Regional Accountable Entity

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology
SFY 2022-2023

COLORADO
Department of Health Care Policy & Financing

This document includes the details for calculations of the Regional Accountable Entity Key Performance Indicators for the seven Regional Accountable Entities

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INTRODUCTION

Overview

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology document describes the approach the Department and IBM Watson Health (Truven Analytics) uses for calcuating the KPIs and historical KPIs of the ACC program.

Incentive Payments are a central component of ACC Pay-for-Performance payments. Since the initiation of the ACC Program, the Department has made incentive payments for performance on identified Key Performance Indicators (KPIs) to signal program-level goals and objectives; encourage improved performance at the PCMP and regional level; and reward Regional Accountable Entities and managed care entities for meeting certain levels of performance. In Phase II of the ACC, incentive payments for KPIs are one of four components of Pay-for-Performance. They complement the Performance Pool, the Behavioral Health Incentive program, and public reporting efforts.

The Phase II KPIs are designed to assess the functioning of the overall system and the individual RAEs and are not as focused on practice-level performance. For this reason, some of the measures are not traditional HEDIS or clinical measures. The Department has attempted to choose measures that indicate the RAEs' progress building a coordinated, community-based approach to serve the needs of Members, reduce costs, and promote health and wellbeing in their region.

Purpose

The purpose of this document is to describe the methodologies used to calculate KPI performance incentive payments for Regional Accountable Entities (RAEs) participating in the Accountable Care Collaborative (ACC) in State Fiscal Year (SFY) 22-23.

Scope

This document addresses only the methodology utilized to calculate the ACC KPIs and historical ACC KPI program measures. Though the Risk Adjusted PMPM measure is a KPI, it is not included in this document. Specification details can be found on the ACC Phase II Provider and Stakeholder Resource Center, under KPI, or can be downloaded here (Please note: This link will download an excel file, it will not bring you to a webpage).

Document Maintenance

This document will be reviewed annually at the start of the new State Fiscal Year and updated as necessary. This document contains a Revision History log on the Document Information page (see page iv). When changes occur, the version number will be updated to the next increment as well as the revision date and change description. Unless otherwise noted, the author of the revision will be the document's author, as identified in the Document Identification table, which is also on the Document Information page.

DATA REQUIREMENTS

The KPIs are calculated for Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) participating in the Accountable Care Collaborative (ACC) program based on the members' utilization of services.

Background

ACC population: Four dollars and twenty-one cents of the per-member per-month (PMPM) payment to each RAE is withheld by the Department of Health Care Policy and Financing (the Department). Approximately two-thirds of this amount is available for RAEs to earn on the following KPIs:

- Behavioral Health Engagement
- Oral Evaluation, Dental Services
- Child and Adolescent Well Visits
- Prenatal Engagement
- Emergency Department (ED) Visits
- Risk Adjusted PMPM

Each KPI calculation is based on the utilization of services by the population enrolled in the ACC. The following sections describe the differences in the methodologies used to calculate and evaluate these measures.

Evaluation and Baseline Period

Monthly, KPI performance is calculated. Each evaluation period is twelve rolling months of data based on service/eligibility dates allowing for three months of claims runout. The baseline period is calculated for: Dental Visits, Child and Adolescent Well Visits, Prenatal Engagement, ED Visits, Risk Adjusted PMPM and retired KPIs (see 3.1.7, 3.1.8, and 3.1.9).. The baseline for State Fiscal Year 2023 is July 1, 2020 through June 30, 2021, or SFY2020-21.

Baseline Population

All members with full Medicaid are mandatorily enrolled into the ACC program. All baseline and evaluation period populations will include all members with full Medicaid residing in each of the seven regions.

> Note: Full Medicaid is defined as having a primary benefit plan of Medicaid State Plan Title Nineteen (PRMY_BPLAN_CD='TXIX') in the ACC Snapshot.

Medicaid Enrollment:

Oral Evaluation, Dental Services; Prenatal Engagement; Well Visits in the first 30 months of life and Child and Adolescent Well Visits include all members who have full Medicaid at the end of the evaluation period according to the ACC Snapshot. ED Visits includes members who have full Medicaid any time during the evaluation period. Enrollment at the end of the evaluation period is not required. This is because ED Visits is a PKPY metric and is based off an event or events that can occur at any time during the evaluation period.
Behavioral Health Engagement will be based on the regional penetration rate and use of the six short-term behavioral health therapy codes for SFY22-23.

Exclusions:

Members who are enrolled in any physical health Medicaid managed care plan for more than three months any time during the baseline period. This exclusion applies to all KPIs except the Child and Adolescent Well Visits measure, which has criteria for continuous enrollment.

