ACC: MMP initiative gives the Department an opportunity to better meet the needs of Medicare-Medicaid enrollees by helping reduce barriers to appropriate care.

The conflicting coverage policies of Medicare and Medicaid are a major challenge to improving the health of Medicare-Medicaid enrollees. One of the tools used in the initiative is a Service Coordination Plan (SCP). The SCP will help

“Colorado Medicaid continues to lead the way on improving the health of our members and supporting health care providers with new tools and resources to serve their patients. The Accountable Care Collaborative model is getting people the right care, at the right time, in the right setting, and delivering high value.”



— GRETCHEN HAMMER, MEDICAID DIRECTOR,
COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING



coordinate client care across providers. It documents medical, social and behavioral needs, as well as client short-term and long-term goals.

As of June 2015, 27,583 clients were enrolled in the ACC: MMP.

ACC: Rocky Mountain Health Plans (RMHP) Prime

ACC: RMHP Prime, established under the authority provided by HB 12-1281, is using alternative payment arrangements and shared savings with RMHP's primary care provider network and community partners to improve the integration and coordination of care for ACC clients.

During FY 2014-15, enrollment surpassed initial projections by roughly 6,500 enrollees, and nearly 34,000 clients were enrolled as of June 2015. Complete quality data is forthcoming, but initial findings demonstrate some early success. The program's unique payment methodology has positively impacted the level of collaboration between diverse provider types and community organizations. The model has also furthered practice transformation efforts and increased the integration of behavioral health in primary care. In FY 2015-16, the program will work to further strengthen collaboration between community partners and examine the long-term sustainability of the model.

"I have never gotten good response from referrals to mental health, though many of my patients need additional support, and all are eligible because of their Medicaid. My RCCO manager found a community resource that really is all I need. It is a drop-in location offering a wellness and health focus, and it's exactly what my patients need and want. Most importantly, they will follow through on their own."



– DR. STEVEN CHAE, M.D.,
FAMILY PRACTICE OF AURORA, RCCO 3

Using Data

The SDAC prepares data that helps RCCOs and PCMPs understand which services are used most frequently. The SDAC tracks several performance metrics so that RCCOs, PCMPs and the Department can be held accountable for meeting program goals. The SDAC also tracks other performance measures that are not tied to payment but allow the RCCOs, PCMPs and the Department to monitor performance.

Paying for Value

Incentive Payments: Regions that meet or exceed targets on Key Performance Indicators receive incentive payments. This encourages RCCOs and PCMPs to engage partners to meet their goals.



Supporting Providers

The ACC relies on RCCOs to help providers navigate the disparate parts of a fragmented health care system while simultaneously working to make the system more cohesive.

Helping Practices Grow and Change

One way the RCCO supports providers is by helping them adapt to changes in health care and make their practices work better for members and providers alike. Practices often believe strongly in the ideal of being person-focused but are working with old processes and systems that make it difficult to put members at the center. Practice transformation is the term used to describe the shift toward new ways of organizing care to make it more person-centered. Practice transformation is a long journey taken one step at a time.

Care Teams Help Improve Provider and Care Manager Job Satisfaction

It can be a powerful learning experience when RCCOs help their PCMPs understand and interpret the claims data compiled by the SDAC. For example, practices may see for the first time how many (or how few) imaging services they use compared to other practices. Practices see the patterns and approach the issues with initiative and curiosity. But it can be challenging to sift through data to find these patterns and the lessons they hold.



“Without the collaboration of the folks at [RCCO] Colorado Community Health Alliance (CCHA), we would not have been able to integrate behavioral health, engage in practice improvement processes or incorporate care coordination and care management. With the help of CCHA, our practice has been able to treat the whole child — from well-child checks to mental health to social support.”

— BARBARA HOSICK, PRACTICE MANAGER, PEAK PEDIATRICS, RCCO 6

Using Data

The SDAC uses a claims data history to connect new ACC members to a PCMP. They look at which provider the member has seen most often in the past, and most recently.

