



ACC Request for Information (RFI) Executive Summary

July 2015

The Accountable Care Collaborative (ACC) is Colorado Medicaid's program that gives clients their full benefits while emphasizing coordinated care, cost savings, and good health outcomes. The ACC is designed to reward providers and Regional Care Collaborative Organizations (RCCOs) for care coordination and the wise use of health services—not just for delivering a high volume of services.

Colorado is preparing for the next version of the ACC Program. The Department of Health Care Policy and Financing (the Department) published a Request for Information (RFI) in late October of 2014 to learn more from stakeholders about how the ACC is working today and what can be improved in the future.

There were nearly 4,000 pages of suggestions from 121 submissions. A variety of stakeholders submitted responses, including clients, providers, advocates, health plans, and others.

We are using this feedback to structure the program. As you can see in the responses, there are multiple priorities and occasionally conflicting suggestions. We will have to balance those. Federal participation is also essential, so we must work with our federal partner, the Center for Medicare and Medicaid Services, to make sure all changes are in full compliance with federal regulations and laws.

We want to work within these bounds to grow the program in bold and innovative ways, while also ensuring its sustainability by creating changes at a pace that the health system can handle. This document summarizes common themes and some of the specific recommendations stakeholders shared.

Key Themes

Stakeholders expressed a range of ideas, sometimes contradictory, that reflect the competing values that we seek to balance in the ACC program. Some of the most common themes:

- **Local vs. statewide.** The ACC is designed to be flexible enough to leverage regional strengths to meet unique community needs. Some responses highlight the benefits of this model and the success of local solutions, while others emphasize the need for more uniformity in services and access across the state, and consistent rules for all providers and RCCOs.
- **Flexible vs. prescriptive requirements.** Similarly, there is a tension between "higher standards" and "fewer requirements" in the responses. Flexibility allows for innovation,



but there is also a need to ensure that the ACC serves Medicaid clients consistently and delivers on its core promises.

- **Incremental vs. broad reforms.** Some respondents advocated for dramatic and broad changes to the ACC that included ideas like capitated at-risk payments rather than fee-for-service, along with a more complete integration of physical and behavioral health services. Others wanted to use a more incremental, slow-but-steady approach to reform through the ACC.

Stakeholders and the Department will work together to strike the right balance between these different values to decide which approaches are most needed and which are most feasible given current limitations and opportunities.

ACC Strengths and Areas for Improvement

Among its greatest strengths, the ACC program is local, flexible, and community-based. Other successes of the ACC noted by respondents are its focus on the Triple Aim (health outcomes, costs, and client experience) and its emphasis on primary care. Respondents also cited the progress in using data for decision-making (through the work of the Statewide Data and Analytics Contractor), and the use of Key Performance Indicators to track progress and maintain accountability.

Respondents also shared their thoughts on what is not working as well in the ACC Program. The greatest number of comments (59%) were about payment. Fee-for-service reimbursement still rewards volume of services rather than good health outcomes. And while incentives based on Key Performance Indicators are a good idea, the frequent shifts in these indicators and the low dollar value of the incentive payments make them relatively ineffective in changing behavior. Other limitations that respondents cited:

- Data is not available real-time and the types of data available are limited.
- There are problems with attribution (assigning a client to a medical home) and changing the assigned medical home.
- The differences in the processes and requirements between different RCCOs often cause confusion or administrative burden for providers.
- Care coordination differs among providers and among RCCOs. Care coordination roles are not always clear or consistent.
- Special populations are often not receiving the attention they need.
- Payment reform and integration are both taking place too slowly.
- There is a lack of communication between physical health and behavioral health providers and administrative organizations.

The ACC and Behavioral Health Organizations

The Department asked questions about the Behavioral Health Organizations (BHOs) in the RFI. Respondents noted that, generally, the BHOs are doing well at managing financial risk and are successful in using evidence-based interventions. They said that having a separate managed care "carve-out" for behavioral health has helped to protect funding dedicated to behavioral health. They also said that BHOs have built strong local relationships and provider networks, and have encouraged steps towards integration.



Stakeholders also shared what they believe is not working in the BHO system. About 45% of respondents said there are serious provider shortages, particularly providers who speak Spanish and those trained in maternal mental health. Respondents also indicated:

- The BHOs exist as a "silo" isolated from the rest of clients' health.
- Provider credentialing should be faster.
- Non-behavioral health providers, such as primary care medical providers, should be allowed to participate in the BHO network.
- The BHOs cover behavioral health services only for certain conditions (a covered diagnosis list), which is an obstacle to behavioral-physical health integration. With this model, BHOs cannot provide for preventative services or health promotion services. This model does not adequately address the needs of children and their families, individuals with intellectual and developmental disabilities, individuals with traumatic brain injuries, and clients with autism.