> Note: these members are identified by the managed care enrollment spans on the ACC Snapshot (MTH_ACC_CLNT_SNPSHT_V). Please note that retroactive enrollment changes are not captured in the ACC snapshot. There are instances where enrollment spans change, which cause misalignment between the current record of enrollment (CLNT_ENRL_FACT_V) and the ACC Snapshot. The ACC Snapshot is used for this exclusion.

Evaluation Population

The KPI population varies slightly by KPI:

ACC Enrollment:

Behavioral Health Engagement; Oral Evaluation, Dental Services; Prenatal Engagement; Well Visits in the first 30 months of life, and Child and Adolescent Well Visits include all members who are enrolled in the ACC program at the end of the evaluation period according to the ACC Snapshot.
ED Visits includes members who were enrolled in the ACC at any time during the evaluation period. Enrollment at the end of the evaluation period is not required. This is because ED Visits is a PKPY and is based off an event or events that can occur at any time during the evaluation period.

Exclusions:

Members who are enrolled in any physical health Medicaid managed care plan for more than three month any time during the evaluation period. Note: these members are identified by the managed care enrollment spans on the ACC Snapshot (MTH_ACC_CLNT_SNPSHT_V). Please note that retroactive enrollment changes are not captured in the ACC snapshot. There are instances where enrollment spans change, which cause misalignment between the current record of enrollment (CLNT_ENRL_FACT_V) and the ACC Snapshot. The ACC Snapshot is used for this exclusion.

Claims Selection Criteria

The following criteria are used to select the claims to calculate the KPIs:

Include:
Both facility and professional claims
Paid claims and Encounters (with three months runout)
Only current records
Last claim (after all adjustments have been taken)
Encounters:
Dental Visits will include dental encounters
Behavioral Health Engagement includes behavioral health and physical health encounters
Exclude
Deleted records

Payment Schedule

Incentive payment files will be submitted to DXC on the third Thursday of the third month of each quarter and will cover the 3-month measurement period from six months prior. For example, incentive payment files submitted at the end of March 2023 would correspond to performance from the July 1, 2022 – September 30, 2022 measurement period. Use the following table to monitor the monthly payment schedule.

July '22	Aug '22	Sept '22	Oct '22	Nov '22	Dec '22	Jan '23	Feb '23	March '23	April '23	May '23	June '23
								Submit incentive payment file for measurement period Jul 2022 - Sep 2022 (Q1)			Submit incentive payment file for measurement period Oct 2022 – Dec 2022 (Q2)

July '23	Aug '23	Sept '23	Oct '23	Nov '23	Dec '23
		Submit incentive payment file for measurement period Jan 2023 - Mar 2023 (Q3)			Submit incentive payment file for measurement period April 2023 - June 2023 (Q4)

KEY PERFORMANCE INDICATORS AND OTHER PROGRAM MEASURES

The section below outlines the steps for creating the KPIs and other measures. For detailed specifications, please refer to Appendix B: KPI Measure Specifications.

Overview

The data displayed within the Data Analytics Portal will allow the state, RAEs and PCMPs to view how their members are performing on six KPIs and three additional measures that are not paid out on. There are two tiers (targets) set for each KPI (with the exception of child and adolescent well visits), which determine how much of the withheld $4.21 each RAE can earn by meeting each tier. The seven KPIs are as follows:

- Behavioral Health Engagement
- Oral Evaluation, Dental Services
- Child and Adolescent Well Visits
- Prenatal Engagement
- Emergency Department (ED) Visits
- Risk Adjusted PMPM

Note: KPIs will be based on Paid Claims and Encounters. Telemedicine visits and services are included in KPI calculations as long as Department policy allows for reimbursement. See the most recent Code Value Set posted on the Department website for more details.

Note: Legacy Non-KPI Measures will be based on Paid Claims Only.

KPI: Behavioral Health Engagement

The denominator for Behavioral Health Engagement is all members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must receive at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit within the 12-month evaluation period.

Behavioral Health Engagement (%) = # Unique Members Who Received At least One Behavioral Health Service / # Unique Members Enrolled in the ACC

KPI: Dental Visits

The denominator for Dental Visits includes all members under age 21 who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must receive at least one oral evaluation within the 12-month evaluation period.

Dental Visits (%) = # Unique Members Who Received At least One Oral Evaluation / # Unique Members Enrolled in the ACC under age 21

KPI: Child and Adolescent Well Visits

The denominator for Child and Adolescent Well Visits includes members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must have the appropriate minimum number of well visits based on their age and according to HEDIS standards. This is a composite measure comprised of two HEDIS measures.

