COLORADO
Department of Regulatory Agencies
Division of Insurance

Colorado Reinsurance Care Management Protocols 2020 Assessment Summary

Overview and Background

In order to promote more cost-effective health care coverage and to be prudent with federal taxpayer funds by restraining growth in federal spending commitments, Colorado House Bill 19-1168 stipulates that Colorado's Insurance Commissioner shall require each health insurance carrier eligible for the Reinsurance Program to file the care management protocols the carrier will use to manage claims within the payment parameters. The Commissioner shall establish by rule the deadlines for filing this information, along with the form and manner of filing.

In June 2020 the Division adopted New Regulation 4-2-71: Concerning Carrier Care Management Protocols for the Colorado Reinsurance Program (effective 8/15/20). As stated in the rule:

> *The purpose of this regulation is to establish carrier submission requirements for the Reinsurance Program Care Management Protocols, pursuant to § 10-16-1105(5), C.R.S. Care Management Protocols are to promote more cost-effective health care coverage and to be fair to federal taxpayers by restraining growth in federal health care spending commitments. Eligible Carriers are required to submit Care Management Protocols to confirm their strategies for managing claims within the Colorado Reinsurance Program Payment Parameters.*

Starting in 2020, all individual market carriers eligible for reinsurance payments must submit their care management protocols in their annual rate filings, using the Colorado Reinsurance Care Management Protocol Assessment developed by the Division (available here). The Assessment aims to capture the information required by Colorado statute and was informed by care management programs from state, federal, and commercial payers, including the Maryland Carrier State Reinsurance Program Accountability Report and the Centers for Medicare and Medicaid Services (CMS) Chronic Care Management services.

Key topics covered by the Reinsurance Care Management Protocol Assessment include:

- Identification of members who generate reinsurance-eligible claims
- Care management strategies, goals, activities, and providers furnishing care management services
- Payments to providers for care management services

- Savings to the Reinsurance Program resulting from care management

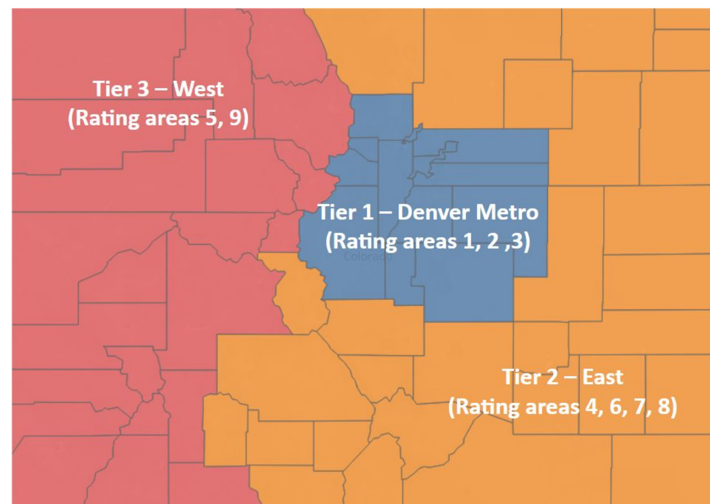
The Division plans to update the Assessment prior to the 2021 rate review period, based on carriers' responses and feedback from the 2020 Assessment. Topic areas that may be added or amended include:

- Member satisfaction surveys and feedback on care management services
- Geographic variation in care management strategies and goals
- Overlap and alignment between payer care management programs (including CMS)
- Addressing equity by including social determinants of health in member risk stratification
- Consistent savings measurement approach between carriers
- Financial counseling about out-of-pocket costs with reinsurance-eligible members
- More focus on reducing low-value care and increasing high-value care

Participating Carriers and Regions

All carriers offering individual health benefit plans in Colorado that comply with Affordable Care Act (ACA) requirements are eligible for the Reinsurance Program, and must complete the Reinsurance Care Management Protocol Assessment. Eight (8) carriers were eligible in 2020: Anthem (HMO Colorado), Bright, Cigna, Denver Health, Friday Health Plan, Kaiser Permanente, Oscar, and Rocky Mountain Health Plan. Carriers offer plans in various insurance rating areas throughout the state.

Colorado's Reinsurance Program is designed to reduce individual market premiums statewide, and to reduce premiums the most in areas of the state that historically have had the highest rates. The program achieves these region-specific savings goals using a tiered payment parameter structure - paying consumer claims more in higher cost areas, in order to reduce premiums more in those areas.The Reinsurance Program's three geographic tiers are shown here on the map.