Behavioral Health Integration

Stakeholders were asked what the next steps should be in behavioral health integration. Responses indicated that integration is occurring too slowly. Many respondents said that for true integration to happen, there need to be changes in payment methodologies, the delivery system, and the benefit package. Respondents also recommended integrating not only mental health and physical health, but also substance use services, dental, and social services together. Respondents suggested:

- RCCOs and BHOs should be combined.
- The Department should explore alternatives to the "covered diagnosis" model.
- Reimburse providers for using Health and Behavior Codes. These codes could allow providers to assess – and work with clients to address – physical, psychological, or social factors that affect treatment or well-being. Ideally, these codes would encourage steps towards closer integration between physical and behavioral health.
- Improve client experience by making the connection between physical and behavioral health services more seamless. Clients benefit greatly when physical and behavioral health providers are sharing accurate and timely data so that all of their providers have the same information. The client experience is also greatly improved when services are co-located or can be scheduled with a single phone call.

Care Coordination

Care coordination is an important part of the ACC Program. Respondents often recommended higher standards for care coordination, yet they also recommended more flexibility for RCCOs and providers. The responses indicate:

- Care coordination should take place at the point of care or in whichever system a client uses most often. It should be face-to-face whenever possible.
- There should be a single "lead" care coordinator for each client.
- Most care coordination should be "behind the scenes" to make the health care system as easy to navigate as possible.
- More clients should have access to care coordination.

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- There should be more transparency about what care coordination is actually taking place.
- Care coordinators should use reminder calls, emails, or texts to remind clients of upcoming appointments.
- RCCOs should have a larger role in addressing the social determinants of health, particularly transportation, economic opportunities, and housing.
- Although flexibility is generally preferable, certain diseases may require more prescriptive care coordination, as may certain special populations, such as:
 - Clients in palliative care
 - Clients with a disability
 - Those leaving the criminal justice system
 - Frail elderly clients
 - Clients with a chronic illness
 - Children involved in the foster care system
 - Children or adults with substance use disorder or a mental health diagnosis
- There should not be set ratios of clients to care coordinators.

ACC Regional Maps

Many respondents wanted to change the ACC regional maps. Suggestions included:

- There should be one RCCO per region. 59% of respondents indicated that multiple RCCOs per region would be too burdensome for providers, clients, and community organizations. However, the Denver-Metro area may need to be considered separately.
- RCCO and BHO regions should be the same. This would reduce confusion and encourage partnership and integration. The new maps should:
 - Align with existing client utilization and referral patterns.
 - Be drawn with consideration of community mental health center areas and federally-qualified health center locations.
 - Align with local public health agencies.
 - Align with the Insurance Geographical Rating Areas.
 - Consider Single Entry Point and Community Centered Board catchment areas.
- Bidders for the RCCO contracts should have pre-established relationships with stakeholders at the local level.
- Primary care medical providers should be allowed to choose one RCCO for all of their patients.

Program Structure

Respondents offered many recommendations to modify the program's basic structure:

- Provide 12-month continuous eligibility for adults. Many stakeholders made this suggestion.
- Shift the state's focus to prevention and wellness and away from a medical intervention focus.

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- Motivate clients to use health services appropriately by making it easier to access primary care, and by enforcing co-payments for non-emergency use of emergency rooms.
- Combine the RCCOs and BHOs into a single, integrated organization.
- Provide for greater oversight, transparency, and accountability, and quality assurance by:
 - Tracking care coordination activities and data
 - Hiring clients to do "secret shopping" of providers
 - Making quality metrics available online, or having public committees evaluate them
- Clearly define, communicate, and coordinate existing services including substance use disorder treatment, mental health, physical health, dental services, physical therapy, occupational therapy, and long-term care.
- Implement Affordable Care Act Section 2703 Health Homes, a program that integrates and coordinates primary, acute, behavioral health and long-term services and supports for people with chronic conditions.
- In general, standardize outcomes rather than processes.

Stakeholder Engagement in the ACC

Respondents said that, since local stakeholder engagement has been so important to the ACC, RCCOs should emphasize working directly with clients, clients' families, advocates, and other stakeholders.

- Clients, their family members, and advocates should have roles in formal governance of the RCCOs, either at the state or regional level.
- The Department or the RCCOs should conduct focus groups or other means of gauging client experience.
- RCCOs should file communication plans with the Department.
- Provide clients with opportunities to engage outside of advisory committees.
- Either require or incentivize RCCOs to use multiple methods of communication.
- Use community experts to help monitor and steer the program.

Network Adequacy and a Comprehensive System of Care

The network of providers in the ACC Program has grown considerably since the program began. Specialty access continues to be a challenge, and it is difficult to operate the ACC without more participation by hospitals. Respondents offered the following suggestions to strengthen regional networks:

- A diverse array of providers should be allowed to serve as Primary Care Medical Providers in the ACC.
- Community health workers and other non-traditional health workers should be a part of the ACC Program, but should not be mandated.
- The ACC should encourage more communication between providers and pharmacies and provide Rx Review (an evaluation of prescription drugs done with the client and/or the clients' family).
- The RCCOs should coordinate with Single Entry Points and Community Centered Boards to avoid duplicating care coordination and case management.