Child and Adolescent Well Visit Part 1 (HEDIS W30) (%) = # Children Who Had Six or More Well Visits with a Primary Care Provider On or Before Their 15th Month Birthday AND Had Two or More Visits Between the Child's 15-month Birthday and 30-month Birthday / # Children Who Turn 15 Months Old and 30 Months Old During the Performance Period

Child and Adolescent Well Visit Part 2 (HEDIS WCV) (%) = # of Children and Adolescents With One or More Well Visits During the Performance Period / # of Members Ages 3-21 as of the End of the Performance Period

KPI: Prenatal Engagement

The denominator for Prenatal Engagement includes all deliveries for members enrolled in the ACC as of the end of the rolling 12-month evaluation period. Members may have multiple deliveries within the evaluation period. To be counted in the numerator, members must have at least one prenatal visit within 40 weeks prior to the delivery and be Medicaid enrolled at least 30 days prior to the delivery.

Prenatal Engagement (%) = # of Deliveries with at Least One Prenatal Visit / # Deliveries

KPI: Emergency Department Visits PKPY (Risk Adjusted)

Member months for all members within the population as specified in Section 2.3 are included in the denominator for this measure. An ED visit will be counted in the numerator if it does not result in an inpatient admission. To normalize this measure, it is expressed as a per thousand member months per year (PKPY), meaning the rate is multiplied by 12,000 for the evaluation period. The PKPY is then risk adjusted using a RAE risk weight. The risk adjusted ED Visits PKPY will be used for payment. This risk adjustment methodology was updated for the baseline and target for SFY22-23.

Actual ED Visits PKPY = # ED Visits / # Member Months *12000

Risk Adjusted ED Visits PKPY = Actual ED Visits PKPY / Average ED RAE Risk Weight

RISK ADJUSTMENT

The ED Visit KPI is the only measure that is risk adjusted.

The methodology used for this measure is outlined below.

Overview

Healthcare cost and utilization for a given population are dependent on the health status of that population. When comparing the per capita experience of various member populations at a summary level, population-based risk adjustment makes the comparison more analytically valid by considering underlying member risk, by looking at member acuity, or level of severity of illness. Once the level of riskiness of a RAEs population is considered by weighting their results, we can make comparisons across RAEs in a meaningful way.

Diagnostic Cost Groupers (DCGs), a healthcare risk assessment method created and licensed through Verscend®, Inc., are used to risk adjust population-based performance and baselines. The DCG models are patient classification systems that evaluates and forecasts healthcare utilization and costs. The models use data from a specific timeframe to predict the healthcare cost of individuals. The predictions are based on the conditions and diseases for which an individual receives treatment over the past year, and the age and gender of the individual.

DCG Extract

Eligibility Records

DCGs are calculated for all Medicaid members for a given month. The following fields are utilized for eligibility:

- Member ID
- Age (in years) as of reporting period end date
- Gender
- Eligible months – number of months eligible (partial months are counted as full months)

Medical Claims

For members in the population, the following fields are required for medical claims:

- Member ID
- Diagnosis codes – all diagnosis codes – and which version, ICD-9/ICD-10
- Claim service start/end dates
- Service location – ER, inpatient, other
- Source – inpatient facility, outpatient, long-term care, diagnostics, DME, or other services
- Medical expenditure – total paid amount

Software Parameters

Verscend's DCG software allows for multiple configuration parameters to be set. The following are the parameters utilized for ED visits:

- Partial eligibility is allowed (i.e. partial month of eligibility);
- The risk adjustment model that is run is: Medicaid FFS All-Medical Predicting Concurrent Total Risk (#73)

Model Output

The outputs of the DCG software are raw cost risk score (ranging from 0.000 to 999.000) and an aggregated diagnostic cost grouper (ADCG) per member. The ADCG categorizes the raw cost risk scores into the five risk levels listed below.

DCG Range	ADCG Value
0.000 to 0.499	0.00 (very low risk)
0.500 to 0.999	0.50 (low risk)
1.000 to 2.499	1.00 (moderate risk)
2.500 to 7.499	2.5 (high risk)
7.500 and higher	7.50 (very high risk)

Rescaling

After running the DCG software, several calculations must be done to convert the raw cost risk scores into an ED visit risk weight by RAE region, as explained below.

