Case study: Colorado Accountable Care Collaborative (ACC)

Colorado Department of Health Care Policy & Financing, Denver, Colorado

Real results*

In its second year of operations, the Colorado Accountable Care Collaborative program and its members have experienced:

- 15–20 percent reduction in hospital readmissions
- 25 percent reduction in high-cost imaging services
- 0.9 percent lower rate of increase in ED use (compared to non-enrollees)
- 22 percent reduction in hospital admissions among ACC members with COPD
- $44 million gross in savings, with a $6 million net reduction in the total cost of care for enrolled members

Snapshot of the Colorado Accountable Care Collaborative

In 2011, Colorado's Medicaid program, managed by the **Department of Health Care Policy and Financing (HCPF)**, began working with a variety of stakeholders to implement the **Colorado Accountable Care Collaborative (ACC)**—an innovative Medicaid reform program. The goals of the ACC are to:

- Improve health outcomes through a coordinated system that proactively addresses the Medicaid population's health needs
- Control costs by reducing avoidable, duplicative, variable and inappropriate utilization

After nearly two years of implementation, the ACC is instituting changes designed to improve access, strengthen quality and improve outcomes, while simultaneously controlling costs.

Using performance and population health measurement to impact health outcomes and costs

The ACC is a statewide program that engages healthcare organizations and providers through regional care collaborative organizations (RCCOs) that form the foundation of the program. Colorado has seven RCCOs that are expected to improve their members' health outcomes and lower costs by reducing preventable or duplicative services.

To meet their objectives, the Colorado RCCOs are:

- Strengthening access to care by building and maintaining a network of primary care medical providers (PCMPs)
- Ensuring that members receive care coordination in a medical home environment that effectively manages and coordinates care to meet both medical and non-medical needs
- Providing clinical tools, member materials, and other resources and support to the PCMPs

A key ingredient for the RCCOs' success is access to extensive data and analytics on populations and providers. The seven RCCOs each receive a per-member-per-month (PMPM) payment and can receive incentive payments based on outcomes. RCCOs monitor their progress on key performance indicators (ED visits, all-cause 30-day readmissions, well-child visits, and high-cost imaging) and are eligible for incentive payments if program successes can be demonstrated.

*The data used in this case study is based on the 2013 Colorado Department of Health Care Policy and Financing report to the Joint Budget Committee. The report is currently available at http://ow.ly/E5Tnb

PCMPs are the focal point of care for the medical home for ACC members and are also responsible for ensuring timely access to primary care. Currently, 80 percent of ACC members are linked to a PCMP and work is ongoing to attribute the remaining 20 percent to PCMPs.

Key performance indicators for measuring outcomes and progress

A unique aspect of the ACC program is the significant investment in data and analytics made by HCPF to ensure that all stakeholders—from the provider group level to the state agency level—have access to data that will strengthen care management initiatives and chart progress toward key performance goals.

To achieve this goal, HCPF created the statewide data and analytics contractor (SDAC) role, which was awarded to **3M Health Information Systems (3M)**, to develop and maintain a client enrollment process, maintain a data repository, provide risk-adjusted analytics and reporting, and develop and host a web portal through which stakeholders can access comprehensive health data and program performance metrics.

The data used to create actionable information and analytics comes from claims paid through the Colorado Medicaid Management Information System. In its role as the SDAC, 3M risk-adjusts this data using various classification systems to take member characteristics into account and offer better "apples-to-apples" comparisons between providers and populations—an important factor for performance improvement.

Three key performance indicators are used in the ACC program because they represent areas in which duplicative or unnecessary services are often delivered. With an initial goal of reducing inappropriate service utilization, the ACC is focused specifically on:

- All-cause 30-day readmissions
- ED visits
- High-cost imaging through diagnostic tools such as MRIs and CT scans

A fourth measure, well-child checks, was added in fiscal year 2014. All of these measures are examined at both the population and provider levels.

Data reveals provider variations, care gaps

Comparisons are made between providers within an RCCO or the state to identify where variation exists. The risk-adjusted population data is examined to determine which cohorts are driving higher costs and higher utilization.

Because efficacious care management is vital, the population data is also used to identify potential gaps in care at the person level or in at-risk populations that often require more intensive intervention. Since the focus is on populations and risk adjustment is done at the whole person level, rather than the disease level, providers can segment the data and examine detailed information about at-risk populations.

Measuring the total cost of care

An important measure monitored by the SDAC for the ACC is **total cost of care (TCC)**, a composite measure of costs defined as the total cost in dollars of all services rendered in the delivery of care for an individual or group. This total includes the amounts paid by the insurer and by the member (e.g., co-payments, deductibles, and other cost-sharing mechanisms) for all utilization (e.g., inpatient admissions, outpatient visits, physician visits, prescriptions, etc.) for a person or a population.

The ACC program also examines TCC at both the unit and utilization levels. While every performance indicator has its own goal and is examined discretely, TCC is a reflection of all the metrics and their impact on overall (total) costs.

Results demonstrate the impact

After two years of operation, the ACC program is reducing utilization rates of preventable services and decreasing TCC.

