# ACC Phase 3: Evaluation Plan Deep Dive

Tamara Keeney

Research & Innovation Section Manager

## Inputs and Activities
What we require the RAEs to do

**ACC Contract Covering:**
- Member engagement
- Grievances and appeals
- Network development and access
- Health neighborhood
- Provider support
- Behavioral health
- Children
- Quality

## Outputs
What we track to know the requirements have been met

Examples:
- Number of members receiving services
- Percent of providers paid on time
- Number of providers available in a region
- Number of members receiving care coordination

## Outcomes
What we measure to assess if we are getting the intended results

Examples:
- Improvement on CMS Core Measures
- Improved scores on member and provider surveys
- Costs shift from acute settings to preventive care and outpatient

## Impact
How we evaluate if the program is meeting our overall goals

**1.** Improved access to care
**2.** Improved quality of care
**3.** Close health disparities and promote health equity for members
**4.** Improve the member and provider service experience
**5.** Manage care to protect member coverage, benefits and provider reimbursements

## **Monitoring and Accountability:** How do we monitor progress and hold the MCEs accountable?

**Monitoring**
- Performance standards
- Audits

**Accountability Tools**
- Commitment to Quality
- Corrective action plans

**Monitoring**
- Narrative Deliverables
- Quantitative Data

**Accountability Tools**
- Commitment to Quality
- Corrective action plans

**Monitoring**
- KPIs, PCMP metrics, BHIP
- Cost trend monitoring
- EQRO activities

**Accountability Tools**
- Commitment to Quality
- Incentive payments

**Mixed Methods Evaluation**
- Focused on behavioral health, primary care providers, and care coordination
- Research questions with mixed methods approaches for each topic

## **Stakeholder Engagement:** How do we solicit feedback to improve our program?

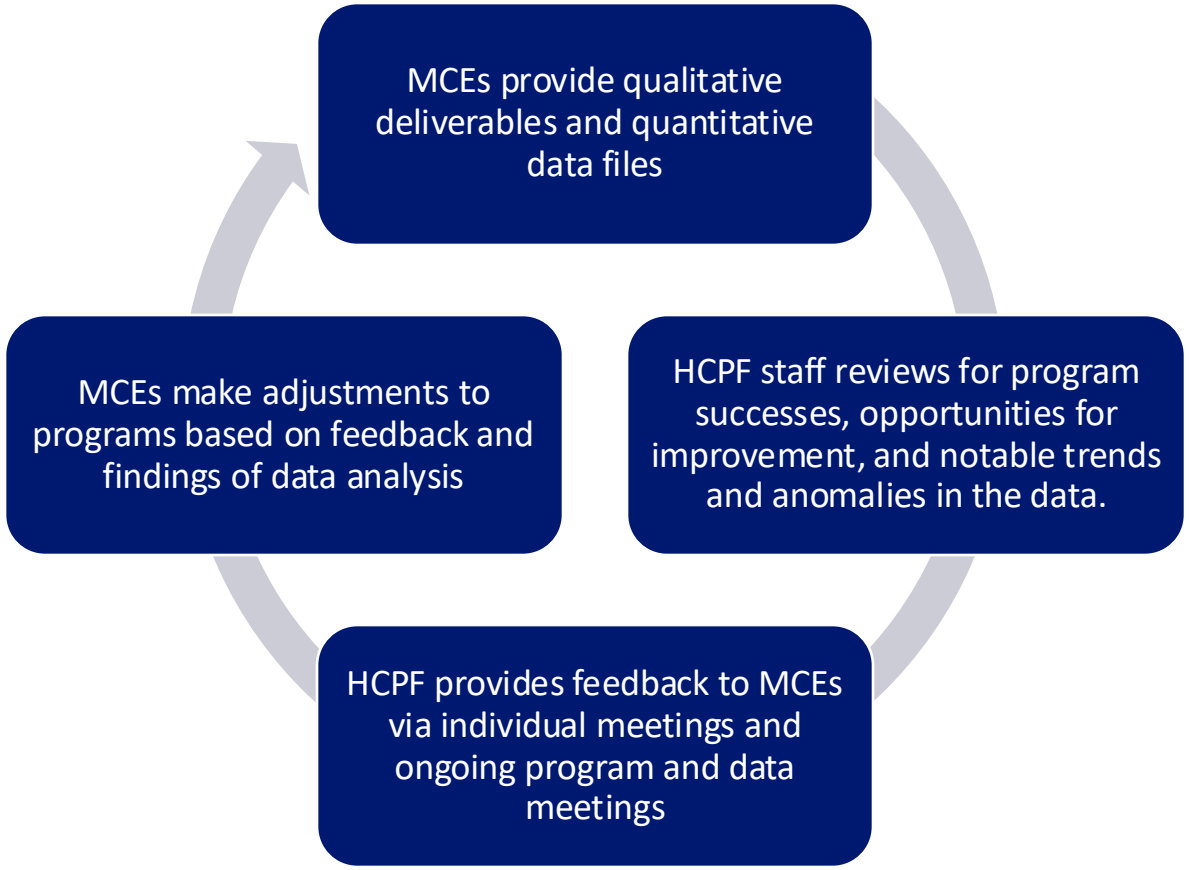
**Department meetings with MCEs and providers • Program Improvement Advisory Committees • Member Experience Advisory Councils**