Risk-Adjusted ED Visit Risk Score

The relationship of the risk score that is predicted by the DCG cost model to the member's cost is linear, meaning that the higher the cost for a member, the higher their risk score is. Due to the nature of ED Visits, when translating this cost risk score to ED Visits, the relationship is no longer linear. To account for this skewed relationship, the cost risk scores get categorized into "buckets" called diagnostic cost groups (DCGs), to better predict this utilization measure. Annually, Truven Health updates their ED Visit risk scale "buckets" based on Medicaid MarketScan data. ED visits risk score buckets are defined using the following criteria:

- (Claim Type O, C, M, B
- AND (Revenue Code in (0450, 0451, 0452, 0456, 0459, 0981)
- OR CPT Procedure Code in (99281, 99282, 99283, 99284, 99285)
- OR (Place of Service = 23
- AND CPT Procedure Codes >= 10030 and <= 69979)))

From the DCG, Truven Health generates an ED risk score for each member. The bucketed risk score is used to calculate ED Risk Adjustment. The bucketing is also used to do a transformation of the cost score into predicting ED likelihood. Below is the table of buckets.

DCG Risk Score Minimum	DCG Risk Score Maximum	ED Visit Risk Score
0.000	0.099	0.068
0.100	0.199	0.154
0.200	0.299	0.298
0.300	0.399	0.467
0.400	0.499	0.642
0.500	0.699	0.863
0.700	0.999	1.235
1.000	1.499	1.714
1.500	1.999	2.265
2.000	2.499	2.808
2.500	2.999	3.231
3.000	3.999	3.731
4.000	4.999	4.385
5.000	5.999	5.029
6.000	7.499	5.796
7.500	9.999	6.866
10.000	14.999	7.987
15.000	19.999	9.069
20.000	24.999	9.467
25.000	29.999	10.900
30.000	39.999	11.277
40.000	49.999	11.399
50.000	59.999	12.232
60.000	69.999	14.701
70.000	and higher	12.974

Rescaled Cost Risk Score

The ED risk score output is scaled based on the population from which Verscend derived its model (Medicaid MarketScan); therefore, to adjust these scores to the Colorado ACC population, the raw ED risk scores are divided by the overall ACC mean to calculate the rescaled ED risk score. Due to the high churn of the Medicaid population, a weighted average is used for the ACC mean. To calculate the weighted average, a member's raw ED risk score is multiplied by the number of months they are enrolled. Then, these values are summed for the entire population and divided by the total number of months of enrollment for the entire state.

Average ED risk score ∑(raw ED risk score x member months) / ∑(member months)

Rescaled ED risk score = raw ED risk score / average ED risk score

For example, if the ACC population consisted of the members in the example below, each member's raw ED risk score would be multiplied by their number of member months. This is then summed and divided by the total number of member months for everyone enrolled in Medicaid with full benefits (288.984/42 = 6.881), so the average ED risk score is 6.881. Then each member's raw ED risk score gets divided by this average to create the rescaled risk score, with those with higher risk being greater than 1.0 and those lower risk being less than 1.0.

Member	RAE Region	DCG Cost Score	Raw ED Risk Score	ED visits	Member Months	Raw ED Risk Score Member Months	Average ED Risk Score	Rescaled ED Risk Score
A	1	7.025	5.796	4	12	69.552	6.881	0.842
B	1	9.014	6.866	3	9	61.794	6.881	0.998
B	2	9.014	6.866	2	3	20.598	6.881	0.998
C	2	13.012	7.987	2	10	79.870	6.881	1.161
C	0	13.012	7.987	1	2	15.974	6.881	1.161
D	0	8.203	6.866	2	6	41.196	6.881	0.998
Total					42	288.984		

The raw DCG cost score will appear on the My Members dashboard as an indicator of overall cost risk for the member compared to other Colorado Medicaid members with full Medicaid benefits.

Risk-Adjusted ED Visits PKPY (ACC Statewide & by RAE Region)

The ED Visit risk score is used to calculate the risk-adjusted ED Visit PKPY using the following formulas:

Average ED risk weight (RAE, ACC or Medicaid) = ∑(rescaled ED risk score x member months) / ∑(member months)

Risk-Adjusted ED Visits PKPY = ED Visits PKPY / Average ED Risk Weight

Using the same example above, the Average ED Risk Weight for all members statewide enrolled in the ACC would be 0.991. Since members may switch RAEs during the year, their risk scores and ED visits will be scaled to reflect their membership months in each RAE. The Average ED Risk Weight for RAE 1 would be 0.909. The Average ED Risk Weight for all of Medicaid would be 1.000.

Aggregation	ED Visits PKPY*	Average ED Risk Weight (RAE)	Risk-Adjusted ED Visits PKPY
RAE 1	4000	0.909	4400
RAE 2	3692	1.123	3287
ACC	3882	0.991	3918
Medicaid	4000	1.000	4000

PAYMENT TIERS

Targets for Tier 1 and Tier 2 incentive payments are established by the Department. Targets are based on an improvement percentage as compared to regional RAE performance during a baseline period. Two different targets are set for each KPI: Tier 1 Target and Tier 2 Target, which equate to different incentive payment amounts if a tier is met during the evaluation period. The exceptions to the two-tier payment structure are the Oral Evaluation, Dental Services and Child and Adolescent Well Visit measures which will only have one tier.

