New Horizons in Access and Coverage for Coloradans

Safety Net Advisory Committee (SNAC) Lab

October 8, 2015

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CHI SNAC LABS 2015

Objectives

- Leverage our collective focus on vulnerable populations
- Provide a forum for opportunities and lessons learned
- Share the latest strategies for using data to measure effectiveness
- Synthesize input from group and develop a shared body of knowledge

2015 Colorado
Access to Care Index

Accountable Care Collaborative
Phase II

Facilitated Discussion

COLORADO ACCESS TO CARE INDEX Colorado Statewide 2015

Overall Index Score 7.8 Out of 10

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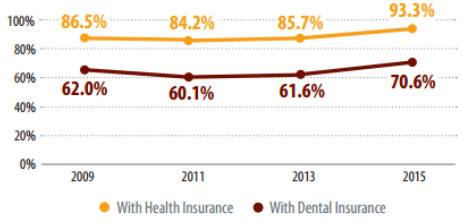
Colorado Coalition for the Medically Underserved

Potential Access

Index Score 7.8

Adequate insurance coverage and enough local care providers make it more likely that people will get care when they need it.

With Insurance, 2009-2015



Health Care Workforce *Per 1,000 Residents 2013 Data

Primary Care Doctors	0.6
Dentists	0.5
Psychiatrists	0.1

Underinsured Coloradans

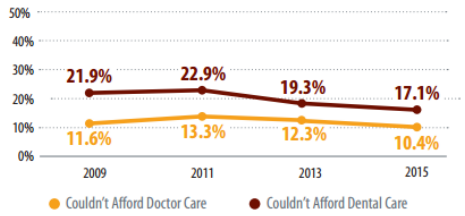
Percentage of Population

Barriers to Care

Index Score 8.8

But many obstacles make it hard for people to get health care – even if they have insurance.

Couldn't Afford Medical or Dental Care in Past 12 Months, 2009-2015



In Past 12 Months ...

Couldn't afford a prescription	9.8%
Couldn't afford specialist care	11.0%
Couldn't get a doctor appointment when needed	18.7%
Didn't have a usual source of care	13.4%
Provider wouldn't accept insurance	9.7%
Didn't get needed mental health care	9.0%
Didn't seek care because uninsured*	40.9%
Didn't go to doctor due to lack of transportation	4.7%

*Only includes those who were uninsured at some point in the past 12 months.

Realized Access

Index Score 6.9

When people obtain preventive services, it's a good indication they have access to care. But hospitalizations or emergency room visits may indicate inadequate access.

Preventive Care

Well-child visits in the past year for those under 19 years

2011	2013	2015
72.3%	72.4%	75.9%

Visited a dentist or dental hygienist in past year, all ages

2011	2013	2015
63.5%	65.3%	68.3%

Received prenatal care in first trimester	87.2%
Pap test in the past three years for women aged 18+	77.0%
Mammogram in the past two years for women aged 50+	72.4%
Colonoscopy or sigmoidoscopy at any time for people aged 50+	69.3%

Avoidable Care

Of those who went to the ER, went for a condition that could have been treated by a regular doctor	Hospitalized for uncontrolled diabetes, adults aged 18+ RATE PER 100,000	Hospitalized for asthma, adults aged 18-39 RATE PER 100,000
40.2%	3.6*	28.1*

Updated December 2015 · Data source details available at ColoradoHealthInstitute.org/COAccessIndex · *2013 data

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Health Access
COVERAGE
EFFECTIVE DATE: XX/XX/XXXX
MEMBER NAME: JANE SMITH
MEMBER NUMBER: XXXXXXX
GROUP #: XXXXXXXX
DRUG CO-PAY
GENERIC: $10
NAME BRAND: $50
CO-PAY: $25
SPECIALIST CO-PAY: $35
XRAY/LAB BENFIT: $250
CLAIMS/INQUIRIES: 1-800-XXX-XXXX

