New Horizons in Access and Coverage for Coloradans

Safety Net Advisory Committee (SNAC) Lab

October 8, 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
Health Access

MEMBER NAME: JANE SMITH
MEMBER NUMBER: XXXXXXXX

GROUP #: XXXXXXXX

CO-PAY: $25
SPECIALIST CO-PAY: $35
XRAY/LAB BENEFIT: $250

DRUG CO-PAY
GENERIC: $10
NAME BRAND: $50

EFFECTIVE DATE: XXXX/XXXX

CLAIMS/INQUIRIES: 1-800-XXX-XXXX
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.

![Image of the Colorado Access to Care Index 2015](#)

**Potential Access**

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

<table>
<thead>
<tr>
<th>Year</th>
<th>With Health Insurance</th>
<th>With Dental Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>86.5%</td>
<td>93.3%</td>
</tr>
<tr>
<td>2010</td>
<td>84.2%</td>
<td>93.3%</td>
</tr>
<tr>
<td>2011</td>
<td>85.7%</td>
<td>93.3%</td>
</tr>
<tr>
<td>2012</td>
<td>62.6%</td>
<td>60.1%</td>
</tr>
<tr>
<td>2013</td>
<td>61.6%</td>
<td>79.6%</td>
</tr>
<tr>
<td>2014</td>
<td>61.6%</td>
<td>79.6%</td>
</tr>
<tr>
<td>2015</td>
<td>61.6%</td>
<td>79.6%</td>
</tr>
</tbody>
</table>

**Barriers to Care**

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Couldn’t Afford Doctor Care</th>
<th>Couldn’t Afford Dental Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>21.9%</td>
<td>22.9%</td>
</tr>
<tr>
<td>2010</td>
<td>13.3%</td>
<td>19.3%</td>
</tr>
<tr>
<td>2011</td>
<td>11.6%</td>
<td>17.1%</td>
</tr>
<tr>
<td>2012</td>
<td>13.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>2013</td>
<td>13.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>2014</td>
<td>13.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>2015</td>
<td>13.3%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

**Realized Access**

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: 87.2%
- Pap tests in the past three years for women aged 18+ years: 77.0%
- Mammograms in the past two years for women aged 50+ years: 72.4%
- Visited a dentist or dental hygienist in past year, all ages: 69.3%

**Available Care**

- Of those who went to the US for a condition that could have been treated by a regular doctor: 40.2%
- Hospitalized for uncontrolled diabetes, adults aged 18+, with no complications: 3.6%
- Hospitalized for asthma, adults aged 18-19 years and over: 28.1%
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

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.7</td>
<td>7.8</td>
</tr>
</tbody>
</table>
### Potential Access

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>
## Barriers to Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>8.8</td>
</tr>
<tr>
<td>2015</td>
<td>8.8</td>
</tr>
</tbody>
</table>
Realized Access
<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.8</td>
<td>6.9</td>
</tr>
</tbody>
</table>
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.
Colorado’s Accountable Care Collaborative Phase II

An Overview

Kathryn M. Jantz
ACC Strategy Lead
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
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

- Improved Health
- More Value
- Better Experience
### Phase II: Outcomes

<table>
<thead>
<tr>
<th>Improved Health</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Health Management</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Social Well-being</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Phase II: Outcomes

<table>
<thead>
<tr>
<th>More Value</th>
<th>Evidence-based Cost Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals by Population and Service</td>
</tr>
</tbody>
</table>
## Phase II: Outcomes

<table>
<thead>
<tr>
<th>Better Experience</th>
<th>Client Engagement</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Efficient Systems</td>
</tr>
</tbody>
</table>
Discussion!
Current ACC: Program Structure
Phase II: Levels of Accountability

- Client
- Health Neighborhood
- Regional Accountable Entity (RAE)
- The Department (HCPF)
## Phase II: Clients

<table>
<thead>
<tr>
<th>FY14-15 YTD Average</th>
<th>Prenatal</th>
<th>Adults 65 and Over</th>
<th>Individuals Under 65 with Disabilities</th>
<th>Adults</th>
<th>Children &amp; Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clients</td>
<td>16,646</td>
<td>69,862</td>
<td>80,641</td>
<td>475,463</td>
<td>515,872</td>
</tr>
<tr>
<td>Percentage</td>
<td>1.43%</td>
<td>6.02%</td>
<td>6.94%</td>
<td>40.95%</td>
<td>44.43%</td>
</tr>
</tbody>
</table>
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
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.

#### Key Performance Indicators (KPIs)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>ER visits</strong></td>
<td><strong>ER visits</strong></td>
<td><strong>ER visits</strong></td>
<td><strong>ER visits</strong></td>
</tr>
<tr>
<td><strong>30-day readmissions</strong></td>
<td><strong>30-day readmissions</strong></td>
<td><strong>30-day readmissions</strong></td>
<td><strong>Well-child check (ages 3-9)</strong></td>
</tr>
<tr>
<td><strong>High cost imaging</strong></td>
<td><strong>High cost imaging</strong></td>
<td><strong>Well child check (ages 0-21)</strong></td>
<td><strong>Post-partum follow-up visit</strong></td>
</tr>
</tbody>
</table>

#### Payments to RCCOs & PCMPs

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Payment to RCCOs:</strong></td>
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<td><strong>Payment to RCCOs:</strong></td>
<td><strong>Payment to RCCOs:</strong></td>
</tr>
<tr>
<td>~$9.50 PMPM (all members)</td>
<td>~$9.50 PMPM (all members)</td>
<td>~$9.50 PMPM (all members)</td>
<td>~$9 PMPM (attributed members)</td>
</tr>
<tr>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
</tr>
<tr>
<td><strong>Payment to PCMPs:</strong></td>
<td><strong>Payment to PCMPs:</strong></td>
<td><strong>Payment to PCMPs:</strong></td>
<td><strong>Payment to PCMPs:</strong></td>
</tr>
<tr>
<td>$3 PMPM (all members)</td>
<td>$3 PMPM (all members)</td>
<td>$3 PMPM (all members)</td>
<td>$3 PMPM (all members)</td>
</tr>
<tr>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
<td>Up to $1 KPI incentive</td>
</tr>
</tbody>
</table>

*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]*

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Original ACC
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

Kathryn Jantz
ACC Strategy Lead
Department of Health Care Policy & Financing

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