Incentive Payment Amounts PMPM

Of the total $16.21 capitation, roughly one quarter - $4.21 - is withheld for payment on KPIs and Performance Pool measures. Of the total $4.21 withhold, approximately two-thirds will be distributed for KPI performance and one-third will be distributed for Performance Pool measures. Any unearned KPI dollars will also carry over and add to the Performance Pool incentive amount.

Payment for the KPIs will be established as follows:

KPI	Tier 1 Payment	Tier 2 Payment
Behavioral Health Engagement[1]	$0.3319 PMPM	$0.4525 PMPM
Oral Evaluation, Dental Services	N/A	$0.4525 PMPM
Child and Adolescent Well Visits P1	N/A	$0.2313 PMPM
Child and Adolescent Well Visits P2	N/A	$0.2313 PMPM
Prenatal Engagement	$0.3319 PMPM	$0.4525 PMPM
Emergency Department (ED) Visits	$0.3319 PMPM	$0.4525 PMPM
Risk Adjusted PMPM	$0.3319 PMPM	$0.4525 PMPM

Note: Payment amounts have been rounded, but the total amount to earn remains $2.7251 PMPM or 64.7% of the withhold. The remainder of the withhold is reserved for Performance Pool payments

[1] IBM does not currently pay out on this metric. The Department will calculate and pay this metric.

APPENDIX A: GLOSSARY

Acronym	Definition
ACC	Accountable Care Collaborative
BIDM	Business Intelligence and Data Management System and Services
CMS	Centers for Medicare and Medicaid Services
Colorado BIDM SharePoint site	The SharePoint site that is hosted by Truven Health for the BIDM project.
DCG	Diagnostic Cost Group
E&M	Evaluation and Management
ED	Emergency Department
HCPF	Health Care Policy and Financing
HEDIS	Healthcare Effectiveness Data and Information Set
KPI	Key Performance Indicator
MMP	Medicare-Medicaid Program
PCMP	Primary Care Medical Provider
PKPY	Per Thousand Per Year
PPA	Physician Performance Assessment
RAE	Regional Accountable Entity

APPENDIX B: KPI MEASURES SPECIFICATIONS

Behavioral Health Engagement

Last Updated: 8/10/2020
Measure Name: Behavioral Health Engagement

Owner: Colorado Department of Health Care Policy and Financing
Evaluation Period: Rolling 12 months; 90 days claims run out
Measure Description: Percent of distinct members who received at least one behavioral health service delivered in a primary care setting within the 12-month evaluation period or under the Capitated Behavioral Health Benefit within the 12-month evaluation period. The Department will calculate the Capitated Behavioral Health portion outside of this measure. Telemedicine claims are included in this measure and indicated by a Place of Service code. RAEs have discretion within specific policy parameters for the specific behavioral health services that can be reimbursed through telehealth. These codes have not been listed in the Code Value Set because they are part of the capitated behavioral health benefit.
The Department will also calculate the Baseline and final rate for this measure.

Denominator:
Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period
Denominator Units: Distinct count of members meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	RAE Enrolled Indicator='Y' Snapshot Date = last month of the evaluation period RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Numerator: Members in the denominator who have had at least one behavioral health visit billed in a primary care setting or a behavioral health encounter within the rolling 12-month rolling evaluation period.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	
Behavioral health visit in primary care for clients enrolled in FFS	1	CPT Code in **BH in PC Value Set**	and	During evaluation period
		(ENC_IND='N'	or	During evaluation period
Any behavioral health encounter within the evaluation period submitted by a physical health managed care excluding a BHO or RAE	1	ENC_IND = 'Y' and MC_PROV_TYP_CD not in ('31','85'))	or	During evaluation period
Any behavioral health encounter within the evaluation period	1	Any BH encounter (ENC_IND='Y' and HLTH_PGM_CDE in (BHO,		During evaluation period

		[placeholder for new code)] and CLM_STS_CD= 'P')		

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from this measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period (Per Decision Log #304)		>3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 20-21 regional penetration rate
Target	**Tier 1**: 1<5% improvement receives 75% of payment **Tier 2:** 5%+ receives 100% of payment.

Notes:
Multiple numerator events in an evaluation period for a unique member will only be counted once
All diagnosis codes on the claim will be considered, not just the primary diagnosis
This measure will be manually calculated by the Department. Only the fee-for-service component of the measure will be displayed on the Data Analytics Portal.
The Department will manually calculate this measure to include paid FFS Claims and the behavioral health services submitted via flat file until data is fully accessible in interChange.

