



**COLORADO**

Department of Health Care  
Policy & Financing

# Accountable Care Collaborative Phase II Overview of Key Concepts

*October 1, 2015*

The Accountable Care Collaborative (ACC) is the delivery system for Colorado Medicaid. The ACC Program is operated by Colorado's Single State Agency, the Colorado Department of Health Care Policy and Financing (the State Agency). The first ACC clients were enrolled in May 2011 and as of August 2015, more than 940,000 of the 1.26 million total Medicaid enrollees were in the ACC. Contracts for the Regional Care Collaborative Organizations (RCCOs), the foundation of the ACC, expire in July 2017, creating a key opportunity for the State Agency to evolve the program.

**The goal of the next iteration of the ACC is to optimize health for those served by Medicaid through accountability for value and client experience at every level and at every life stage.**

This document outlines a number of key concepts for the program in Phase II. This document, as well as a longer concept paper to be released in mid-October, serve as a request for our federal, state, and local partners to collaborate with us to build a more integrated health system, with the shared goal of improving the health of Coloradans served by Medicaid.

## Outcomes

The Accountable Care Collaborative is an outcomes-driven program. Outcomes for the next phase of the program, like those in the current phase, are built on the Triple Aim – improved experience, improved care and lower costs. Outcomes the State Agency aims to achieve in the next phase of the ACC are aligned with the Governor's State of Health, the Colorado State Innovation Model (SIM), and the Institute of Medicine Core Measure Set. Three key domains will be used to measure outcomes: **Improved Health, More Value, and Better Experience.**

## Phase II Structure

### Regional Accountable Entity

To reach a complete state of health, individuals and families served by Medicaid need access to services and support for their physical health, behavioral health, and social needs. To ensure innovation, flexibility, and local control, the ACC will continue to be delivered through seven regions in the state. The regional map will be similar to the current ACC map, with one exception – Elbert County will be part of Region Three (rather than Region Seven). In Phase II, one entity, the Regional Accountable Entity, will be responsible for duties currently performed by the Regional Care Collaborative Organization and Behavioral Health Organization. This will improve client, family, and provider experience by integrating administrative functions and responsibility for all services.

### Health Teams

To ensure access to care coordination services and health providers in Phase II, clients will be automatically and mandatorily enrolled in the ACC and immediately connected with a Primary Care

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Medical Provider. Like today, Primary Care Medical Providers must be medical practitioners with a focus on primary care. However, behavioral health providers, including Community Mental Health Centers, who meet the criteria are encouraged to become Primary Care Medical Providers. The Regional Accountable Entity will be responsible for supporting ongoing efforts to advance integrated health services that align and build upon integration efforts of SIM.

Many clients identify a variety of providers as core members of their Health Team including long-term services and supports case management agencies, behavioral health providers and particular specialists. To acknowledge the role of these additional providers in a client's care, the Primary Care Medical Provider will be part of a larger Health Team that will be responsible for providing care coordination services. Each Regional Accountable Entity will assist Primary Care Medical Providers, as needed, to develop relationships across a client's Health Team and will establish contracts with Primary Care Medical Providers, specialty behavioral health providers, and long term services and supports case management agencies.

### **Client Engagement**

Client engagement is a priority for Phase II. Each Regional Accountable Entity and provider will be expected to test various methods of client and family engagement and activation. Upon enrollment in the program, a screening will be conducted to identify the client's and family's behavioral health, physical health, social needs, and life stage. This screening will help clients and families identify goals and will help the Regional Accountable Entity and Primary Care Medical Provider identify appropriate Health Team members. Additionally, this screening will help to identify services for clients and families, including health maintenance services for healthy individuals, and allows the Regional Accountable Entity and Health Team to prioritize clients and families for care coordination.

In addition to the initial screening and engagement work, Regional Accountable Entities will be encouraged to use new technology to connect with clients and will be required to have 24-hour availability for both clients and providers. In addition, Phase II will include a statewide client incentive program that promotes healthy behaviors and appropriate use of the health care system.

Certain clients, such as clients engaged in the correctional system and children at risk of out of home placement, require additional support and coordination between state agencies. The State Agency and the Regional Accountable Entity will work to provide coordinated systems of care for these populations.

