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Medicaid Payment and Delivery Reform in Colorado: ACOs at the Regional Level

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Abstract: Colorado is one of a handful of states piloting innovative health care payment and delivery reforms through Medicaid. Under the Accountable Care Collaborative Program, which began enrollment in May 2011, the state Medicaid agency contracts with seven regional organizations to create networks of primary care providers and ensure care coordination for Medicaid enrollees. Providers receive increased payments, and will eventually be eligible for incentives and shared savings and risk agreements. Results from November 2012 show reduced use of acute care, better control of chronic conditions, and lower total costs among enrollees. This case study is one of three in a series on innovations being undertaken by states to improve quality and efficiency in their Medicaid programs.

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OVERVIEW

A major health care delivery system reform under way in Colorado is the Accountable Care Collaborative Program, a Medicaid initiative to shift the program toward an accountable care organization (ACO) model. Under the program, Medicaid contracts with one Regional Care Collaborative Organization (RCCO) in each of seven regions to create a network of Primary Care Medical Providers (PCMPs). Medicaid provides the regional organizations with support for care management and administration, and they in turn seek to ensure care coordination for Medicaid enrollees and better integrate their care with hospitals, specialists, and social services to improve quality and reduce costs. RCCOs and Medicaid contract with the PCMPs to provide comprehensive primary care and coordinate clients' health needs across specialties. Medicaid also contracts with a Statewide Data and Analytics Contractor (SDAC) to analyze performance data for the program.

Enrollment began in May 2011. As of December 2012, about 30 percent of the Medicaid population was participating. The state hopes to achieve 5 percent reductions in emergency department utilization, hospital readmissions, and high-

cost imaging and to achieve overall savings to offset the $20 per member per month fee it is currently investing. The first report on results was released in November 2012,[1] and indicates reduced utilization of emergency room services, hospital readmissions, and high-cost imaging; lower rates of aggravated chronic health conditions; and lower total costs of care for enrollees. Incentive payments to the PCMPs and RCCOs will begin in 2013, and the state plans to slowly increase the portion of payment at risk, as well as pilot payment alternatives to fee-for-service contracts. Under a new State Innovation Models Initiative grant, Colorado will plan incentives that promote integration of behavioral and clinical care.

Drivers of Reform

A combination of economic and political factors contributed to the enactment in 2008 of the Medicaid Value-Based Care Coordination Initiative, now known as the Accountable Care Collaborative Program (the ACC Program), as part of the Medicaid agency's budget request for FY 2009:

- An escalation in Medicaid enrollment because of the economic recession and an expansion in Medicaid eligibility resulted in severe state budget pressures and a call for a change from fee-for-service payments.
- Prior negative experience with capitated managed care precluded the state from returning to traditional managed care organizations.
- Leadership from the governor and the Medicaid agency made delivery system and payment reform a priority.

Lessons

The results of the first year of the ACC Program indicate progress toward its quality and cost goals. Colorado's experience in developing and launching its ACC Program offers the following lessons:

- Regional organizations with flexibility and some independence enable reforms to be tailored to meet local needs, culture, and circumstances.
- Robust data collection is necessary to establish state and local accountability and understanding of the impact of the payment and delivery changes. The SDAC has provided a great deal of actionable Medicaid data that is helping the ACC Program implementation to succeed. Further, the development of an all-payer claims database in Colorado is expected to be critical to delivery system reform.
- Developing standards for quality measures and aligning provider incentives with the Medicaid program's quality and cost goals promotes efficiencies and the potential effectiveness of reforms.
- Building on what exists may be necessary, but planners must be careful not to add more complexity.
- Delivery system reform requires true integration and coordination of services (not just capitation or payment reform), realignment of incentives for providers, and breaking down of barriers between traditionally separated services.
- The scope of care integration can and should continue to broaden. Opportunities to further integrate care are a priority in Colorado, including the integration of behavioral health and long-term care with physical health.
- Health system reform requires leadership and willingness to "jump right in," test approaches, evaluate issues along the way, and adjust policies in response.

Opportunities for Federal Action to Support State Efforts

Interviewees acknowledged they have received support from the Centers for Medicare and Medicaid Services (CMS) and noted ways in which the federal–state partnership is working well. Based on the challenges faced, however, we believe CMS can further support states pursuing health care payment and delivery reform in several ways:

- **Payment flexibility:** Through programs such as the State Innovation Models Initiative, CMS could continue to grant states flexibility to test strategies for integrating care and funding, particularly on a small scale.
- **Establishment of quality standards:** Based on our interviews, there is support for the creation of a small set of standard, well-validated, and actionable quality metrics to enable performance comparisons across regions and states.
- **Additional financial support:** CMS could consider additional ways to help states bear their share of Medicaid costs, such as greater financial support for administrative costs and slower phasing out of federal matching funds than had been planned.
- **Data-sharing:** CMS could help states share data in multiple ways:
  - CMS could provide best practices for establishing all-payer claims databases that combine claims data from all public and private insurance payers in a state to capture quality, utilization, and cost information. CMS could make Medicare data readily available for such databases.
  - States would welcome greater CMS assistance in promoting timely exchange of health data. CMS could continue to explore ways to reduce barriers to information-sharing related to state and federal privacy laws such as HIPAA or to restrictions on sharing substance use information.