Oral Evaluation, Dental Services

Last Updated: 7/1/2022

Measure Name: Oral Evaluation, Dental Services

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year. (Reference: CMS FFY 2022 Child Resource Manual and Technical Specifications and Value Set Directories)

Denominator:

Children who are under age 21 as of the last day of the measurement year. Report 9 age stratifications and a total rate. Payment will be dependent on Total Ages <1 to 20:

- Age < 1
- Ages 1 to 2
- Ages 3 to 5
- Ages 6 to 7
- Ages 8 to 9
- Ages 10 to 11
- Ages 12 to 14
- Ages 15 to 18
- Ages 19 to 20
- Total ages < 1 to 20

Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period

Denominator Units: Distinct count of members meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	Condition Description	Condition Description	Condition Description
Enrolled in the ACC	1	RAE Enrolled Indicator='Y' Snapshot Date = last month of the evaluation period RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Numerator: Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service

The unduplicated number of enrolled children who received an oral evaluation as a dental service during the measurement year. Check if beneficiary received an oral evaluation as a dental service.

- [CDT CODE] = D0120 or D0150 or D0145, AND
- [RENDERING PROVIDER TAXONOMY] code

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members	1		and	

included in the denominator				During evaluation period
Oral Evaluation	1	[CDT CODE] = D0120 or D0150 or D0145,	AND	
Rendering Provider Taxonomy Code	1	T.TXNMY_CD IN ('122300000X','1223P0106X','1223X0008X','125Q00000X','126800000X','1223D0001X','1223P0221X', '1223X0400X', '261QF0400X', '261QD0000X', '1223D0004X', '1223P0300X','124Q00000X', '261QR1300X', '204E00000X', '1223E0200X', '1223P0700X', '125J00000X', '1223X2210X', '261QS0112X', '1223G0001X', '1223S0112X', '125K00000X', '122400000X')		

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
	180 days during measurement year		

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 20-21 performance for members with full Medicaid residing in each RAE region
Target	The target of this measure will vary by RAE based on gap closure between the baseline and the department goal of 80%. There is only one tier for performance and payment. The target is 2.5% per quarter, for a cumulative gap closure of 10%.

Notes:
Multiple numerator events in an evaluation period for a unique member will only be counted once
All diagnosis codes on the claim will be considered, not just the primary diagnosis
Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
Only claims and encounters submitted through the MMIS (interChange) will be used for this measure

Child and Adolescent Well Visits

Last Updated: 7/1/2021

Note: This KPI measure is structured differently in terms of baseline, target, specifications, and payment due to the Department's shift toward incorporating more standard measures.

Measure Name: Child and Adolescent Well Visits – This is a composite measure with Part 1 (HEDIS W30) for children 30 months and younger, and Part 2 (HEDIS WCV) for children and adolescents ages 3-21

Owners: Colorado Department of Health Care Policy and Financing and IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of children and adolescents who receive the appropriate minimum number of well visits for their age during the performance period as indicated in the HEDIS measure.

Part 1 (HEDIS W30):
Numerator: Number of members who had the following number of well child visits with a primary care provider in the last 15 months: 6 or more well child visits on different dates of service on or before the 15-month birthday; and two or more visits on different dates between the child's 15-month birthday and 30-month birthday.
Denominator: Children who turn 15 months old during the performance period and children who turn 30 months old during the performance period.

Part 2 (HEDIS WCV):
Numerator: Number of members with one or more well visits during the performance period.
Denominator: Members 3-21 years of age as of the end of the performance period.

The well visit codes that are counted for this measure are available in the proprietary HEDIS specifications. The questions and answers below provide additional detail about the measures for those who are unable to access the HEDIS specifications.

Question: What types of visits generally are included or not included in the definition of a well visit?
Answer: Any well visit procedure code or diagnosis code as recognized by HEDIS. In-person and telemedicine visits are permitted. Well visits include visits by a PCMP or OBGYN and does not have to be with the provider that a member is attributed to. Visits for immunizations only are not included in the calculation. For more information about well visit standards, view the Bright Futures guidelines.

Question: Which telemedicine well visits are permitted with these measures?
Answer: Any well visit code that HEDIS recognizes that has also been approved by Colorado Medicaid policy will be counted in this measure. Telemedicine options for children's well visits were not permitted until mid-November 2020, and this measure may be impacted by the timing of the public health emergency period and any subsequent telemedicine policy changes.