Paying for Value

Enhanced Payments: PCMPs receive an enhanced payment for meeting five out of nine factors for a person-centered medical home. This encourages PCMPs to make improvements like adopting electronic health records, using evidence-based guidelines and providing education to support self-management and greater self-responsibility.



Future of the ACC

The Department looks forward to another year of growth for the ACC, with new opportunities to strengthen Colorado's health care infrastructure as well as improve health outcomes and contain costs. The ACC plans to implement these new program strategies as our mission to improve the health and quality of life of Coloradans in our care continues:

Integrating Physical and Behavioral Health Care

A significant share of total health costs and population health outcomes may be attributable to behavior, decision-making, and substance use. Therefore, the integration of behavioral health services into an accountable system of care is of primary importance. ACC health system transformation efforts are aligning with the State Innovation Model

and are supporting this new Colorado health system initiative. Also, the ACC will continue to allow integrated Community Mental Health Centers to apply to be PCMPs within the ACC.

Colorado Opportunity Project

The goal of the Colorado Opportunity Project is to deliver proven interventions that create opportunities for all Coloradans to move beyond poverty in adulthood. The RCCOs are supporting new Colorado Opportunity Project Liaisons in communities across the state. Liaisons are working with RCCO members, partners and stakeholders to focus on interventions with positive, measurable outcomes.

Chronic Pain Disease Management

This initiative aims to improve the health of clients with chronic conditions and address rising rates of prescription abuse in Colorado. The initiative links expert specialist teams at an academic hub with primary care clinicians in local communities. Primary care clinicians become part of a learning community, in which they receive mentoring and feedback from specialists.

The initiative promotes the use of evidence-based pain management practices, and it supports PCMPs in treating clients with chronic pain within their primary care

practice. Interactive video connections with fellow providers allow any PCMP to participate, even those who are located far from the nearest specialist. The initiative uses HIPAA-compliant interactive video technology to connect PCMPs to a team of specialists with expertise in a variety of pain management disciplines. Through the program, PCMPs are able to more effectively manage care for chronic pain conditions, and clients can remain in their medical home to receive care.

The initiative has been well received; approximately 40 clinic sites and more than 80 total providers have participated. Nearly 40 percent of the practice sites are outside the Front Range area. The Department is currently working with the University of Colorado to develop other similar initiatives.

Electronic Consultation

The Electronic Consultation, or eConsult initiative, will increase access to specialty care for ACC clients by allowing PCMPs to quickly and easily consult with specialty physicians using an online, private electronic consultation system. With this telemedicine technology, PCMPs and specialists can co-manage care for ACC clients. The program is scheduled to undergo a test group in late 2015 and will begin with rheumatology specialists. The Department looks to gradually include other medical subspecialties, such as neurology.