**Outputs**
What we track to know the requirements have been met

**Outcomes**
What we measure to assess if we are getting the intended results

# Monitoring Process

Monitoring is an **ongoing process** where ACC staff review the work being completed by the MCEs. The products are MCE-submitted deliverables and MCE-submitted data, which will combined with other sources such as claims, ADT feeds, clinical data submissions, etc. and then transformed into dashboards.



**Impact**
How we evaluate if the program is meeting our overall goals

# Evaluation Plan

The evaluation will be a **deep dive** into three focus areas. The products will be mixed-methods reports that provide insight into how the program is working and the experience of members and providers.

## Three Evaluation Focus Areas with Two Scopes of Work for Each

**Behavioral Health Benefit**

**Scope 1:** At what points along the continuum of services are strengths and gaps in access to care most impacting member health?

**Scope 2:** How are specific member groups experiencing the continuum and what improvements can be made?

**Primary Care**

**Scope 1:** How do members understand the role of their PCMP and how do they utilize their PCMP?

**Scope 2:** What is the impact of MCE support to primary care providers?

**Care Coordination**

**Scope 1:** What is care coordination's impact on access to care and member experience?

**Scope 2:** What is care coordination's impact on cost and quality outcomes?

## Each Scope of Work Contains:

- Research questions (3-5 per scope) that collectively touch on all five goals of the ACC
- Mixed methods approaches to answer the questions
- Opportunities for stakeholder input and member feedback

# Things To Keep In Mind

- This is our first pass and the first look at the **draft** research questions – please give us your feedback, we have lots of time to retool.

- There will be many questions that are interesting (and we want to hear them!), but we must stay within scope, focus on what is actionable, and what is feasible within our capacity as an internal team.

- The monitoring plan will track the progress hundreds of metrics – the evaluation is about deeper research questions. You may have ideas that are already being tracked elsewhere.

# Evaluation Topic 1: Primary Care

**Objective:** Primary care is a pillar of the ACC in that all members are expected to have a designated primary care medical practice (PCMP), which is intended to support them in meeting preventive and chronic health needs as well as navigating health care transitions and accessing social supports. Topic 1 will explore the impact of primary care to members and providers.

| Scope 1 | Scope 2 |
| --- | --- |
| Primary Care Impact to Members | Provider Support |
| How do members understand and utilize their PCMP to attain improved health and well-being? | What is the impact of RAE support to primary care providers, particularly smaller providers with less capacity to serve complex members? |

### Potential Methods Examples

- Spreadsheet of PCMPs and attributes mapped to cost and quality
- Surveys of members and providers
- Patterns of care cluster analysis

### Policy/Program Levers

- Provider support/Payment to PCMPs
- Attribution/outreach
- Coaching

# Topic: Primary Care

## Scope 1: How do members understand and utilize their PCMP to attain improved health and well-being?

- How do members understand and value their PCMP assignment?
- Are members using their assigned PCMP? Including members who were initially unattributed and RAEs connected them to a PCMP (attribution)
- What patterns of care do we see for members with their PCMP? Break out examples: members with multiple chronic conditions, members with multiple providers outside the PCMP, members who go once but don't return; OCL members (HCBS needs), and children for preventive care. Develop cohorts of members with a particular focus on equity, including rural.
- What are members' perspectives on their access to and quality of care for PCMPs? Target surveys to specific groups identified above. Include complaints and grievances to the extent they are helpful.
- From the perspective of the health neighborhood, how well are medical homes connecting members to social needs that impact health?

# Topic: Primary Care

## **Scope 2:** What is the impact of RAE support to primary care providers, particularly smaller providers with less capacity to serve complex members?