Question: Do multiple visits on the same date count toward the measure?
Answer: No, visits must be distinct with different service dates.
(Reference: CMS FFY 2022 Child Resource Manual and Technical Specifications and Value Set Directories)

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Continuous enrollment	Members must be continuously enrolled with no more than a one-time gap of 45 days during the performance period	N/A	SFY 2022-2023

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members are enrolled in hospice are excluded from the measure	OR	As of the last day of the performance period
Populations excluded from the measure	Members enrolled in a managed care organization (MCO) plan		Any length of time with the exception of a 45-day gap

Baseline and Targets

Condition Description	Detailed Criteria
Performance Period	The Performance Period will be SFY22-23.
Baseline	SFY20-21
Target	The target for both Part 1 and Part 2 of this measure will vary by RAE based on gap closure between the baseline and the national goal of 80%. There is only one tier for performance and payment. The target is 2.5% per quarter, for a cumulative gap closure of 10%. For Part 1 of the measure, the RAE must achieve the target for both age groups to receive payment.

Notes:
Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period. Only claims submitted through the MMIS (interChange) will be used for this measure

Prenatal Engagement

Last Updated: 9/20/2022

Measure Name: Prenatal Engagement

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of members who received a prenatal visit during pregnancy. Prenatal visits that are allowable for telemedicine are included in this measure as indicated by the OB global bill. Additional telehealth covered codes for OB-related appointments are listed in the telemedicine billing manual, such as codes for ultrasounds.

Denominator:

Members will be counted in the denominator if they meet the following criteria:
- Are enrolled in the ACC as of the last month of the evaluation period
- Have gender code= F
- Have had a delivery (as described below)

Denominator Units: Unduplicated count of deliveries meeting the above criteria. Members can have multiple deliveries within an evaluation period, but only one delivery within a 60-day period. Delivery logic will incorporate the earlier delivery date if two claims fall within 60 days of each other.

Denominator Eligibility/ACC Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period
Enrolled in Medicaid at least 30 days prior to delivery		• Medicaid Enrollment Effective Date<=30 days prior to the delivery	30 days
Gender		Gender Code = F	Female

Denominator: Number of deliveries

Detailed Criteria	# Event	Detailed Criteria	Criteria Connector	Timeframe
Women with a delivery procedure code	1	CPT Code in **Deliveries Value Set**	or	During evaluation period
	2	ICD-10 Procedure Code in **Deliveries Value Set**		

Denominator Exclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Exclude pregnancies not ending with a live birth		ICD-10-CM Codes in **Non-Live Births Value Set**		From the Delivery Date through 60 days after the delivery date

Numerator: Number of deliveries where the member had at least one prenatal visit prior to delivery
*Note: in the event that a delivery claim contains bundled services, the pre-natal visits will be counted in the numerator as long as pre-natal falls within the 40 weeks prior to the delivery date, including the delivery date.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Deliveries included in the denominator	1		and	
Prenatal Visit	1	CPT Code in **Prenatal Visits Value Set**	or	<= 40 weeks preceding delivery
	1	(CPT Code in **Office Visits Value Set**	and	Note: these criteria include service dates 40 weeks prior to the start of the evaluation period
	1	Modifier=TH)		

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Medicaid Enrolled	Medicaid enrolled at least 30 days prior to the delivery.		30 days prior to delivery

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 20-21 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1**: 1-5% improvement receives 75% of payment **Tier 2:** greater than 5% receives 100% of payment

Notes:

- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims submitted through the MMIS (interChange) will be used for this measure

Emergency Department (ED) Visits

Last Updated: 10/29/2020

Measure Name: Emergency Department (ED) Visits

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Number of emergency department visits per-thousand members per-year (PKPY) risk adjusted

The risk-adjustment methodology will be updated for the baseline and performance period when the adjusted DCG methodology is ready for implementation. Q1 baselines and targets currently follow the existing DCG methodology. Please refer to Section 4 for more details on this change and the methodology.

Denominator: Members will be counted in the denominator if they are enrolled in the ACC any month in the rolling 12-month evaluation period.