In designing and implementing this program, Colorado's healthcare leaders understood that changing the Medicaid system would be an evolutionary process. In the short-term, the goal of the ACC is to improve care and costs through an immediate focus on cost- and clinically-effective utilization of services. After two years, the ACC program and its members have experienced:

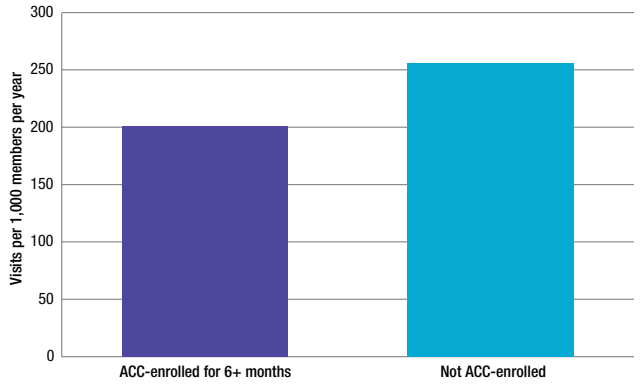
- A 15–20 percent reduction in hospital readmissions
- A 25 percent reduction in high-cost imaging services
- A lower rate of increase (1.9 percent) in ED utilization compared to an increase of 2.8 percent for those not enrolled
- $44 million in gross savings, with $6 million net reduction in total cost of care

Better outcomes for the chronically ill

While the ACC focuses on the whole person, the results are showing that segments of the population with chronic illnesses are being positively impacted, too.

For example, as the chart below shows, there was a 22 percent reduction in hospital admissions among ACC members with COPD who were enrolled in the program six months or more, compared to those not enrolled. Lower rates of exacerbated chronic health conditions such as hypertension (5 percent) and diabetes (9 percent) were also detected, relative to members not enrolled in the ACC program.

Reduced admissions for ACC program members*



An examination of hospital admissions for COPD illustrates that ACC-enrolled members have lower rates of hospital admission for this disease than those not enrolled in the ACC.

Care management: An essential ingredient

These early successes can be attributed to the care management programs conducted by the RCCOs and PCMPs engaged in the ACC. These programs are employing data-driven care to identify areas of need and achieve better health outcomes — thus impacting utilization and costs.

Traditionally, healthcare providers and systems relied solely on their own physician data and were missing a more expansive view of the member experience (e.g., medications not prescribed by the physician, ED visits and social issues impacting the health of the member). With the analytics accessible through the web portal developed by 3M, RCCOs and PCMPs can now examine data on provider practices, utilization, key performance indicators, individual and population risk scores, and TCC.

*Data based on the 2013 Colorado HCPF report to the Joint Budget Committee: http://ow.ly/E5Tnb

The overall program is also demonstrating reduced total cost of care for Medicaid members enrolled in the ACC program. In fiscal year 2012–13, the ACC program analysis identified **$44 million** in gross savings or cost avoidance.

The use of data and a diverse team have led to innovations in care management from both the health and social perspectives.

With this data, PCMPs are segmenting and organizing populations by risk scores to determine where intervention and focused care management are needed. They are also looking at utilization in relation to total TCC, particularly for ED visits and readmissions, since these are two of the three ACC key performance indicators. The examination begins by looking at complex members, as determined by risk scores and TCC, and then tying this data to ED use, readmissions, and high-cost diagnostics.

Recognizing potential care needs

At some PCMPs, the data related to costs, utilization, and risk scores is used in the weekly care management meetings. During these meetings, the care management team identifies "hot spotting" issues on both micro and macro levels.

At the micro level, a diverse team of case managers and providers review the data and the cases, sharing experiences and knowledge to contribute to better overall care management for all members and create community care plans for individuals.

For example, if a case is presented in which a member is exhibiting changing or challenging behaviors, the team may recommend that this member receive a mental health assessment.

The use of data and a diverse team has led to innovations in care management from both the health and social perspectives. One such innovation is the incorporation of paramedics into the care management team by a regional organization in Northern Colorado. The paramedics become familiar with members and can stop to visit individuals when needed to help prevent unnecessary trips to the ED.

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The right resources for the right people

Data also lets PCMPs cluster members so they can determine if they are assigning the right resources for managing those members, and then look at the member-level detail. From 5,000 members attributed to a PCMP for care management, there may be 45 identified as "at risk." These 45 members can then be rank-ordered by cost, illness burden risk score, and utilization, which may reduce the number of those requiring intensive intervention to a more focused and manageable number for whom providers can have an immediate impact.

At the macro level, the data has been used to identify systemic issues and focus on super-users and trends in utilization.

The data-driven care management and hot spotting being done in all the RCCOs are showing results. Abundant anecdotal evidence describes how stronger care management and outreach are reducing ED use among members with high utilization rates (e.g., 20 to 32 times in a year).

With the experience at the local, regional and statewide levels, the Colorado ACC model serves as an example of innovation and best practice for other initiatives—whether they are statewide reform efforts, health plan initiatives or provider-driven reforms.

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