- What types of support are providers receiving from the RAEs currently, and what types of support do they want to receive? Is there alignment? Do RAE investments in provider support target areas of lowest performance/greatest need?
- How do providers of different sizes (select based on scope 1 cohort mapping) value RAE support/coaching?
- What types of support do providers that provide delegated care coordination seek from the RAEs? Alternately, do providers that do not care coordinate members directly know the RAE provides this and do they use it?
- What is the correlation between the amount of support a PCMP receives and the performance on metrics among cohorts of members identified in scope1?

# Evaluation Topic 2: Behavioral Health Benefit

**Objective:** The RAEs are responsible for ensuring Health First Colorado members can access services across the behavioral health continuum of care. It is essential that SUD and mental health services are available at the right levels of care to meet the needs of our population. Topic 2 will explore the strengths and gaps of the Medicaid behavioral health continuum (Scope 1) with the intention of identifying actionable steps to address priority concerns for specific service areas and populations in Scope 2.

| Scope 1 | Scope 2 |
|---|---|
| Strength and Gap Analysis of BH Continuum | Deep Dives into Populations and Service Areas |
| At what points along the continuum are strengths and gaps in access to care most impacting member health? | How are specific member groups experiencing the continuum (quality, cost, satisfaction), and what improvements can be made? |
| **Potential Methods Examples**<br>• Mapping of continuum<br>• Cohort analysis: patterns of care after acute event<br>• Surveys of members | **Policy/Program Levers:**<br>• TBD in collaboration with BHIC Team |

# Topic: Behavioral Health

## Scope 1: At what points along the continuum are strengths and gaps in access to care most impacting member health?

- How is the Medicaid behavioral health continuum of care defined?
- How do Medicaid members access to care levels align with estimated need for behavioral health services? Break out data by geography and population to the extent possible.
- What are the strengths and gaps in the continuum, who is most (and disproportionately) impacted and how? Get into equity and populations here.
- What are members' and providers' perspectives on areas of weakness and how to make improvements?
- Are RAEs investing in areas of the continuum that are intended to increase access to community-based care and maximize member access to care in general?

# Topic: Behavioral Health

## Scope 2: How are specific member groups experiencing the continuum, and what improvements can be made?

- What patterns of care do we see for members along the continuum of care where we have concerns about access to care and member health/well-being? What cost differences do we see among groups with different utilization patterns?

- Which population groups are most impacted by the strengths and weaknesses and how? Deep dive into root causes and identification of solutions.

- How are RAEs collaborating with trusted health neighborhood organizations to assist members with accessing care where needs are high?

# Evaluation Topic 3: Care Coordination

**Objective:** RAEs are required to provide care coordination to complex members directly or to delegate this responsibility to providers and/or community organizations. The ACC 3.0 contract stipulates minimum standards for the delivery of care coordination, but there are many models and approaches across the state for serving complex members. Topic 3 will explore whether care coordination implementation efforts are resulting in a measurable impact to members.

| Scope 1 | Scope 2 |
|---|---|
| Impact of care coordination on access, member experience, and equity | Impact of care coordination on cost and quality |
| Are the intended complex members actually receiving care coordination, and if so, what does this look like in practice and what do they think about quality? | Among those who received care coordination, are interventions effective at shifting costs, improving clinical outcomes, and increasing continuity of care? |

**Potential Methods Examples:**

- Cost-shift analysis among care coordinated group and matched members
- Surveys of members

**Policy/Program Levers:**

- Targeting methodologies
- Investment levels and strategies
- Models of interventions
- Health neighborhood partnerships

# Topic: Care Coordination

**Scope 1:** What is the impact of care coordination on access, member experience, and equity?

- Which complex populations are utilizing care coordination, and which populations are targeted for care coordination but are not getting it?
- Of those who do connect to care coordination, what is the duration and frequency of use, including consecutive monthly engagement? Are there differences by care coordination model and/or member group? By RAE?
- **Member Experience:** What do members think about the quality of their care coordination experience? Target surveys by group (e.g., members with a recent monthly CC engagement, members who went through the care planning process then nothing additional)
- Among members who had a recent care coordination interaction, was their need met, did they feel adequately supported?
- Of health neighborhood organizations that RAEs list as partners, what is their perspective on the efficacy of care coordination efforts for the people they serve?

# Topic: Care Coordination

## Scope 2: What is the impact of care coordination on cost and quality outcomes?

- **Cost:** Do members who receive care coordination have a shift in total costs toward less acute, lower cost services over time?
- **Quality:** Do members who receive care coordination have improved clinical quality outcomes ?
- **Access:** Is continuity of care improved for members who receive complex care coordination interventions?
- **Cost:** Is our investment in care coordination delivering on the value we hoped to see? Are certain models or implementation strategies more value-added than others?


# Tamara Keeney

tamara.keeney@state.co.us