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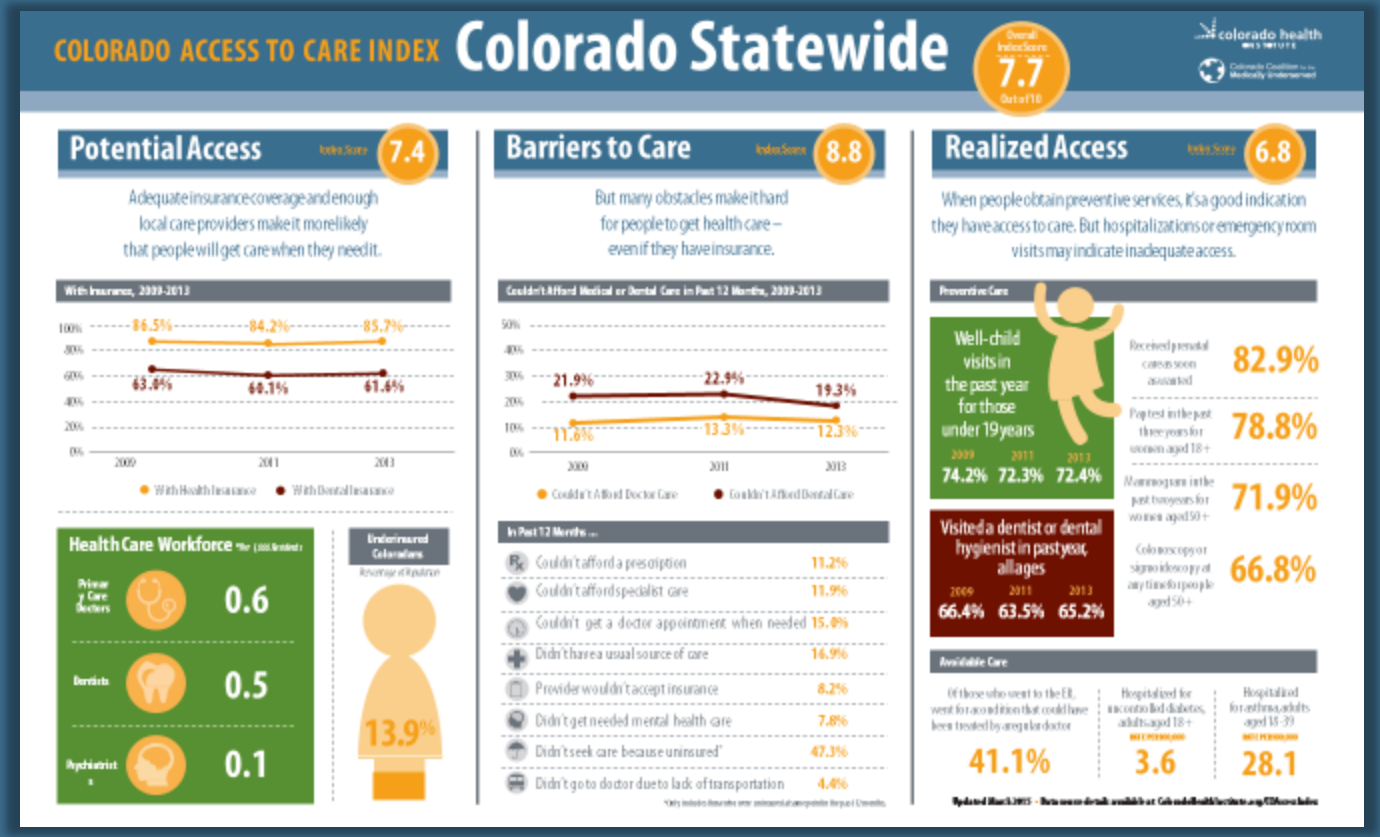
Baseline Index Scores

March 2015:

- Used 2013 data for baseline measure.