### **Practice Support**

Primary Care Medical Providers who directly engage with clients to maximize their health will continue to be the foundation of the Accountable Care Collaborative. To support and strengthen these practices, Regional Accountable Entities will have greater latitude to contract only with practices that meet established minimum requirements. Minimum requirements will be defined for both small practices and large practices in a way that encourages the participation of small practices. The State Agency will work with Health Team providers to ensure that program requirements do not place an undue burden on practices and are aligned with existing policies.

To address problems related to Primary Care Medical Providers located in communities on the borders of Regional Accountable Entity regions, clients will be enrolled in a Regional Accountable Entity based on their attribution to a PCMP, rather than by county of residence. This enrollment and attribution methodology will ensure that most Primary Care Medical Providers have a contractual relationship with just one or two Regional Accountable Entities.



## Health Neighborhood: Engaging Specialists and Hospitals

Some individuals served by Medicaid have episodically urgent or ongoing complex health needs that require a well-coordinated network of providers. In Phase II, specialists and hospitals that are involved in providing higher acuity services will be a more formal part of the program and join Primary Care Medical Providers and Health Teams as members of a Health Neighborhood. The Regional Accountable Entity will be responsible for ensuring access to specialty and hospital care and developing infrastructure that supports coordination between the Health Team and Health Neighborhood. In addition, the Regional Accountable Entity will be responsible for promoting and supporting the State Agency's electronic consultation and other telehealth initiatives.

## Community

Since an individual's health is impacted by many things other than clinical services, the Regional Accountable Entity will be responsible for convening non-medical community partners and engaging communities to address systems issues impacting the health of Medicaid clients and to improve population health. The Regional Accountable Entity will assist in creating interconnectivity between the Community and Health Neighborhood.

## Payment

In Phase II, payment methodologies will create accountability for whole person health outcomes and costs through value based payment models. The Regional Accountable Entities will be paid an administrative payment in a per member per month payment structure and have the opportunity to earn value-based or outcomes-based payments such as Key Performance Indicators or Shared Savings. However, to ensure more value is achieved in Phase II of the ACC, a much higher percentage of payments will be tied to value.

To support access to wellness services and services that are needed when a client is ill or injured, the State Agency is exploring provider payment methodologies that support the provision of high-quality, integrated, and efficient care. In Phase II, the Regional Accountable Entity will be responsible for making value-based administrative payments to Health Team providers with more than 1,000 attributed ACC clients.

Recognizing the importance of flexibility, innovation, and local variation, the ACC will continue to support payment methodologies for different regions and providers that promote value based purchasing. For example, the State Agency intends to build on current work to move towards an aligned, alternative payment methodology for federally qualified health centers and community mental health centers. In addition, the State Agency is continuing to explore various partial risk models that support integrated care delivery and build on payment methodologies currently being piloted in the first phase of the ACC program and through SIM.

## Sound Administration

The model of Phase II of the Accountable Care Collaborative is driven by accountability for value and client experience at every level and every life stage. The State Agency will invest in enhanced program oversight and program maximization efforts. Program oversight will be increased by strengthening deliverables through clearer contract requirements and templates; team-based contract management to leverage expertise and capacity across the State Agency; staff training; and leveraging stakeholders as part of the oversight and monitoring process. The State Agency will invest in program maximization



efforts, including technical assistance, to identify best practices and ensure that the program is attaining the most value possible.

## **Health Information Technology**

Health Information Technology (HIT) is foundational to every activity in Phase II. Regional Accountable Entities must maximize the use of State Agency systems and regional Health Information Exchange (HIE) network data to effectively coordinate care on a daily basis and to track changing Medicaid population demographics and utilization patterns. The Regional Accountable Entity will be required to offer practices support in the use of their own internal data and capturing care coordination information.

The State Agency will have the capability to formally link the additional Health Team members in the Medicaid Provider Portal, currently known as the Statewide Data and Analytics (SDAC) provider portal. The Medicaid Provider Portal will include, at a minimum, the names and contact information of the Health Team providers and client claims data. This will help to ensure clear lines of responsibility, facilitate more coordinated care, promote data sharing, and ensure that the Regional Accountable Entity is supporting the entire team. Phase II will include a strategy to ensure all Health Teams have access to a care coordination tool to support tracking, monitoring, and communication between Health Team members.

## **Conclusion**

Building on the successes of the current ACC Program, Phase II will bring a new focus on the provision of high-quality, integrated, person- and-family-centered, and whole-person services. The next phase of the ACC Program begins in July 2017.

