Regional Accountable Entity Key Performance Indicator Specification Document SFY 2023-2024

This document includes the details for calculations of Key Performance Indicator Measures for the seven Regional Accountable Entities.

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Revision History		
Document Date	Version	Change Description
06/29/2023	V1	Final KPI Document for SFY 23-24

Section 1: Introduction

Overview

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology document describes the approach the Department and IBM Watson Health uses for calculating 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. 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) 23-24.

Scope

This document addresses only the methodology utilized to calculate the ACC. Though the Risk Adjusted PMPM measure is a KPI, it is not included in this document. The Risk Adjusted PMPM Specifications can be downloaded here (Please note: This link will download an excel file, it will not bring you to a webpage).

Health First Colorado acknowledges that we are required to meet the goals and objectives of EPSDT in addition to CMS Core Metrics. ACC KPI Metrics reflect our-commitment to achieving high quality care for both programs.

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. 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.

Section 2: Data Requirements

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 thirty-four 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:

- Screening for Depression and Follow-up Plan
- Oral Evaluation, Dental Services
- Child and Adolescent Well Visits
- Prenatal and postpartum Care
- 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.

Note: KPIs will be based on CMS Core Measure Technical Specifications. Telemedicine visits and services are included in KPI calculations if specifications allow. See the most recent Code Value Set posted on the Department website or the CMS Core Measure Reporting Resources for more details.

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: Oral Evaluation, Dental Services; Child and Adolescent Well Visits; Prenatal and Postpartum Care; ED Visits; and Risk Adjusted PMPM. The baseline for State Fiscal Year 2024 is July 1, 2021, through June 30, 2022, or SFY2021-22.

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:

1. Screening for Depression and Follow-up Plan; Oral Evaluation, Dental Services; Prenatal and Postpartum Care; 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.
2. 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.

Exclusions:

1. 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:

1. Screening for Depression and Follow-Up Plan; 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.
2. 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:

1. 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 measures:

- 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 Encounter Data
- Behavioral Health Encounter Data

Exclude:

- Deleted records
- MCO and CHP+ Encounter Data

Supplemental Data

The following data may be incorporated into appropriate measures where available and appropriate:

- Colorado Immunization Registry (CIIS)
- Clinical/EHR Data
- Laboratory Data
- Vital Records Data

Section 3: Baselines and Targets

Evaluation and Baseline Periods

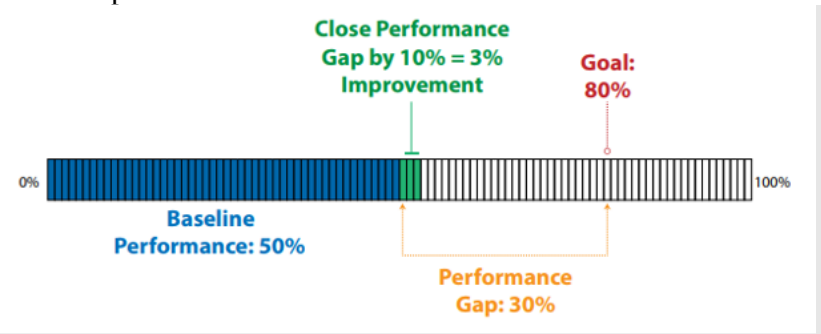
Performance Period: July 1, 2023 through June 30, 2024
Baseline Period: July 1, 2021 through June 30, 2022

Calculation of Department Goals

Measures in the KPI Program that are using national standards have Department Stretch Goals typically based on the NCQA 90th percentile for all Medicaid Lines of Business, when available.

Gap Closure

Each RAE will be responsible for closing gaps for specific measures during the performance year. Please see the example below.