Big Changes in 2014

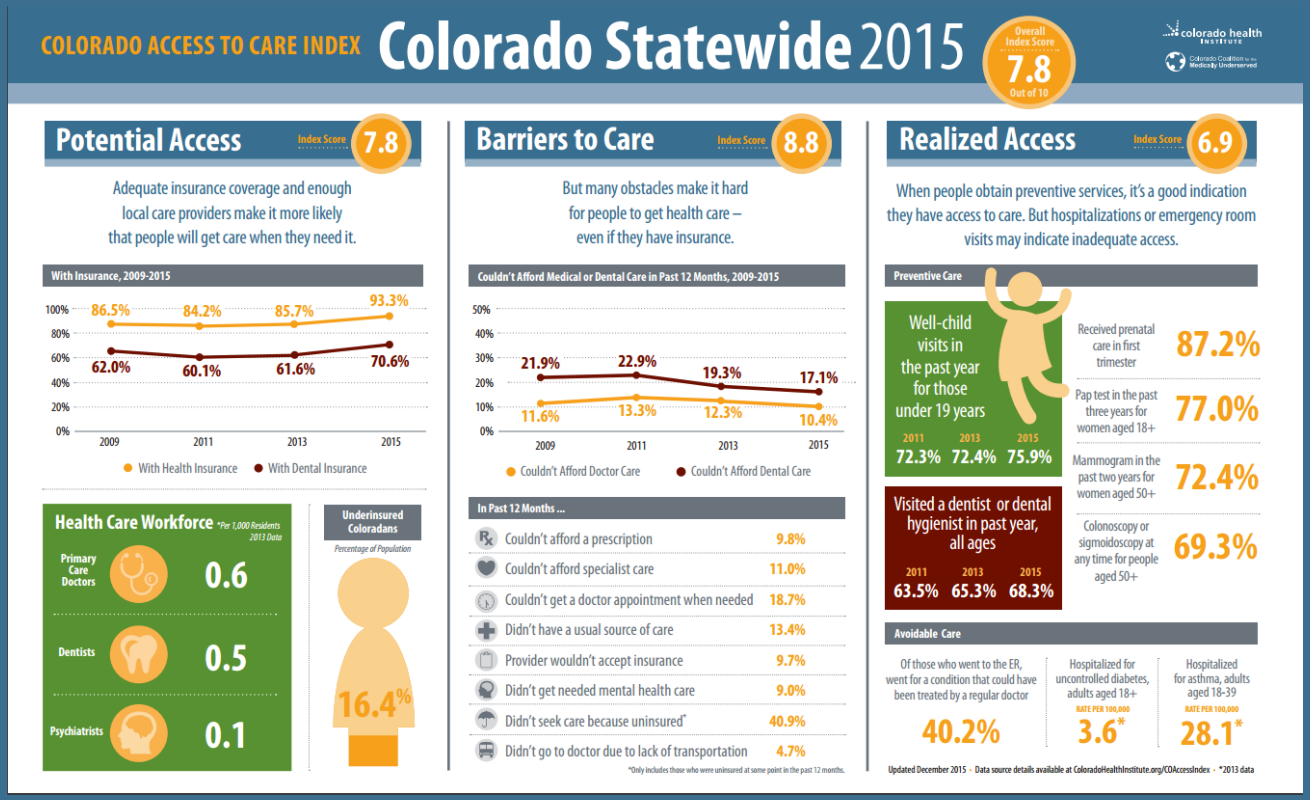
Medicaid
Eligibility Expansion

Health Insurance
Marketplace

Updated Index Scores

October 2015:

- Used 2015 data to measure change.



Three Takeaways

- We see a slight increase in Colorado's access to care score from 2013 to 2015.
- We're just beginning to see the impact of having more people with health insurance.
- Regional disparities from 2015 mirror those of 2013.