Summary of 2020 Assessment Findings

All Colorado carriers eligible for the Reinsurance Program submitted Reinsurance Care Management Protocol Assessments during the 2020 rate review process. The Division reviewed all submissions for completion and to ensure carrier compliance with the statutory requirement

to implement care management protocols. All carriers submitted complete and timely assessments, and no objections were filed by the Division. Carrier responses to key questions from the 2020 Assessment are summarized below.

Identification of Reinsurance-Eligible Members

Colorado statute requires carriers to implement care management protocols for all members whose claims fall within the reinsurance payment parameters. To do so, carriers must first identify members whose annual claims are expected to exceed the $30,000 attachment point under the 2020 reinsurance payment parameters. Assessment responses indicate nearly all carriers use claims data algorithms, including diagnosis codes, pharmacy claims, and utilization data, to identify eligible members. Some carriers also use provider or care team referrals to identify potentially eligible members. Since claims data is retrospective, carriers typically use members' prior diagnoses, health care spend, and utilization to predict which members' claims will likely reach the reinsurance attachment point.

"Bright uses a proprietary identification and stratification algorithm based on pre-existing and compounding conditions, pharmacy utilization, and projected disease associated costs."

Most carriers risk-stratify their members into groups based on case complexity and chronic disease. A typical risk stratification paradigm classifies members into complex member groups, healthy member groups, and potential or emerging risk member groups. Carriers generally implement outreach plans to connect members in the complex and emerging risk groups with care management services and personnel. Outreach strategies may include phone calls, emails, electronic patient portal messages, and/or in-person assistance during provider visits.

The Division notes that identification of reinsurance-eligible members and subsequent member outreach efforts may be easier for carriers that are part of integrated delivery systems than for carriers that are entirely separate business entities from their provider partners. Integrated networks have less cumbersome and restrictive data sharing processes, which allows carriers to more easily access and analyze member data, including claims and other electronic medical record data. Such data is crucial to identify reinsurance-eligible members. Carriers with easier data access may be more successful in their reinsurance care management protocol implementation.

Care Management Strategies, Goals, Activities, and Providers

The Assessment asks carriers to describe their care management goals and strategies for identified members, including care management activities performed by providers and other care team members. Most carriers reported increasing health care value - through care quality enhancement and/or cost reduction - as a key goal of their care management work. Carriers also reported moving towards more patient-centered care approaches and helping members

improve or maintain their health as important goals. Carriers were adamant about providing the best possible care for members and removing barriers to care, especially for those with the greatest health care needs.

Steering Members to Appropriate Care Settings

"Denver Health Medical Plan uses care management protocols to ensure that the most cost-effective and appropriate services and treatment plans are delivered to members."

Nearly all carriers listed steering members to the most appropriate site of service ("right place") at the appropriate time ("right time") as a core component of their care management strategies. Such steerage may help reduce overall cost of care, as it generally reduces the number of unnecessary emergency room visits, and may also improve patient experience by providing more tailored and appropriate care.

Managing Chronic Conditions and Transitional Care

Management of multiple chronic conditions and transitional care management also emerged as important strategies for carriers. Members with comorbidities and those transitioning from acute care facilities to longer term or home-based care usually have significant care management and care coordination needs. These needs may include medication management, scheduling follow-up appointments, communication between health care providers and facilities, monitoring for duplicative services, and other types of member support.

Using Care Teams Effectively

Most carriers report relying on care teams consisting of many different roles and responsibilities to provide services for members with complex care needs. Care teams typically include clinical and non-clinical personnel, with nurses and social workers handling most of the direct member support. Primary care providers usually serve as the hub or quarterback of a care team, and coordinate activities and services with other providers as needed. Carriers noted that clear and consistent communication channels between providers are crucial for successful coordination.

"Anthem has a care management program focused on the role of primary care providers. This model promotes access to care, coordination of care, wellness and prevention by collaborating with primary care physicians in ways that allow them to successfully manage the health of their patients and thrive in a value-based reimbursement environment."

Exploring Innovative Approaches to Care Management and Cost Containment

One carrier uses an innovative care management program that helps members optimize use of available community resources in order to maximize their health coverage benefits and access high quality care in all settings. This carrier's care managers collaborate with members to

develop personalized care plans that focus on each member's self-identified health needs. These plans make optimal use of program benefits and available community resources, ensuring members can access the care they need, and helping to address the social determinants of members' health.