The other case studies in the *Aligning Incentives in Medicaid* series look at Vermont's multipayer Blueprint for Health program and Minnesota's introduction of accountable care organizations, which will enter into shared savings and risk agreements with Medicaid.

INTRODUCTION

Colorado is building its health care delivery system reforms on many fronts, but its major public-sector reform is the Accountable Care Collaborative Program, which aims to increase providers' responsibility for coordinating care and achieving good outcomes for Medicaid beneficiaries, building on the existing fee-for-service Medicaid program. The ACC Program began enrolling beneficiaries in 2011, and had about 210,000 enrollees by December 2012, or about 30 percent of the Medicaid population. The state will determine whether to expand the program to the full Medicaid population in the future.

The state is pursuing other payment reforms—some built on the ACC Program—aimed at gradually shifting away from fee-for-service payments. In early 2013 the state received a State Innovation Models Inititative grant of more than $2 million from CMS to refine its plan for integrating behavioral and clinical health care through payment incentives to providers. This "Statewide Health Innovations Fostering Transformation" program would target high-risk, high-cost individuals with co-occurring chronic disease and behavioral health issues, and would incorporate prevention strategies. The state views this effort as a starting point for integration of a wider range of services, including oral health, public health, and long-term care. In addition, Colorado is participating in the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care Initiative, in which a number of major payers in the state (Anthem Blue Cross Blue Shield, Cigna, Colorado Access, Humana, Rocky Mountain Health Plans, San Luis Valley HMO, United Healthcare, and the Medicaid program) will provide care coordination payments to primary care provider networks, with the potential for shared savings.[2] Colorado is also participating in a multipayer, multistate, patient-centered medical home pilot.[3] Another initiative, the Colorado Beacon Consortium, is a federally funded three-year demonstration program supporting health information exchange and practice transformation teams working with providers.[4] This report focuses on the ACC Program.

DRIVERS OF HEALTH REFORM IN COLORADO

Colorado's reform effort predated the establishment of ACOs in the Affordable Care Act and resulted from an effort within the state to move away from fee-for-service reimbursement in Medicaid without moving to

Exhibit 1. Colorado's Payment and Delivery System Reform

State Population (2010–2011)[a]	4,986,300
Medicaid Enrollment (#, % of pop.), December 2012[b]	658,000, 13%
Medicaid Members in Managed Care Organizations (#, % of Medicaid), July 2010	43,786, 7%
Payment/Delivery System Reform	Accountable Care Collaborative (ACC) Program
Payers Participating	Medicaid only
Key Components	Medicaid contracts with seven Regional Care Collaborative Organizations to create and support network of primary care medical providers; coordinate care for enrollees; and integrate care with hospitals, specialists and social services. Medicaid also contracts with a Statewide Data and Analytics Contractor to analyze performance data for incentive payments, quality improvement activities, and cost-effectiveness.
#, % Medicaid Population Participating[c]	Approx. 210,000, 30%
Medicaid Participation Goal	Dedicated to expand monthly; ultimate participation level not yet determined

[a] "Total Number of Residents, states (2010–2011), U.S. (2011)," http://www.statehealthfacts.org, from Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

[b] Colorado Department of Health Care Policy and Financing, Dec. 2012.

[c] Ibid.

capitated managed care. A combination of economic and political factors contributed to the enactment in 2008 of the Medicaid Value-Based Care Coordination Initiative, now known as the Accountable Care Collaborative Program, as part of the Department of Health Care Policy and Financing budget request for FY 2009, enacted as SB 09-259. At the same time, the state enacted a Medicaid coverage expansion with leadership from the former governor and the Medicaid agency (where the idea for the ACC Program originated).

The Colorado Health Care Affordability Act (Colorado House Bill 09-1293), passed in April 2009, instituted a fee on hospitals to finance expanded Medicaid eligibility for pregnant women, children, parents, people with disabilities, and adults without dependent children.[5] This legislation, along with unprecedented growth in the Medicaid caseload because of the recession, reinforced the urgency of containing escalating costs. Policymakers acknowledged the need to move away from fee-for-service reimbursement, which had been the predominant payment mechanism for the program since about 2007, after nearly all Medicaid managed care plans left the state as a result of conflict over rates. For this reason, a return to traditional Medicaid managed care was unlikely to be feasible.[6] The ACC Program was developed in parallel with other Medicaid changes, including establishing the Center for Improving Value in Health Care, which is tasked with tracking quality and cost information and creating an all-payer claims database.