Access to Care in Colorado

2013	2015
7.7	7.8

POTENTIAL ACCESS

Potential Access

2013	2015
7.4	7.8

Barriers to Care

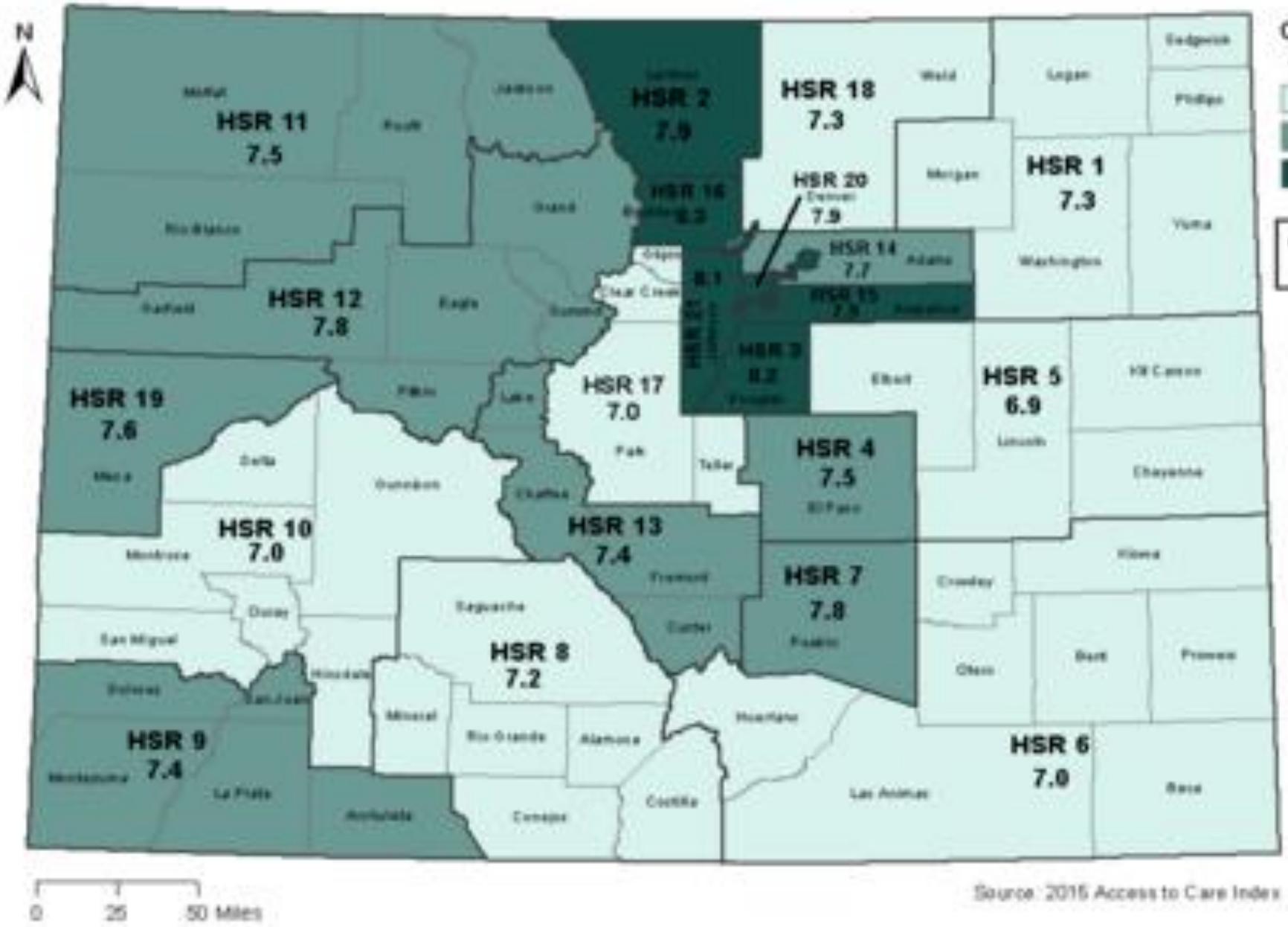
Barriers to Care

2013	2015
8.8	8.8

Realized Access

Realized Access

2013	2015
6.8	6.9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HSR 11
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HSR 19
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HSR 4
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HSR 7
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HSR 9
7.4
HSR 6
7.0
Overall Ind
6.9 -
7.4 -
7.9 -
Colorado S
7.8
0
25
50 Miles
Source: 2015 Access to Care Index

Three Takeaways

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Colorado's Accountable Care Collaborative Phase II

An Overview

Kathryn M. Jantz
ACC Strategy Lead

COLORADO
Department of Health Care Policy & Financing

ACC Program History

Created in response to:

- Unsuccessful experience with capitated Managed Care
- 85% in an unmanaged Fee-For-Service (FFS) system
- Unprecedented economic situation, highest Medicaid caseload and expenditures in state history
- Desire not to continue to pay for higher volume/utilization

Colorado's delivery system reform

- Governor's agenda, stakeholder input, and budget action
- Developed prior to federal ACO concept

ACC Successes

- FY 2012-2013: $6 million net reduction in total cost of care
- FY 2013-14: $30 million net reduction in cost (after all program expenses)
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%) relative to clients not enrolled in the ACC Program
- Over 75% of enrollees are linked to a PCMP after six months of enrollment

Community Behavioral Health Services Program History

- The Community Behavioral Health Services (CBHS) Program is a carved-out managed care model for mental health and substance use disorder treatment in Colorado
- Authorized by the General Assembly in the mid-1990s when most services were offered either fee-for-service or through comprehensive managed care plans
- Today, the CBHS Program is operated by 5 Behavioral Health Organizations (BHOs)
- System operates under 1915(b) waiver authority from the Centers for Medicare & Medicaid Services.

BHO Successes

- BHOs have been successful in using **evidence-based programs**
- Many CMHCs are **partnering**, **co-locating**, and exploring other **moves towards integration**
- BHOs have **strong relationships** with many community partners and have established **comprehensive networks** to address the needs of many clients
- The Community Behavioral Health Services Program has **protected funding** for behavioral health services
- The BHOs have successfully managed **program costs**.
- Developed a continuum of **alternative community based services**

Why Make a Change?

- Fragmented Medicaid System
- Required to re-procure Regional Care Collaborative Organizations
- Desire for greater physical and behavioral health integration
- Opportunity to continue to reduce costs and improve quality
- New federal opportunities

Designing ACC Phase II

GOAL:

To optimize health for those served by Medicaid through accountability for value and client experience at every level of the system and at every life stage

This is the impact we want to see in Colorado.

