Rocky Mountain Health Plans Prime

Medical Loss Ratio Specification Document

SFY 2020-2021

Objective: This document provides details concerning the
Medical Loss Ratio (MLR) metrics for the managed care organization, Rocky Mountain Health Plans Prime (Prime), that operates within Region 1 of the Accountable Care Collaborative (ACC).

Context: The MLR is a financial and policy tool that ensures at least 85% of managed care capitations are spent on medical care. To ensure that these expenditures support high quality care, four percent (4%) of the MLR is placed at risk for three (3) quality metrics. Prime may earn percentage points back as they achieve respective quality metrics. Metrics have been developed to reflect the populations and the benefits for which Prime is responsible and to align with broader programmatic and Department goals are improved health outcomes and cost containment.

TABLE OF CONTENTS

Heading	Description	Owner	Page #	Percentage Allocation
Revision History	Version Control Details	HCPF	3	-
Acronym List	List of common acronyms	HCPF	4	-
Baselines and Targets	Performance Baselines, Targets, and Methodology	HCPF	5	-
Calculation	Calculation Timeframes and Methodology	HCPF	6	-
Metric 1	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HCPF	7	1%
Metric 2	Emergency Department Rate	HCPF	8	2%
Metric 3	Housing and Health	HCPF	9	1%
Appendix 1	Housing and Health Deliverable Template	HCPF	10	-

Appendix 2	Social Needs Screening Deliverable Template	HCPF	15	

Revision History		
Document Date	**Version**	**Change Description**
6/30/2020	V1	
10/07/2020	V2	Clarifying revisions
10/15/2020	V3	Appendix addition
11/25/2020	V4	Social Screening Spec
1/6/2021	V5	Social Screening Template
5/10/2021	V6	SUD Metric Change

Acronym List

ACC – Accountable Care Collaborative
eCQM – Electronic Clinical Quality Measure
MCO – Managed Care Organization
MLR – Medical Loss Ratio
RMHP – Rocky Mountain Health Plans
SUD – Substance Use Disorder

Performance Pool Baselines and Targets

Metric	Baseline Performance	Performance Target
1: SUD Tx	14.46% 18 Practices Reporting	15.18% 25 Practices Reporting
2: ER Rate	771.12	747.99
3: Housing and Health	Quarterly Report and Meetings	Quarterly Report and Meetings

Performance Target Methodology

Performance Targets were determined using one of the following methods:

- For Metric 1, Prime is required to improve its performance by 5%;
- For Metric 2, Prime is required to improve its performance by 3%;
- For Metric 3, Prime is required to submit four (4) quarterly reports and participate in four (4) quarterly forums with the Departments and its partners.

The Department and Prime will review and update each metric's goals annually during the Spring in advance of the coming fiscal and contract year.

Calculation Timeframes and Payout Methodology

The Department and Prime will calculate performance for indicators on the following timeframe:

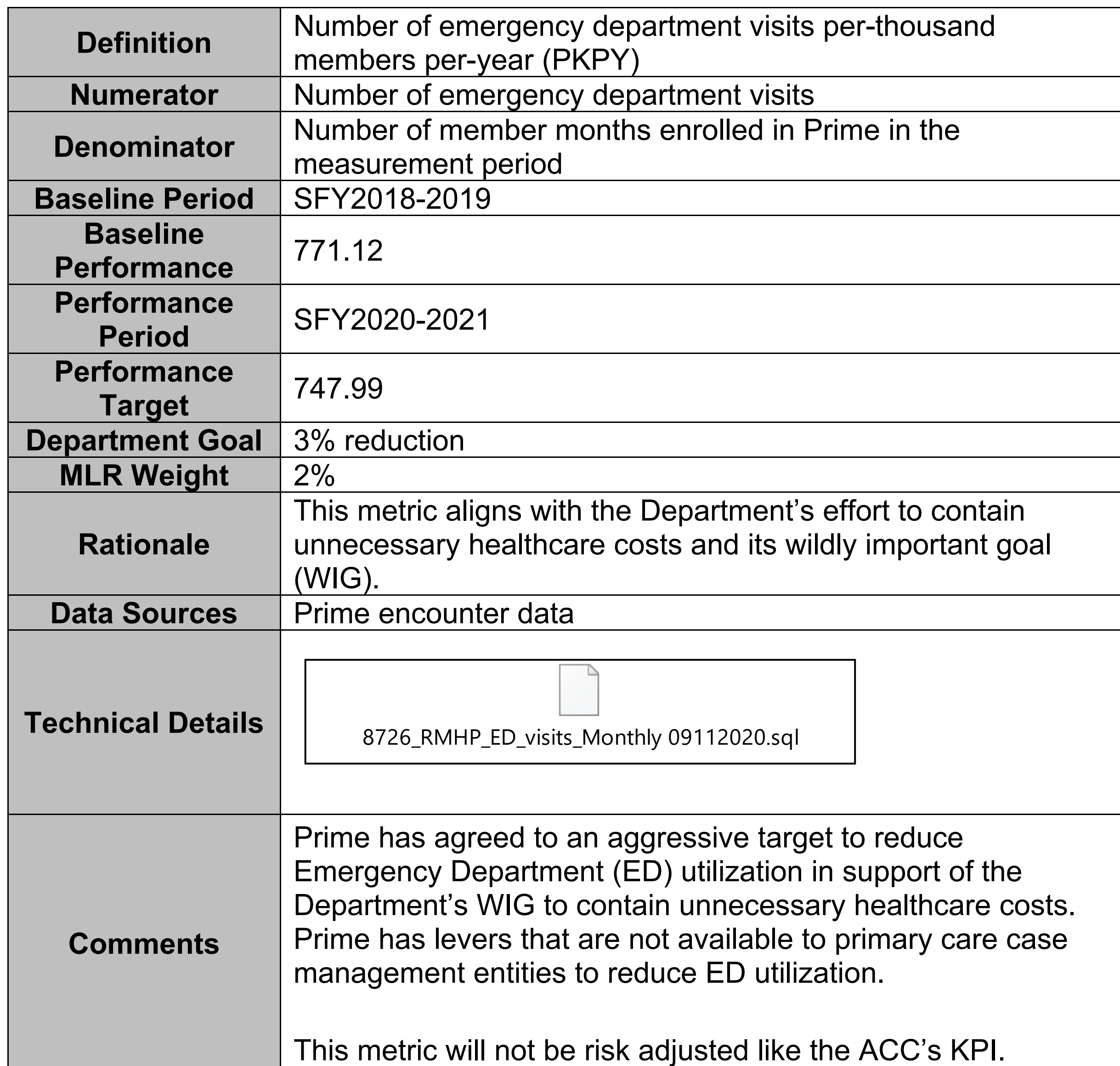
- Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Calculation Timeframe: March 2022
- Metric 2: Emergency Department Rate
  - Calculation Timeframe: November 2021
- Metric 3: Housing and Health
  - Calculation Timeframe: November 2021

Prime's MLR will begin at 89%, 4% above the national standard of 85%. The Department determine the percentage points earned for Prime's MLR once the performance for each metric is calculated. The final MLR will be determined and assessed by June 2022.

Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Definition	Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who initiated treatment within 14 days of the diagnosis
Numerator	Patients who initiated treatment within 14 days of the diagnosis
Denominator	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency during a visit between January 1 and November 15 of the measurement period
Baseline Performance	14.46% 18 Practices Reporting
Baseline Period	Calendar Year 2019
Performance Target	15.18% 25 Practices Reporting
Performance Period	Calendar Year 2021
Department Goal	5% improvement 7 Practices Reporting
MLR Weight	1%
Rationale	This metric fosters integration across behavioral and physical health benefits and supports the expansion of eCQM data infrastructure.
Data Sources	Aggregate clinical data via Google form submission submitted on a quarterly basis 45 days after the quarterly reporting period ends Prime will submit a list of reporting practices by June 30, 2021, and February 14, 2022 to assess the increase of practices reporting.
Technical Details	eCQM Google Form eCQM CMS 137 Part A Measure Specification
Comments	This measure was proposed in the Alternative Payment Model (APM) measure set but due to system difficulties was not selected. This measure allows the Department to better understand and develop systems strategies to improve performance. Data will be collected on a quarterly basis for performance monitoring purposes. The final submission will be used to evaluate the performance period. This measure has been amended in May 2021 from eCQM CMS 137 Part B to eCQM CMS 137 Part A.