Baselines and Targets

Indicator 1: Depression Screening and Follow-Up Plan (Screening)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	9.45%	17.48%	11.46%	13.47%	15.48%	17.48%
2	16.21%	23.57%	18.05%	19.89%	21.73%	23.57%
3	16.65%	23.96%	18.48%	20.31%	22.14%	23.96%
4	17.02%	24.30%	18.84%	20.66%	22.48%	24.30%
5	15.90%	23.39%	17.75%	19.59%	21.44%	23.39%
6	14.07%	21.64%	15.96%	17.86%	19.75%	21.64%
7	33.35%	38.99%	34.76%	36.17%	37.58%	38.99%
HCPF	17.68%	89.79%				
Indicator 1: Depression Screening and Follow-Up Plan (Follow-Up Plan)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	18.84%	25.21%	20.43%	22.02%	23.61%	25.21%
2	13.19%	20.12%	14.92%	16.66%	18.39%	20.12%
3	15.17%	21.90%	16.85%	18.54%	20.22%	21.90%
4	14.85%	21.62%	16.54%	18.23%	19.92%	21.62%
5	7.55%	15.05%	9.42%	11.30%	13.17%	15.05%
6	16.43%	23.04%	18.08%	19.73%	21.39%	23.04%
7	22.89%	28.85%	24.38%	25.87%	27.36%	28.85%
HCPF	16.86%	82.50%				
Indicator 2: Oral Evaluation, Dental Services						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	49.29%	52.36%	50.06%	50.83%	51.59%	52.36%
2	47.95%	51.16%	48.75%	49.55%	50.35%	51.16%
3	51.22%	54.10%	51.94%	52.66%	53.38%	54.10%
4	47.49%	50.74%	48.30%	49.12%	49.93%	50.74%
5	54.73%	57.26%	55.36%	55.99%	56.63%	57.26%
6	50.74%	53.67%	51.47%	52.20%	52.93%	53.67%
7	49.36%	52.42%	50.13%	50.89%	51.66%	52.42%
HCPF	50.33%	80%				
Indicator 3a: Well-child Visits in the first 30 months of life (part 1)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	63.19%	63.67%	63.31%	63.43%	63.55%	63.67%
2	58.02%	59.02%	58.27%	58.52%	58.77%	59.02%
3	59.00%	59.90%	59.23%	59.45%	59.68%	59.90%
4	57.12%	58.21%	57.39%	57.66%	57.94%	58.21%
5	61.34%	62.01%	61.51%	61.67%	61.84%	62.01%

6	56.77%	57.89%	57.05%	57.33%	57.61%	57.89%
7	56.38%	57.54%	56.67%	56.96%	57.25%	57.54%
HCPF	59%	68%				
Indicator 3a: Well-child Visits in the first 30 months of life (part 2)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	65.15%	66.44%	65.47%	65.79%	66.11%	66.44%
2	54.23%	56.61%	54.82%	55.42%	56.01%	56.61%
3	61.96%	63.56%	62.36%	62.76%	63.16%	63.56%
4	58.54%	60.49%	59.03%	59.51%	60.00%	60.49%
5	64.90%	66.21%	65.23%	65.56%	65.88%	66.21%
6	57.59%	59.63%	58.10%	58.61%	59.12%	59.63%
7	56.83%	58.95%	57.36%	57.89%	58.42%	58.95%
HCPF	61%	78%				
Indicator 3b: Child and Adolescent Well-care Visits						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	40.58%	42.82%	41.14%	41.70%	42.26%	42.82%
2	33.96%	36.86%	34.69%	35.41%	36.14%	36.86%
3	42.08%	44.17%	42.60%	43.13%	43.65%	44.17%
4	36.48%	39.13%	37.14%	37.81%	38.47%	39.13%
5	49.17%	50.55%	49.52%	49.86%	50.21%	50.55%
6	40.08%	42.37%	40.65%	41.23%	41.80%	42.37%
7	34.03%	36.93%	34.75%	35.48%	36.20%	36.93%
HCPF	39.00%	63.00%				
Indicator 4: Prenatal and Post-Partum Care (Prenatal)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	51.02%	55.12%	52.04%	53.07%	54.09%	55.12%
2	56.24%	59.82%	57.13%	58.03%	58.92%	59.82%
3	65.24%	67.92%	65.91%	66.58%	67.25%	67.92%
4	64.01%	66.81%	64.71%	65.41%	66.11%	66.81%
5	72.87%	74.78%	73.35%	73.83%	74.30%	74.78%
6	60.98%	64.08%	61.76%	62.53%	63.31%	64.08%
7	58.98%	62.28%	59.81%	60.63%	61.46%	62.28%
HCPF	62.00%	92.00%				
Indicator 4: Prenatal and Post-Partum Care (Postpartum)						
RAE	**Baseline (SFY 21-22)**	**Target (SFY 23-24)**	**Q1 Target**	**Q2 Target**	**Q3 Target**	**Q4 Target**
1	40.06%	44.45%	41.16%	42.26%	43.36%	44.45%
2	41.47%	45.72%	42.53%	43.60%	44.66%	45.72%
3	47.38%	51.04%	48.30%	49.21%	50.13%	51.04%
4	50.00%	53.40%	50.85%	51.70%	52.55%	53.40%