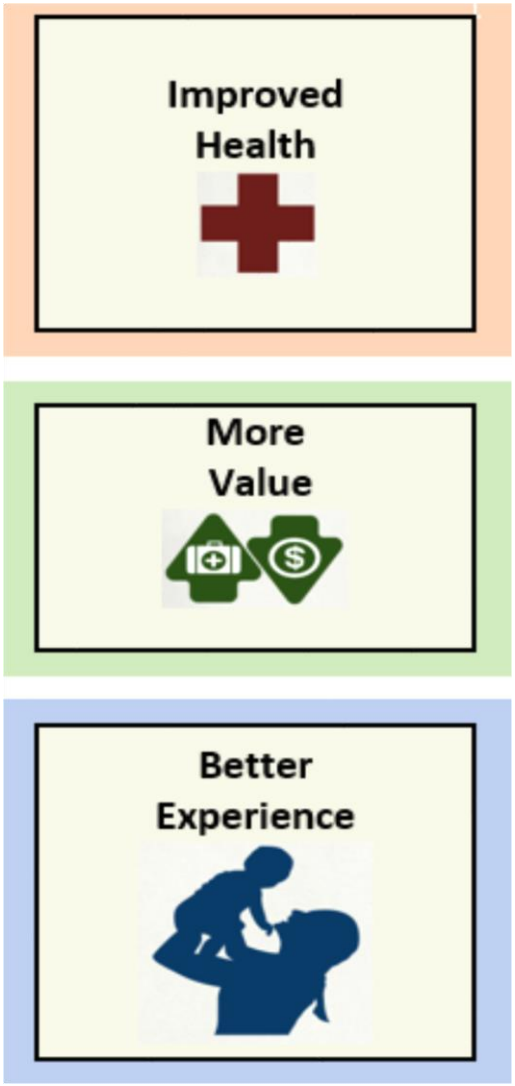
Phase II: Guiding Principles

1. Person- and family-centeredness

2. Accountability at every level

3. Outcomes-focused and value-based

Phase II: Outcomes



Phase II: Outcomes

Improved Health 	Health Management
	Population Health
	Social Well-being

Phase II: Outcomes

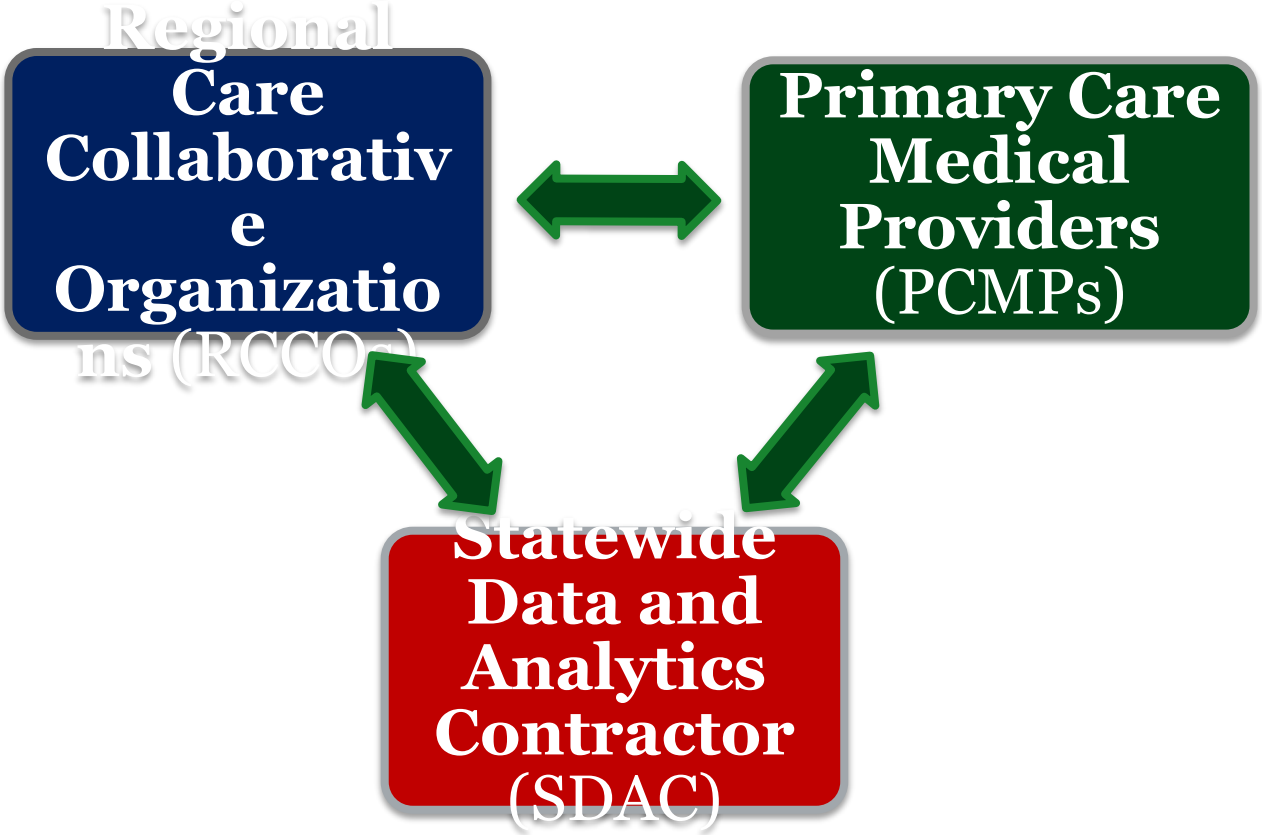
More Value 	Evidence-based Cost Efficiency
	Goals by Population and Service

Phase II: Outcomes

Better Experience 	Client Engagement
	Efficient Systems

Discussion!