Pharmacy spending is another key area of interest for carriers. While most use pharmaceutical claims data to help identify members whose claims may be eligible for reinsurance, only a few carriers note using pharmacy utilization management in their broader care management strategies. One carrier assigns nurses to track reinsurance-eligible members and look for pharmaceutical programs that can help reduce drug costs for members with high-cost medications. While this approach does not impact drug selection, it may help reduce plan costs and member out-of-pocket spending on expensive medications. Carriers may continue exploring ways to shift members towards higher value, lower cost drugs.

Payments for Care Management Services

Carriers also report on reimbursement strategies and payment mechanisms for care management activities and services. Nearly all carriers provide per-member-per-month (PMPM) care management payments for members with complex cases or chronic conditions (i.e., members whose claims are likely reinsurance-eligible). These payments are often *not* claims-based or traditional fee-for-service (FFS) expenditures, since they may cover a broad range of services that occur at different times and places, depending on patients' needs. Carriers often include these PMPM payments in alternative payment models (APMs), which aim to increase quality of care while maintaining or reducing its cost.

One carrier offers a claims-based care management payment, similar to Medicare's Chronic Care Management (CCM) and Transitional Care Management (TCM) payments. Claims-based payments may be administratively easier for carriers than non-claims-based payments because they utilize existing claims processing mechanisms. However, these payments often include the same limitations as other FFS payments, namely, a lack of flexibility in coverage due to their prescriptive nature. One carrier reported offering no specific payments for care management.

"Payments made by [Kaiser] to Colorado Permanente Medical Group for patient care services including care management activities are not made on a claims basis, but are part of an annual contract and are made monthly based on a per member, per month formula. This allows for outcomes-based focus without fee-for-service constraints."

Carriers generally reported either contracting with care management companies to provide services (three carriers), or paying contracted providers directly for care management services (six carriers). While partnering with companies that specialize in patient care management may offer more consistent care across a carrier's member population, this approach risks disconnection between care managers and other members of the care team. Coordination and

communication between case managers and other providers is essential for its success. On the other hand, carriers that pay contracted providers directly for care management services must ensure all providers offer appropriate services and must compensate providers for additional services. Carriers' assessments did not show a preferred approach or best practice between partnering with care management companies or paying providers directly for care management.

Savings Resulting from Care Management

Nearly all carriers reported their care management protocols generate savings on total cost of care, compared to expected expenditures without care management. Carriers generally expect savings to result from fewer unnecessary emergency room visits and better management of comorbidities and chronic conditions. Some carriers noted prescription drug selection and management as another potential avenue for savings. While most carriers acknowledged the importance of preventive care, they did not expect prevention to drive significant savings. This may be more true for reinsurance-eligible members than for others, since the former group tends to have chronic conditions, making health maintenance the primary goal, rather than prevention.

"[Cigna's] financial goal is to continue driving savings of at least $4,200 per member per year while not compromising customer satisfaction, which was 95% in 2017."

Savings estimates, goals, and calculation methodologies vary between carriers. Some reported having specific savings targets per reinsurance-eligible member per year, compared to expected spending without care management. However, most carriers reported more general savings goals and did not provide specific line item breakdowns of their savings estimates. Carriers did not always specify whether their savings were reported on net, accounting for any additional payments for care management services. The Division plans to revise care management protocol assessment questions around savings to ensure more detailed and consistent responses from carriers going forward.

Finally, several carriers reported utilizing APMs to reimburse and reward providers for offering care management services. Shared savings models, where carriers share savings resulting from better care management with their contracted providers, are a common approach. Capitated or PMPM payments for care management enable providers to determine how best to use financial resources to improve care for patients and contain costs. Many carriers report moving towards these types of payment models, particularly for reinsurance-eligible members.

Conclusion

Carriers' first annual Reinsurance Care Management Protocol Assessment submission showed Colorado's insurance carriers are testing and implementing strategies to effectively manage care and contain costs for their highest needs members. The Division will use information gathered in this initial assessment to help explore best practices in member care management

for reinsurance-eligible members in Colorado’s individual market. The Division hopes to convene carriers to disseminate and discuss these experiences and lessons learned from care management protocol implementation. Carriers’ submissions and feedback will help inform updates to the annual Assessment, as well as inform broader policy efforts around care management and health care cost containment.