Metric 2: Emergency Department Rate

Definition	Number of emergency department visits per-thousand members per-year (PKPY)
Numerator	Number of emergency department visits
Denominator	Number of member months enrolled in Prime in the measurement period
Baseline Period	SFY2018-2019
Baseline Performance	771.12
Performance Period	SFY2020-2021
Performance Target	747.99
Department Goal	3% reduction
MLR Weight	2%
Rationale	This metric aligns with the Department's effort to contain unnecessary healthcare costs and its wildly important goal (WIG).
Data Sources	Prime encounter data
Technical Details	 8726_RMHP_ED_visits_Monthly 09112020.sql
Comments	Prime has agreed to an aggressive target to reduce Emergency Department (ED) utilization in support of the Department's WIG to contain unnecessary healthcare costs. Prime has levers that are not available to primary care case management entities to reduce ED utilization. This metric will not be risk adjusted like the ACC's KPI.

Metric 3: Housing and Health

Definition	A quarterly deliverable describing the implementation and outcomes of a housing program and its strategies for Medicaid members enrolled in Prime. Additionally, Prime will participate in quarterly meetings with the Department and its partners collaborate on housing and health issues on a strategic level.
Numerator	N/A
Denominator	N/A
Baseline Performance	N/A
Baseline Period	N/A
Performance Target	Four (4) quarterly deliverables submitted forty-five (45) days after the end of the quarter and attendance at four (4) quarterly check in meetings hosted by the Department
Performance Period	SFY2020-2021
MLR Weight	1%
Rationale	This metric supports the Department's efforts to understand how housing and healthcare services can collaborate improve health and cost outcomes for members with complex needs.
Data Sources	Prime will submit quarterly deliverables in a format determined by the Department that describes the implementation of the initiatives, including outcomes, stakeholder participation, and interventions.
Technical Details	Deliverable Template See Appendix 1
Comments	The Department will facilitate workgroups with RAE Prime, DHMC, their partners, and the Division of Housing under the Department of Local Affairs to discuss and understand the implementation of housing initiatives. Discussions will also address new opportunities to partner and scale solutions for members. The Department intends to leverage a data sharing agreement with Department of Local Affairs and its Division of Housing to move this metric from a process measure to a health outcome metric. The Department will also use lessons learned from this metric to guide its approach for members with complex needs and its development of a population management dashboard for members experiencing housing instability.

Metric 4: Social Needs Screening

Definition	A semi-annual deliverable describing how social needs screening tools and programs connect to and re-enforce the Population Management Framework and key performance incentives within Prime
Numerator	N/A
Denominator	N/A
Baseline Performance	N/A
Baseline Period	N/A
Performance Target	N/A
Performance Period	SFY2020-2021
MLR Weight	
Rationale	This metric supports the Department's efforts to understand how social needs affect key health and utilization outcomes, how identified social needs inform population management strategies and interventions, specifically programming for complex members and condition management, and how the ACC creates a broader health community.

Data Sources	Prime will submit semi-annual report on February 14, 2021, and August 15, 2021, in a format determined by the Department that describes, at minimum, the following information:
	• Program Overview
	    ○ Screening Tool
	    ○ Workflow
	    ○ Data and Analytics Infrastructure
	    ○ Care Coordination and Condition Management
	• Key Metrics
	    ○ Demographics
	    ○ Prevalence of Social Needs
	    ○ Prevalence of Chronic Conditions
	    ○ Housing Overlap
	    ○ Health Care Utilization
	    ○ Care Coordination
	• Emerging areas of focus identified by data collected by Prime.
	Information, including strategies, interventions, and data, must be specific members enrolled in Prime.