Current ACC: Program Structure



Phase II: Levels of Accountability

- Client
- Health Neighborhood
- Regional Accountable Entity (RAE)
- The Department (HCPF)

Phase II: Clients

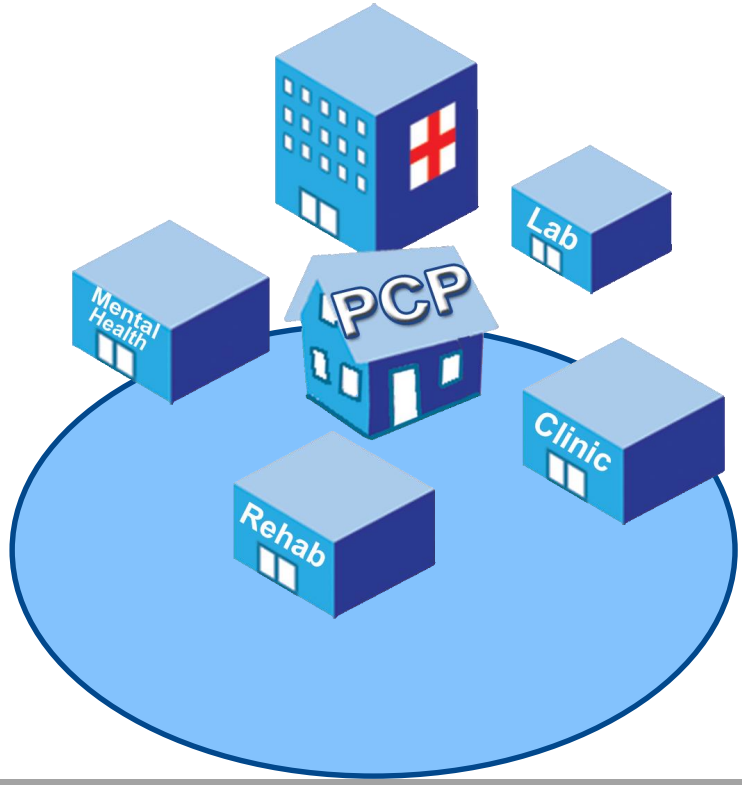
FY14-15 YTD Average	Prenatal	Adults 65 and Over	Individuals Under 65 with Disabilities	Adults	Children & Foster Care
Number of Clients	16,646	69,862	80,641	475,463	515,872
Percentage	1.43%	6.02%	6.94%	40.95%	44.43%

Phase II: Clients

- Onboarding
- Client engagement
- Client incentives

Current: Primary Care Medical Provider (PCMP) Role

- Approximately 550 PCMPs
- PCMPs serve as Medical Homes
- Member/family centered
- Whole-person oriented
- Promotes client self-management
- Care provided in a culturally and linguistically sensitive manner



Phase II: Health Neighborhood

Health Team

- Behavioral Health Providers
- Primary Care Medical Providers
- LTSS Case Management Agencies
- Certain specialists

Phase II: Health Neighborhood

Health Team

- Team-based client care
- Provide care coordination
- Utilize non-traditional health workers
- Promote integrated care within practices

Phase II: Health Neighborhood

Broader Health Neighborhood

- Specialists
- Hospitals
- Other medical providers
- Non-medical providers

Phase II: Health Neighborhood

Broader Health Neighborhood

- Provider compact
- Electronic consultation and other telehealth
- Hospital engagement and other incentives

Current: RCCO Role

- Achieve financial and health outcomes
- Ensure a Medical Home level of care for every Member
- Network Development/Management
- Provider Support
- Medical Management and Care Coordination
- Accountability/Reporting