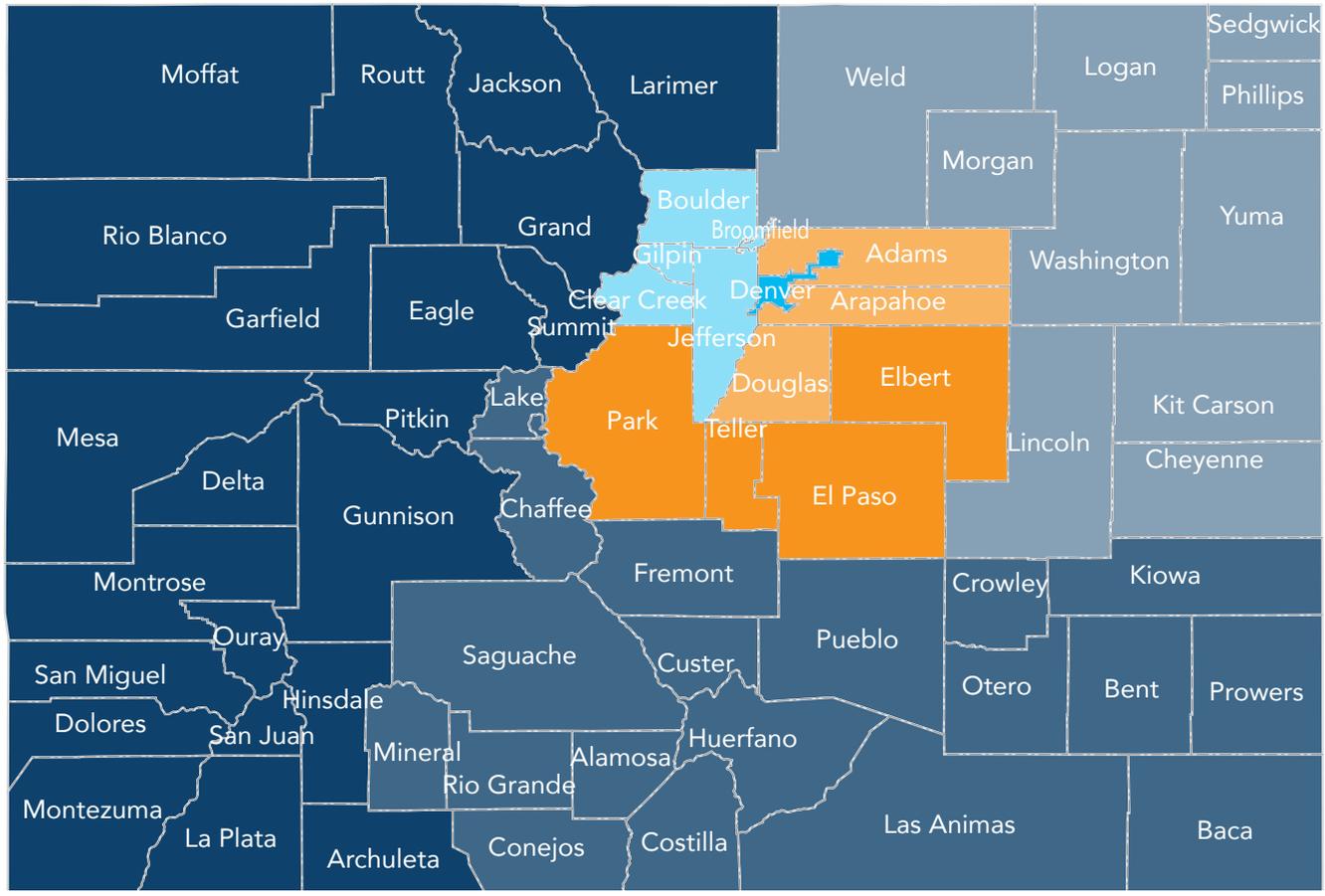
The State Innovation Model's goal is to provide 80 percent of our state's residents with the support they need to move towards greater behavioral health integration.

Health Care Transformation Continues

As the ACC evolves, it will continue to build on the successes of the program's first four years. The ACC was designed with a long-term vision in mind, and the understanding that health system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate to improve client outcomes and reduce health care costs, and is well-poised to continue to do so in the future.

Through the ACC, the Department will continue to be a careful steward of the tax dollars entrusted to it, while honoring Colorado's values: the opportunity to lead a healthy, productive life so together, we can make Colorado the healthiest state in the nation.

RCCO MAP



- REGION 1
Rocky Mountain Health Plans
- REGION 2
Colorado Access
- REGION 3
Colorado Access
- REGION 4
Integrated Community Health Partners
- REGION 5
Colorado Access
- REGION 6
Colorado Community Health Alliance
- REGION 7
Community Care of Central Colorado



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Policy & Financing

The Accountable Care Collaborative demonstrates good value while honoring Colorado's dedication to be the healthiest state in the nation.