Technical Details	Deliverable Template
Comments	

Appendix 1. Housing and Health Deliverable Template

MCO Name	
Reporting Period	[SFYXX-XX QX MM/DD/YYYY – QX MM/DD/YYYY]
Date Submitted	
MCO Contact	

The objective for this deliverable is to build collaboration across housing and health stakeholders at community and state levels for the purposes of:

1. Developing relations and working across agencies within the Continuum of Care to address the needs and improve the health of Medicaid members.
2. Building data capacity to identify which Medicaid members are housing insecure.
3. Evaluating and improving housing programs across the state of Colorado.

RMHP Prime and Denver Health Medicaid Plan are expected **to report on the progress of existing housing and health strategies and initiatives.** However, this template includes space for additional **reporting on collaborative efforts among stakeholders throughout the year to address a more comprehensive vision of housing and health for Medicaid members.**

RMHP Prime and Denver Health are expected to report on as much information and data as they have available each quarter. For sections that require cross-agency collaboration and where collective progress was not made, please state "not yet available" and state the reason why.

Housing and Healthcare Initiatives

(1) Please provide a description for your housing program including objectives, target population, program requirements, and length of services. Please also include a description of the role of your MCO. (If there is a logic model or guiding framework, attach in an appendix.)
Click or tap here to enter text.

(2) Please describe your MCO's role in this initiative. Include how your MCO more broadly sees its role in supporting the connections between housing and health.
Click or tap here to enter text.

(3) Please list any requirements for program participation (i.e. income, housing status, etc.).
Click or tap here to enter text.

Metrics	**Data**
Total individuals currently being served	
Number of individuals served by subpopulation 1 (e.g., people with SUD)	

Number of individuals served by subpopulation 2 (e.g., people with disabilities)	
Add lines as needed	

(4) **What are the services** – medical, behavioral, housing, and supportive – available to participants as part of the initiative? *Please place an "X" next to the type of service (medical, housing, or supportive service) and describe the funding source, such as Medicaid, housing authority, etc.*

Service Description	Medical	Behavioral	Housing	Supportive	Funding Source
Tenant orientation/move-in assistance					
Tenant's rights education/tenants council					
Case management					
Coordination of all resident services					
Psychosocial assessment					
Individualized service planning					
Individual counseling and support					
Referrals to other services and programs					
Crisis intervention					
Peer mentoring					
Recreational/socialization opportunities					
Support groups (list below)					
Legal assistance					
Transportation					
Meals					
Other nutritional services					
Emergency financial assistance (specify)					
Furnishings					

(5) Please list the partners involved in this PSH initiative and their roles.

Partner	Role

(6) Please describe the current phase of your program implementation.
Click or tap here to enter text.

(7) What have been the challenges of implementation so far? Please include broader challenges of the initiative as well as challenges that the MCO is experiencing.
Click or tap here to enter text.

(8) How has your MCO supported partners in explaining Medicaid covered benefits and expanding opportunities for services?
Click or tap here to enter text.

(9) What are the strengths of this housing initiative, and what opportunities exist for improving access to and quality of care for members?
Click or tap here to enter text.

Care and Utilization Outcomes	**Medicaid Participants**
Total Cost of Care (population & per capita)	
ER Rate	
Hospitalization Rate	
Care Coordination Engagement Rate	
BH Engagement Rate	
SUD Engagement Rate	
Acute Care Rate	
Wellness Care Rate	
Other (Fill in / Add rows	

Programmatic Outcomes	**Medicaid Participants**
Program Retention Rate	
Program Dropout Rate	

Justice Involvement Rate	
Recidivism Rate	
Employment Rate	
Health Condition Profile (below)	
Diabetes Prevalence	
Hypertension Prevalence	
HIV Prevalence	
SUD Prevalence	
Depression Prevalence	
Disability Prevalence	

*Outcomes and health metrics can be changed to reflect metrics that are captured by existing MCO evaluations. These metrics are suggestions.

(10) Please share one or two anecdotes that exemplify early success in the initiative, either from a member's perspective or from the community perspective.

Appendix 2. Social Needs Screening Deliverable Template

MCO Name	
MCO Region No.	
Contract Citation	
Reporting Period	[MM/DD/YYYY – MM/DD/YYYY]
Date Submitted	
Contact	

Social Needs Screening Program Overview

Social Needs Screening Tool

What tool(s) is used for Social Needs Screening? What domains are included in the screening tool? Is this a standardized tool?