5	53.65%	56.69%	54.41%	55.17%	55.93%	56.69%
6	51.43%	54.69%	52.24%	53.06%	53.87%	54.69%
7	38.76%	43.28%	39.89%	41.02%	42.15%	43.28%
HCPF	47.00%	84.00%				

Indicator 5: Emergency Department Visits			
RAE	**Baseline (SFY 21-22)**	**Tier 1 Target**	**Tier 2 Target**
1	509.37	504.28	483.90
2	616.42	610.26	585.60
3	559.54	553.94	531.56
4	471.35	466.64	447.78
5	617.64	611.46	586.76
6	471.93	467.21	448.33
7	620.42	614.22	589.40
HCPF			

Indicator 6: Risk Adjusted PMPM	
RAE	**Baseline (SFY 21-22)**
1	$418.90
2	$385.36
3	$462.85
4	$400.15
5	$444.42
6	$455.70
7	$459.46
HCPF	$439.97

Section 4: Payment Information

Payment Tiers

Targets for 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 the ED Visits 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 remaining measures will only have one payment tier.

Incentive Payment Amounts PMPM

Of the total $16.70 capitation, roughly one quarter - $4.34- is withheld for payment on KPIs and Performance Pool measures. Of the total $4.34 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
Screening for Depression and Follow-Up Plan	N/A	$0.4679 PMPM
Oral Evaluation, Dental Services	N/A	$0.4679 PMPM
Child and Adolescent Well Visits P1	N/A	$0.2339 PMPM
Child and Adolescent Well Visits P2	N/A	$0.2339 PMPM
Prenatal and Postpartum Care	N/A	$0.4679 PMPM
Emergency Department (ED) Visits	$0.3478 PMPM	$0.4679 PMPM
Risk Adjusted PMPM	See Measure Detail	See Measure Detail

Note: Payment amounts have been rounded, but the total amount to earn is$2.8073 PMPM or 64.7% of the withhold. The remainder of the withhold is reserved for Performance Pool payments

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 2024 would correspond to performance from the July 1, 2023 – September 30, 2023 measurement period. Use the following table to monitor the monthly payment schedule.

July ‘23	Aug ‘23	Sept ‘23	Oct ‘23	Nov ‘23	Dec ‘23	Jan ‘24	Feb ‘24	March ‘24	April ‘24	May ‘24	June ‘24
								Submit incentive payment file for measurement period Jul			Submit incentive payment file for measurement period Oct

								2023 - Sep 2023 (Q1)			2023 – Dec 2023 (Q2)

July '24	Aug '24	Sept '23	Oct '24	Nov '24	Dec '24
		Submit incentive payment file for measurement period Jan 2024 - Mar 2024 (Q3)			Submit incentive payment file for measurement period April 2024 - June 2024 (Q4)

Section 5: Key Performance Indicators

Indicator 1: Depression Screening and Follow-up Plan

[Core Measure – Measure Steward - NCQA]

Measure Description

Percentage of beneficiaries age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.

The denominator for this measure includes beneficiaries age 12 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:

- Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
- Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 2: Oral Evaluation, Dental Services

[Core Measure – Measure Steward - DQA]

Measure Description

Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 3a: Well-child Visits in the first 30 months of life

[Core Measure – Measure Steward - NCQA]

Measure Description

Percentage of children who had the following number of well-child visits with a primary care practitioner (PCP). The following rates are reported:

- Well-Child Visits in the First 15 Months. Children who turned age 15 months during the measurement year: Six or more well-child visits.
- Well-Child Visits for Age 15 Months–30 Months. Children who turned age 30 months during the measurement year: Two or more well-child visits.