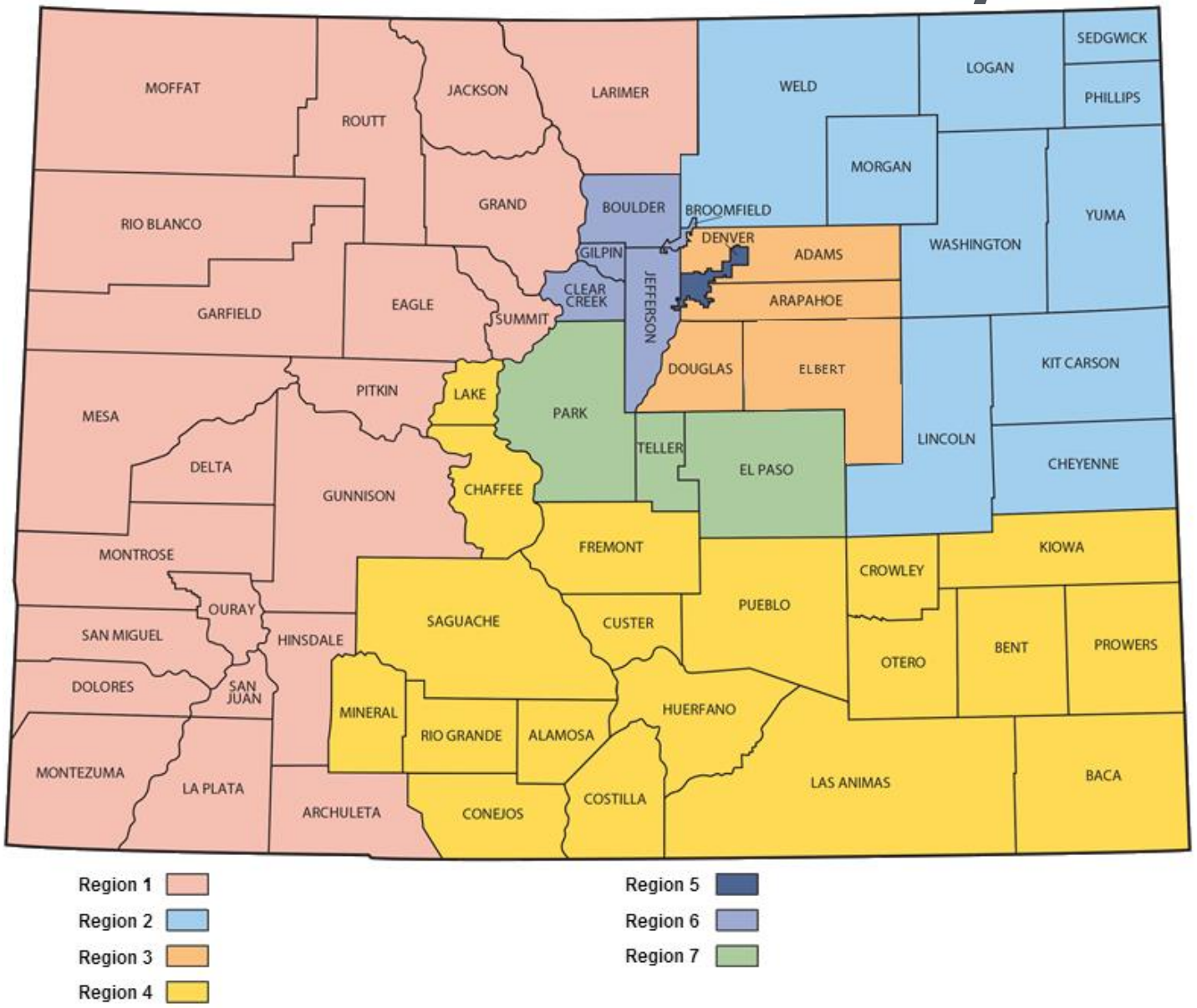
Current: BHO Role

- Provide comprehensive behavioral health benefit
- Manage provider networks
- Operate authorization processes
- Pay providers
- Perform audits and quality functions
- Care coordination
- Accountability and reporting to the State

Phase II: Regional Accountable Entity

- Unified administration of physical health and behavioral health
- Onboard clients
- Contract, support, and oversee network
- Develop a broad health neighborhood
- Convene Community
- Manage systems of care for special populations
- Make value-based payment to Health Team

ACC Phase II: RAE Map



Phase II: The Department (HCPF)

- Administer benefit package
- Enrollment into the RAEs
- Cross-program and cross-agency alignment

Discussion!

Phase II: Program Infrastructure

There will need to be infrastructure investments at every level of accountability. These fall into three domains:

1. Payment
2. Health Information Technology
3. Sound Administration

Current: ACC PMPM Payments

- RCCO PMPM: Payment is reduced for clients unattributed longer than 6 months
- PCMP PMPM: Enhanced Primary Care Standards
- FFS reimbursement for Medical Services

Current: BHO Payment

Capitated managed-care payment. BHO is responsible for the claim when:

- The client is enrolled in the BHO
- The client has a BHO-covered diagnosis
- The service in question is covered by the BHO contract
- The service is medically necessary for the covered condition