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- RCCOs should partner with local public health agencies.
- RCCOs should also partner with county departments of human services, sharing information and supporting each other in issues such as eligibility and care coordination for shared populations.
- Nonprofits and other NGOs that serve special populations should be considered part of the RCCOs' extended networks.
- RCCOs should keep accurate, up-to-date lists of dentists that accept Medicaid.
- Transportation can be a barrier to care, so the Department and RCCOs should work together to improve the availability of transportation services.

Practice Support

Supporting practices is an important role of the RCCOs. Responses noted that provider training, practice support, and culture change are all critical to developing and sustaining integrated clinics. While most kinds of practice support are useful and welcome, data reports and health information technology support are particularly needed and most helpful. Other recommendations:

- The ACC should leave it to RCCOs and providers to choose the specific tools (such as software, or technical assistance) they want to use to address local or regional needs.
- The ACC should include resources for Americans with Disabilities Act compliance to support providers.

Payment Structure and Quality Monitoring

As payment reform and improving quality are major goals of the ACC Program, the RFI contained several questions on these topics. Stakeholders offered diverse and often competing recommendations about how to change the payment structure. Responses include:

- The current payment structure does not fully support the goals of the ACC, as it divides physical and behavioral health, and continues to reward volume over outcomes.
- Colorado should move towards whole-person, global capitations to RCCOs for physical, behavioral, and oral health. However, many providers, especially smaller practices, rural providers, and others said they would not be able or willing to accept capitation payments.
- There should be risk adjustments to payments based on social considerations (for example, socioeconomic status), not just medical conditions. These considerations should factor in, no matter whether payments are per-member per-month, fee-for-service, or capitations. Social conditions have a big impact on health status and outcomes.
- Providers need extensive practice support before they can thrive in a situation where payments are tied predominately to value.
- Clinical, process, and utilization outcomes should be rewarded at the practice level to support high-performing providers.
- Emphasize measurements of client experience.
- Quality and other measures should align with national standards and commercial payers in order to reduce burden on providers.

Regarding the key performance indicators (KPIs) that serve as the program's pay-for-performance quality and utilization measures:

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- KPI incentive payment dollar values are too low to change behavior.
- There should be no more than seven KPIs. Providers should be held to fewer measures than RCCOs.
- The Department should track and publicly report more measures than simply the ones which are tied to payment.
- KPIs should be measured at the practice level, and paid directly to practices by the RCCOs.
- Most KPIs should be the same across all RCCOs, although some variability between regions could be useful.
- KPIs should be based on data that can be provided monthly.
- Pay-for-performance should reward all improvements, even modest ones, to encourage change. However, payments should be larger for high performance.

Health Information Technology

The consistent flow of accurate, up-to-date information is important to ensure that the right services are available at the right time. The Department used the final section of the RFI to ask respondents to share their insights about and priorities for health information technology:

- A statewide, shared data and analytics platform should be available to anyone who serves Medicaid clients in the ACC. This system should allow stakeholders to run their own data reports in addition to the data reports that the ACC runs and sends regularly. The system should be flexible and should have the capacity to be customized by the end user.
- There should be a common care coordination data system statewide. This system should be usable by everyone who coordinates or provides care for clients in the ACC. It should update in real-time, be similar to other existing systems, have access to client contact information and demographic information, and be usable on mobile devices. The system should also identify the "lead" care coordinator.
- Providers need near real-time clinical data.
- Providers should be able to know in near-real-time when their patients are at the hospital.

Summary: Building the Next Iteration of the ACC

Changing the delivery system requires making changes throughout the entire Medicaid program.

- Integrating physical and behavioral health will require changes in payment and administration. Integration also relies upon solid data-sharing and a platform of health information technology.
- Clients, families and providers benefit when medical and non-medical needs are addressed together. Factors other than health care, such as stable housing, education and employment, healthy lifestyles, and environmental factors are often more important to health outcomes than is health care. Addressing these non-medical factors is critical to improving health equity, self-sufficiency, and outcomes for Coloradans.
- Colorado Medicaid must coordinate with other agencies and provide seamless health and social supports to individuals and communities to achieve the goal of improved health and reduced cost.
- The core operations of the program including attribution, payment, and evaluation must be strengthened.

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The ACC has built a strong foundation by focusing on health outcomes, cost savings, and the experience of clients and providers. Relationships within and between communities in the Program will serve the ACC for years to come.

Updates and reforms to the program must afford RCCOs and providers the flexibility to innovate while ensuring high standards, closer integration, access to quality care, and protections for vulnerable populations.

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