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 3b: Child and Adolescent Well-care Visits

[Core Measure – Measure Steward - NCQA]

Measure Description

Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 4: Prenatal and Post-Partum Care

[Core Measure – Measure Steward - NCQA]

Measure Description

Two Rates are Reported:

Timeliness of Prenatal Care: The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

Postpartum Care: Percentage of deliveries of live births on or between April 14 of the year prior to the measurement year and April 13 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.

Measurement Period

July 1, 2023 – June 30, 2024
Rolling 12 Months Reported Quarterly

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Measure Calculation

This measure will be calculated by the Department.

Measure Reporting Details

Please see Appendix B for links to detailed measure information and value sets.

Indicator 5: Emergency Department Visits

[Measure Steward - HCPF]

Emergency Department (ED) Visits

Measure Name: Emergency Department (ED) Visits

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.

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	1. RAE Enrolled Indicator='Y' 1. Snapshot Date = at least one month in the evaluation period 2. 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 21-22 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:

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

Indicator 6: Risk Adjusted PMPM

[Measure Steward - HCPF]

Payment Methodology:

- 100% Payment:
  - Less than the ACC average risk-adjusted PMPM during the performance period

- 50% Payment
  - Improvement (decline in risk adjusted PMPM over baseline) from baseline by any amount

Description:

1. Cost – total spent on Medicaid claims and capitations during 12-month period.

2. Member Month – member in the member monthly snapshot (Budget) or member had at least one claim in the month or member had at least one capitation in the month.

3. PMPM (per member per month) – sum (Cost) / sum (Total Member Months)

4. Risk Score (DCG) – concurrent non-rescaled risk score calculated in the final month of the 12-month period. Members need at least one record in the monthly snapshot during the 12-month period in which the member was not in PACE, Denver Health, Rocky Prime or a partial dual eligible member to get a risk score.

5. Weighted Population Average Risk Score – sum (Individual Risk Score * Individual Member Months) / sum (Individual Member Months). Total individual members only include those for members that have a risk score. This will be fewer than the member months used in the PMPM calculation since members cannot be retroactively eligible and receive a risk score.

6. Risk Adjusted PMPM – PMPM / Population Average Risk Score

You can find additional detail on the Risk Adjusted PMPM calculation on the ACC Phase II Provider and Stakeholder Resource Center ***webpage.***

Appendices

Appendix A: Quarterly Data Sharing

Schedule for Sharing Quarterly Data

Timeframes for metrics run by HCPF through Care Analyzer:			
Performance Period*	90 Day Runout Period Ends	HCPF Detailed Data Availability	RAE Detailed Data Availability
Jan 1 – Dec 31	30-Mar	30-Apr	15-May
Apr 1 – Mar 31	30-Jun	31-Jul	15-Aug
Jul 1 - Jun 30	30-Sep	31-Oct	15-Nov
Oct 1 – Sept 30	31-Dec	31-Jan	15-Feb
*Most recent 12 months of available data. This is updated every 3 months.			

Appendix B: CMS Core Measure Technical Specifications

Important information regarding Indicators 2-12:
The following measures are defined using the 2023 CMS Core Measure Set Technical Specifications and Value Set Directories. You can find the Reporting Resources at the links below for each of the following measures.

2023 CMS Adult Core Measure Set Reporting Resources
2023 CMS Child Core Measure Set Reporting Resources

Appendix C: Risk Adjustment Methodology

1. RISK ADJUSTMENT

The ED Visit KPI is the only measure that is risk adjusted using this methodology.
The methodology used for this measure is outlined below.

2. 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.

3. DCG Extract

4. 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)

5. 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

6. 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)

7. 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)

8. 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.

9. 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

10. 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

$$\frac{\sum(\text{raw ED risk score} \times \text{member months})}{\sum(\text{member months})}$$

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.

11. 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