Colorado Department of Health Care Policy and Financing (HCPF)

Overview

HCPF subcontracts with various entities to administer certain health care programs, rather than administering programs directly. In most cases, the service level detail is overseen by Regional Care Collaborative Organizations (RCCOs). RCCOs connect members of Health First Colorado (Colorado's Medicaid Program) to providers and help members find services in their area. Among other things, RCCOs help providers communicate with Medicaid members and each other, so members receive coordinated care.

RCCOs are part of the state's Accountable Care Collaborative (ACC), Health First Colorado's primary health care program. The ACC, established in 2011, is a managed care arrangement that aims to improve members' health and help connect members' to services. The next phase of the ACC program is scheduled to begin in July 2018 when new contracts go into effect for the Regional Accountable Entities (RAEs), the new iteration of RCCOs and Behavioral Health Organizations (BHOs). Over the last six years, the ACC has shown progress in creating a health care delivery program that improves health outcomes, better manages care and is a smarter use of resources.

The ACC was designed with a long-term vision in mind, and the understanding that delivery system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate to improve member outcomes and reduce health care costs, and is poised to continue to do so in the future.[1] One important improvement will be to continue to move toward more coordinated and integrated care that increasingly rewards improved health outcomes. Additionally, the payment structure is changing for primary care medical providers; for the next phase the per-member-per-month payments will no longer be provided by the Department, rather the RAEs will support the primary care medical providers directly.

In addition to changes made in the next phase of the ACC, the Department, with input from stakeholders, is transforming payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is developing differential payment structures to change the way Colorado pays providers and is currently pursuing two different payment reform models; the first for primary care providers and the second for Federally Qualified Health Centers.

[1] Please see HCPF's "Research, Data and Grants" website for more information regarding ACC evaluation findings at https://www.colorado.gov/hcpf/research-data-and-grants.

Program Inventory

Traditionally, Colorado Results First reports have presented benefit-cost analyses, or return on investment projections, of evidence-based programs. To produce benefit-cost analyses through the Results First model, cost data for specific program activities is needed. Currently, HCPF is able to provide a per-member, per-month cost, based on a set amount paid to RCCOs per member, regardless of the service(s) members receive. Specific program activity costs were not available; RCCOs often do not provide specific program-activity details, including specific program activity costs, as budgeting is typically not done that way. Since specific program activity costs were not available, benefit-cost analyses are not included in this report. What is presented, however, are benefit projections. Benefit projections are an estimate of the monetary benefits that accrue as a result of a participant going through the evidence-based program. These projections are included to provide a general estimate of how beneficial an evidence-based program may be.

Given the particulars of HCPF's budgeting and expenditure processes, the Research and Evidence-Based Policy Initiatives team is presenting HCPF's program information in a program inventory, rather than in the traditional Colorado Results First report format. The program inventory identifies programs supported by the Department and their levels of evidence, and highlights the best available research demonstrating evidence of program efficacy and outcomes affected.

The Research and Evidence-Based Policy Initiatives team will continue to work with HCPF to identify ways that the information assessed through the Results First model and process can provide utility to the Department and providers, especially as the new iteration of the ACC rolls out in 2018. In particular, the team hopes this inventory can be used as a resource to identify programs that can improve health for Coloradans.

The program inventory contains the following information:[2]

- **Program Name:** Provides the name of the program as referred to by the Department.
- **Program Description**: Provides general information about the population served by the program and the program's purpose, goals, and operations.
- **Population(s) Served:** Provides who is intended to benefit from, or who participates in, the program.
- **Frequency/Duration:** Describes how long the program lasts.
- **Level of Research:** Lists the Research and Evidence-Based Policy Initiatives team's ranking of program research, as determined through an assessment of the available research on WSIPP's website and in the clearinghouses.[3]

[2] HCPF acknowledged that some health programs might not be fully reported, as the RCCOs that administer Health First Colorado programs report program information to the Department differently.
[3] Please see the section "Further Discussion on Definitions and Evidence Ratings" for more information regarding the clearinghouses used by the Research and Evidence-Based Policy Initiatives team.

- **Source(s) of Evidence**: Provides the name of the resource that contains program research, and the search term one can use to locate the research findings.
- **Evidence of program favorably impacting outcome(s)**: Indicates, based on national research, whether the program has been shown to favorably impact outcomes. If so, the outcomes are listed. For evidence-based programs, the outcomes must have: (1) statistical significance based on a meta-analysis of multiple, rigorous studies that measured the outcome,[4] or (2) statistical significance from one rigorous research study that measured the outcome,[5] and the research study had to have had a sample size (n) that was over 400. For evidence-informed/promising programs, outcomes must be listed in the clearinghouse's review of the program and be favorable.
- **Evidence of program having neutral or no impact on outcome(s)**: Indicates, based on national research, whether the program has been shown to have no impact, or a neutral impact, on outcomes. If so, the outcomes are listed. Outcomes included in this category are those that had no statistical significance based on either a meta-analysis of multiple rigorous studies or one single rigorous study.[6]
- **Evidence of program unfavorably impacting outcome(s)**: Indicates, based on national research, whether the program has been shown to unfavorably impact outcomes. If so, the outcomes are listed. To be included in this category, the adverse outcome must have statistical significance based on either a meta-analysis of multiple, rigorous studies or one single rigorous study.[7]
- **Projected Benefits:** Provides an estimate of the monetary benefits that accrue over the lifetime as a result of a participant going through the evidence-based program.[8] These projections are included to provide a general estimate of how beneficial an evidence-based program may be to the participant, taxpayers, and society, overall.
- **Provider(s):** Lists where in the state the program is being administered and/or provided.

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[4] Statistical significance defined as $p < 0.1$. Put in another way, the Research and Evidence-Based Policy Initiatives team deems an outcome as "favorable" if we can say with 90 percent or greater confidence that the outcome measured is due to the program.

[5] Ibid.

[6] Neutral effect defined as $p > 0.1$. Put in another way, the Research and Evidence-Based Policy Initiatives team deems an outcome as "neutral" if we cannot say with 90 percent or greater confidence that the outcome is not due to chance.

[7] Statistical significance defined as $p < 0.1$. Put in another way, the Research and Evidence-Based Policy Initiatives team deems an outcome as "unfavorable" if we can say with 90 percent or greater confidence that the outcome measured is due to the program.

[8] Program benefits are monetized over the lifetime of the participant, starting at the age the participant receives the program. For example, if a participant begins a program at age 16, benefits of the program are estimated from age 16 onward. Benefits of health programs may include future health care cost avoidance, benefits associated with a participant earning higher wages over their lifetime, and benefits associated with reduced mortality rates.