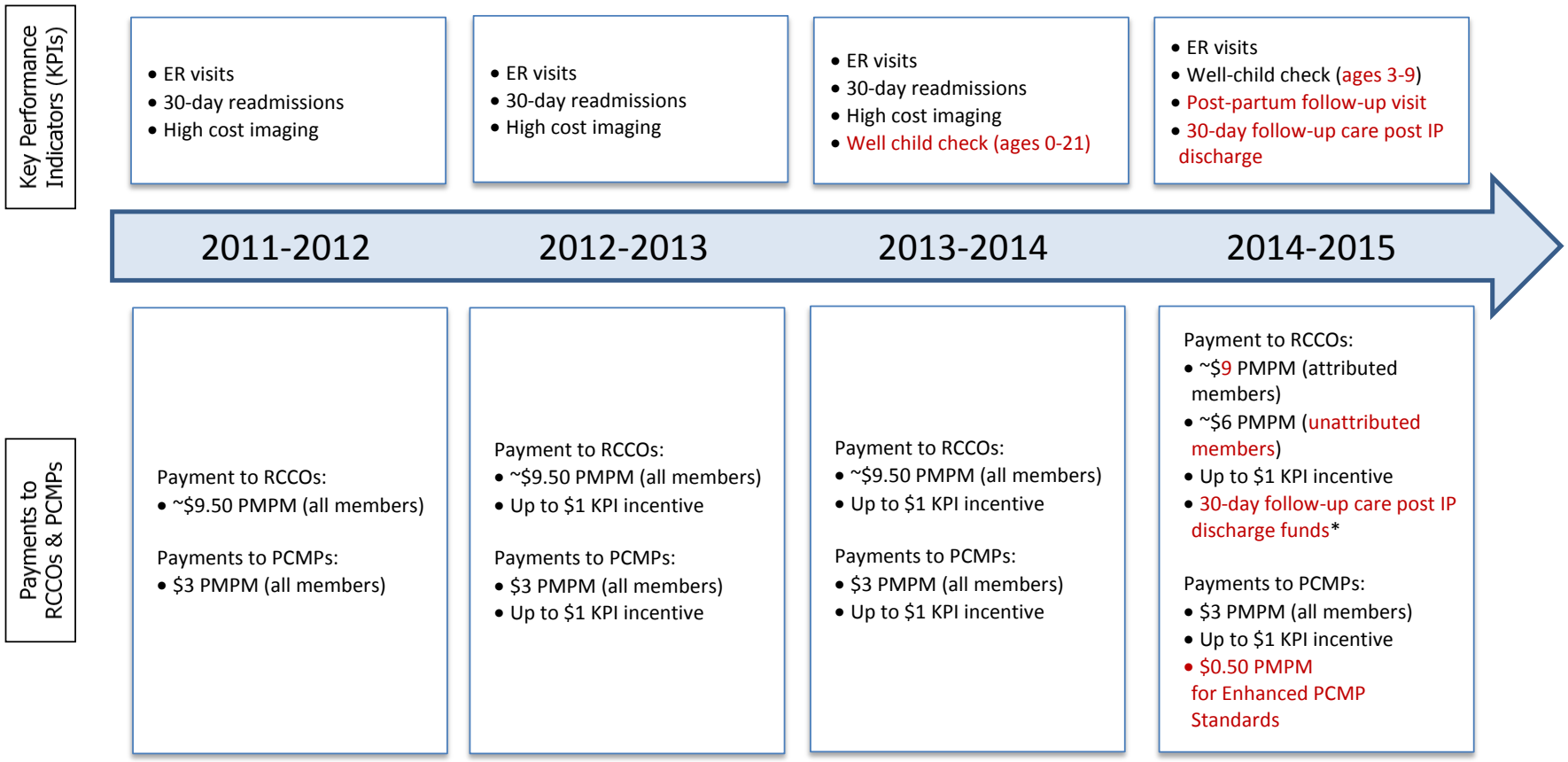
Phase II: Payment

- PMPM to RAE: RAE makes value-based payments to Health Team providers
- Leverage new functionality for hospital payments
- Exploring aligned alternative payment methodologies for FQHCs and CMHCs
- Value based payment formula
- Payments to support integration
- Outpatient professional capitation

Current: Pay for Performance

KPI & Payment Evolution (2011-2015)

ACC Goal: Improve care, lower cost, and improve client & provider experience.



*Calculation: [All funds saved from reducing RCCO PMPM by $0.50] + [funds retained from tiered payments for unattributed members] – [Amount paid for enhanced PCMP standards]

Phase II: Pay-for-Performance

- Key Performance Indicators
- Competitive Pool
- Shared Savings

Current: Statewide Data Analytics Contractor Role

- Data Repository
- Data Analytics & Reporting
- Web Portal & Access
- Accountability & Continuous Improvement

Phase II: Health Information Technology

- Data, analytics, HIT
  - Enhanced Provider Portal
  - Additional analytics
  - New data sources

- Focus on Health Information Exchange

- Care coordination tool

Phase II: Sound Administration

- Program oversight
- Program maximization

Phase II: Request for Proposals (RFP) Timeline

- Spring-Summer 2014: Stakeholder meetings across Colorado
- Fall 2014: Request for Information (RFI) published
- Winter-Spring 2016: Drafting RFP and developing federal waiver authority
- Winter-Spring 2016: Draft RFP released
- Summer 2016: RFP published
- 2017: New ACC (RAE) contracts begin

Opportunities to Get Involved

- October 21, 2015: ACC Phase II: Overview and Client Engagement
- November 10, 2015: Open Forum
- November 18, 2015: Program Improvement Advisory Committee Retreat
- December 16, 2015: Health Team Support & Payment
- January 12, 2016: Open Forum
- January 20, 2016: Advisory Structure and Stakeholder Engagement
- February 17, 2016: Care Coordination Strategy

Discussion!

Thank You

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