Denominator Units: Count of ACC member months

Denominator Eligibility Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	RAE Enrolled Indicator='Y' Snapshot Date = at least one month in the evaluation period RAE Enrollment End Date>=last day of each month	Last month of the 12-month rolling evaluation period

Numerator: Number of emergency department visits

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Emergency Department Visit	1	(Claim type in ('O','C','M','B') - Outpatient, Outpatient Crossover, Professional, Professional Crossover	and	During evaluation period
	1	(Revenue Code in **ED Visits Value Set**	or	During evaluation period
	1	CPT Code in **ED Visits Value Set**	or	During evaluation period
	1	(Claim with Place of Service = 23	and	During evaluation period
	1	CPT Code in **ED Visits 2 Value Set**)))		

Continuous Enrollment Criteria

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
ED visit ending in an inpatient admission	Claim type in (I, A) – Inpatient and Inpatient Crossover	and	On the same day as the ED visit or 1 day following
	Rendering provider type not in (20, 36) – Nursing facility, Home and Community Health Services		On the same day as the ED visit or 1 day following
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 20-21 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1**: 1-5% improvement receives 75% of payment **Tier 2:** greater than 5% receives 100% of payment

Notes:
Multiple ED claims in a single date of service will only be counted once
This measure will be reflected as a PKPY (Per Thousand per Year). PKPY Calculation = (Annual ED Visits/Member Months) x 12,000.
This measure is risk adjusted
All diagnosis codes on the claim will be considered, not just the primary diagnosis
Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
Only claims submitted through the MMIS (interChange) will be used for this measure

APPENDIX C: RAE BASELINES AND TARGETS

Measure	Baseline SFY 20-21	Tier 1 Target Value		Tier 2 Target Value	
Emergency Department PKPY	**Risk Adjusted PKPY**				
RAE1	470.361	465.66		446.84	
RAE2	481.828	477.01		457.74	
RAE3	490.38	485.48		465.86	
RAE4	419.422	415.23		398.45	
RAE5	498.503	493.52		473.58	
RAE6	454.037	449.50		431.34	
RAE7	540.361	534.96		513.34	
Behavioral Health Engagement	**Rate**				
RAE1	15.99%	16.15%		16.79%	
RAE2	15.55%	15.71%		16.33%	
RAE3	16.53%	16.70%		17.36%	
RAE4	18.13%	18.31%		19.04%	
RAE5	20.24%	20.44%		21.25%	
RAE6	18.93%	19.12%		19.88%	
RAE7	18.41%	18.59%		19.33%	
Well Visits Part 1 (First 15 months)	**Rate**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	64.70%	65.08%	65.47%	65.85%	66.23%
RAE2	58.20%	58.75%	59.29%	59.84%	60.38%
RAE3	63.10%	63.52%	63.95%	64.37%	64.79%
RAE4	57.20%	57.77%	58.34%	58.91%	59.48%
RAE5	64.50%	64.89%	65.28%	65.66%	66.05%
RAE6	58.40%	58.94%	59.48%	60.02%	60.56%
RAE7	59.60%	60.11%	60.62%	61.13%	61.64%
Well Visits Part 1 (15-30 months)	**Rate**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	65.60%	65.96%	66.32%	66.68%	67.04%
RAE2	54.90%	55.53%	56.16%	56.78%	57.41%
RAE3	60.20%	60.70%	61.19%	61.69%	62.18%
RAE4	53.90%	54.55%	55.21%	55.86%	56.51%
RAE5	64.20%	64.60%	64.99%	65.39%	65.78%
RAE6	58.30%	58.84%	59.39%	59.93%	60.47%
RAE7	54.80%	55.43%	56.06%	56.69%	57.32%

Well Visits Part 2 (3-21 years)	**Rate**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	42.50%	43.44%	44.38%	45.31%	46.25%
RAE2	37.20%	38.27%	39.34%	40.41%	41.48%
RAE3	45.60%	46.46%	47.32%	48.18%	49.04%
RAE4	35.30%	36.42%	37.54%	38.65%	39.77%
RAE5	52.00%	52.70%	53.40%	54.10%	54.80%
RAE6	41.60%	42.56%	43.52%	44.48%	45.44%
RAE7	36.00%	37.10%	38.20%	39.30%	40.40%
Oral Evaluation, Dental Services *(Targets are pending approval from the Department)*	**Rate**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	49.11%	50.34%	51.57%	52.79%	54.02%
RAE2	49.02%	50.25%	51.47%	52.70%	53.92%
RAE3	50.65%	51.92%	53.18%	54.45%	55.72%
RAE4	47.45%	48.64%	49.82%	51.01%	52.20%
RAE5	54.48%	55.84%	57.20%	58.57%	59.93%
RAE6	49.63%	50.87%	52.11%	53.35%	54.59%
RAE7	47.38%	48.56%	49.75%	50.93%	52.12%
Prenatal Visits	**Rate**	**Tier 1 Target Value**		**Tier 2 Target Value**	
RAE1	56.61%	57.18%		59.44%	
RAE2	64.17%	64.81%		67.38%	
RAE3	62.79%	63.42%		65.93%	
RAE4	69.24%	69.93%		72.70%	
RAE5	74.05%	74.79%		77.75%	
RAE6	57.03%	57.60%		59.88%	
RAE7	65.93%	66.59%		69.23%	