The Colorado Medicaid Accountable Care Collaborative Program

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Colorado Medicaid’s Accountable Care Collaborative Program: Overview

- Hybrid model, includes elements of Accountable Care Organizations and Primary Care Case Management.
- Goals: Improve quality, increase access and reduce costs in Medicaid.
- Establish medical home for enrollees.
- Intent: Enroll all Medicaid participants within a few years.
Notable Features

• Process: State Plan Amendment
• System: two tiered – Regional Accountable Care Organization and Primary Care Medical Provider (PCMP)
• Passive enrollment with opt out
Notable Features

• Payment structure:
  – Fee for service
  – Participating RCCOs and providers get base payment plus incentives if meet targets
  – Option for shared savings later on

• Goal to enroll all Medicaid participants within a few years.
Regional Care Collaborative Organizations (RCCOs)

- Colorado divided into seven Regional Care Collaborative Organizations (RCCOs).

- RCCOs
  - Responsible for care coordination/practice support
    - Each member assigned a care coordinator
  - Develop provider networks/contract with Primary Care Medical Providers (PCMP)
  - Facilitate referral process
  - Provide network and care coordination data to the Department and/or SDAC
RCCOs

– Provide tools for PCMP – examples:
  • Clinical care guidelines and best practices
  • Chronic Care templates
  • Client management and education tools
  • Guidance and education on the principles of the Medical Home
  • Listing of available resources to guide providers and Members to community based resources
  • Specialized assessment, tools, consultation and training for members with substance abuse diagnoses.
RCCOs

• Special assistance in transitions for those with behavioral health needs or DD
  Call provider to inform them of referral
  Assist Member in making appointments.
  Assist Member in getting to appointments.
State Data Analytics Contractor

- State Data Analytics Contractor (SDAC) (TREO)
  - RCCOs provide data and data analysis
  - TREO mines data from MMIS system
  - TREO analyzes data to measure results and guide performance improvement efforts
Enrollment Broker

• Health Colorado (Maximus): enrolls, counsels, assists with PCMP selection.
• Client must call broker if unassigned, to change their PCMP, or to opt out of the program.
Timeframe

• Initial Phase:
  – RCCO’s go-live date (April 1st or July 1st 2011)
  – Roll out to targeted communities.
  – Enrollment goal: 120,000 by June 30, 2012.

• Expansion phase:
  – Begins July 1, 2012
  – Majority of the Medicaid population will be rapidly enrolled into the program
Compensation

- $13 PMPM for RCCOs and $4 PMPM for PCMPs in the initial phase
- $11.53 PMPM for RCCOs and $3 PMPM for PCMPs in the expansion phase
  - PCMPs are still reimbursed for services through FFS payment system
<table>
<thead>
<tr>
<th>Measurement Area</th>
<th>Performance Target</th>
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<tbody>
<tr>
<td>Emergency Room Visits per 1,000 full time enrollees (FTEs)</td>
<td>Level 1 Target: Utilization shows greater than 1.0% but less than 5.0% improvement</td>
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## Incentive Payments

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<td><strong>Level I Target: 66% of the Full Amount</strong>&lt;br&gt;<strong>Level II Target: 100% of the Full Amount</strong>&lt;br&gt;The Full Amount for this measurement area is $0.33 PMPM</td>
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Level I – total incentive that can be earned: 66 cents PMPM
Level II – total incentive that can be earned: 99 cents PMPM
PCMP earn no more than the RCCO, but are paid directly by the Department.
Stakeholder Engagement

• Significant engagement in design phase by providers and health plans.
• Statewide Advisory Committee - one consumer seat.
• Each RCCO must have a Performance Improvement Advisory Committee and a Local Advisory Council that includes at least:
  – members and members families, advocacy groups, behavioral health community, providers, and other stakeholders.
Other issues

• Cost savings written into FY11-12 budget: $4.8 million total funds.

• Colorado applying for demonstration grant to enroll dual eligibles in some version of ACC model beginning fall 2012.
Concerns

• Attribution
• Provider/RCCO/State relationship
• Incentives and payment structure
• Data and reporting
• Startup costs
• Timeframe
• Grievance process and infrastructure.
• Meaningful consumer engagement
Community Care of North Carolina

- The RCCO Program is modeled after Community Care of North Carolina (CCNC)
  - Divides North Carolina into 14 non-profit networks
  - Each enrollee in the network is assigned to a Medical Home
  - As of 2009, 67% of the North Carolina Medicaid population was enrolled in CCNC
Network Responsibilities

- Coordinating enrollees’ care
- Providing disease and care management
- Launching quality improvement programs
Network Compensation

• Networks and Medical Homes both receive enhanced care management fees
  – $3 PMPM for networks
    • Increased to $5 PMPM for elderly or disabled enrollees
  – $2.50 PMPM for Medical Homes
    • Increased to $5 PMPM for elderly or disabled enrollees
Results

• Including Aged, Blind, and Disabled (ABD) population, CCNC saved the state nearly $1.5 billion from 2007-2009 according to external analysis by Treo Solutions.

• CCNC ranks in the top 10 percent nationally in quality measures for diabetes, asthma, and heart disease compared to Medicaid managed Care Organizations.
Lessons from CCNC

• Avoid a top-down approach
• Can’t do it alone, must partner
• Can’t be done without investment and time
• Systems for supports and improvements must be in place
• Feedback is essential
• Accountability is essential
Contact information

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Colorado Department of Health Care Policy and Financing (HCPF) ACC page:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246