Screening Workflow

Who is screened? Are screenings at the individual or household level? Who conducts screening? Where do screenings occur? What frequency are screenings conducted? Are screenings stand alone or with other assessments? What interventions occur after screening?

Data and Analytics Infrastructure

How are the screening results aggregated, analyzed and shared?

Social Needs and Care Coordination Stratification

How are social needs incorporated into the programming for complex members and condition management?

Social Needs Screening of Prime Members- Key Metrics

The following data points are sample data points and may be modified to ensure data presented is meaningful and reliable. Data will only include Prime Members.
Discussion of the data below will be included here.
Screening metric timeframes will be defined here.

Social Needs Screening Demographics	
Overall Screening Metrics	
Count of total social needs screenings for the most recent six month period	
Count of total unique Members screened within most recent six month period	
Count of total social needs screenings to date	
Count of total unique Members screened to date	
Percent of Total Population Screened	

Screening Metrics for Members Meeting Complex Criteria	
Count of total unique Members screened meeting the Complex criteria	
Percent of Members meeting the Complex criteria screened	
Screening Metrics for Members with a Labor and Delivery Claim in the Last Twelve Months	
Count of total unique Members screened with a labor and delivery claim in the last twelve months	
Percent of Members with a labor and delivery claim screened	
Screening Metrics for Members with a Diabetes Diagnosis	
Count of total unique Members screened with a diabetes diagnosis	
Percent of Members with a diabetes diagnosis screened	
Screening Metrics for Members with Substance Use Disorder (SUD)-related Claims	
Count of total unique Members screened with an SUD–related claim	
Percent of Members with an SUD-related claim screened	

Prevalence of Social Needs

Discussion of Data Below

Prevalence of Social Needs within the Screened Population					
	All Members Screened	Members meeting Complex criteria	Members with a labor and delivery claim	Members with diabetes	Members with an SUD claim
Food insecurity					
Housing instability & quality					
Transportation					
Utilities					
Interpersonal Violence					
Social Isolation					

Prevalence of Chronic Conditions

Discussion of Data Below.

Prevalence of Chronic Conditions					
	Members with no social needs	Members with one social need	Members with two social needs	Members with three social needs	Members with four or more social needs
SUD					
Depression					
Anxiety					
Diabetes					
Heart Disease/Failure					
Chronic Pain					

Housing Needs & Healthcare Utilization

Discussion of Data Below

Housing Needs & Healthcare Utilization				
	Members without steady housing	Members worried about losing their housing	Members with housing quality needs and worried about losing their housing	Members with housing quality needs
Total count of members				
Percent of Members with any housing need				
Average count of ER Visits				
Average PMPM Total Cost				
Percent of population with a well visit in the last 12 months				
Percent of population with any primary care visit in the last 12 months				
Percent of population with a Behavioral Health visit in the last 12 months				
Percent of population in extended care coordination				

Social Needs and Healthcare Utilization

Discussion of data below.

Social Needs and Healthcare Utilization							
		Housing	Utilities	Food	Transportation	Interpersona l Violence	Social Isolation
ER Visits	With Need						

	Without Need						
	Ratio						
Inpatient Admission	With Need						
	Without Need						
	Ratio						
Total Health Care Costs	With Need						
	Without Need						
	Ratio						

Care Coordination Metrics

Discussion of data below.

Care Coordination/Community Navigation					
	Total	Members meeting Complex criteria	Members with a labor and delivery claim	Members with diabetes	Members with SUD
Members who received care coordination due to a social need screening referral in the last quarter					
Members who received care coordination due to a social need screening referral to date					

Care Coordination Resolution of Need Metrics							
	Housing	Utilities	Food	Transportation	Interpersonal Violence	Social Isolation	Average Number of Needs
Members Engaged In Navigation							
Members with Resolved Needs							
Resolution Rate							

Conclusion & Emerging Areas of Focus

1. (example)
2. (example)
3. (example)