By June 2012, the state legislature had also passed legislation, HB 1281, requiring global payment or other payment reform pilots within the ACC program, and SB 127, creating long-term care health homes in the ACC.[7]

Colorado's reforms also reflect agreement on the following goals for delivery system reform among multiple stakeholders:[8]

- improving health outcomes;
- reducing costs;
- improving care experiences for both patients and providers;
- creating a "focal point" of care for all patients; and
- using data and analytics on an "unprecedented" level.

ACCOUNTABLE CARE COLLABORATIVE PROGRAM

Colorado's Accountable Care Collaborative Program is a Medicaid initiative to shift a portion of the program's fee-for-service population into an ACO in which providers will deliver comprehensive, coordinated care and receive incentives to improve health outcomes. It is considered a step toward paying for the value rather than the volume of services. Under the program, the state finances regional collaboratives to build networks of integrated care around primary care medical homes. It contracts with one Regional Care Collaborative Organization in each of seven regions to create a network of primary care providers, drawn from medical practices, federally qualified health centers, and rural health clinics and known as Primary Care Medical Providers. The RCCO provides the PCMPs with support for care management and administration, helps them coordinate care for Medicaid enrollees, and works to better integrate primary care with hospitals, specialists, and social services. The RCCOs and Medicaid contract with the PCMPs to provide comprehensive primary care for ACC Program enrollees and coordinate their health needs across specialties. The PCMPs vary widely in terms of their experience and capacity to act as medical homes.

The state also contracts with a Statewide Data and Analytics Contractor to create a data repository and Web portal for the purpose of collecting performance-related information from PCMPs and providing actionable data and analytic reports for RCCOs, PCMPs, and Medicaid. The emphasis on collecting and using data is intended to foster accountability and identify opportunities to improve care and outcomes.

The Medicaid program pays for the extra services and supports through a $20 per member per month payment comprising: $13 to the RCCO, $4 to the PCMP, and $3 to the SDAC for data services.[9]

Starting in July 2012, the agency has been withholding $1 of the RCCO fee and $1 of the PCMP fee to create an incentive pool, to be awarded quarterly if targets for reducing emergency department admissions, hospital readmissions, and high-cost imaging are met. The first incentive payments will be based on claims from July through September 2012 and paid out in early 2013.

The state's intent is to increase the portion of the monthly fee that is at risk, as well as to pilot payment reforms that test alternatives to the fee-for-service component. The ACC payment reform pilots (HB 1281) "may include, but need not be limited to, global payments, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to, gain-sharing, to achieve improved quality and to control costs."[10]

Through competitive bidding, the Department of Health Care Policy and Financing selected RCCOs and a vendor to serve as the SDAC. Medicaid enrollment into the RCCOs began in May 2011, with timing slightly staggered for the various regions. As of August 2012, the RCCOs had contracted with 535 provider organizations that include 3,776 practitioners. As of December 2012, about 210,000 Medicaid beneficiaries were enrolled, or 30 percent of the Medicaid population. The Department and the RCCOs are developing a plan to continue expanding the ACC Program while ensuring financial sustainability. They are considering expanding enrollment by 30,000 people per month. Enrollees in the Comprehensive Primary Care Initiative practices began enrolling in the ACC Program in November 2012.[11]

RCCO Design and Diversity

The Regional Care Collaborative Organizations must fulfill certain functions: ensuring that every member receives care coordination when they need it, being accountable for the cost and quality performance of their PCMPs, and developing a network of primary and ancillary care providers. In addition, they must coordinate with Medicaid and each other through regular ACC Program activities. However, they also have significant latitude to tailor their structure, financing, and activities to local needs and opportunities. Exhibit 2 compares selected characteristics of two of the RCCOs: Region 2's Colorado Access, an organization that administers RCCOs in three of the seven regions in the state, and the Rocky Mountain Health Plans in Region 1. As shown in the exhibit, both organizations have been able to adapt to geographic differences in population density, provider characteristics, and other local factors.

The RCCOs were launched under one-year contracts in the spring of 2011, with each having the potential to renew their contracts annually for up to four years. Two groups of Medicaid beneficiaries are enrolled into the ACC Program: those who have a relationship with an ACC-participating provider are passively enrolled, and those who have no primary care medical home are enrolled in the RCCO and directed to select a provider. Enrollees who already have a relationship with a primary care provider who does not participate in the ACC Program are not enrolled, to avoid disrupting their existing relationships. New ACC members are sent enrollment letters and have 30 days to opt out of the program prior to being enrolled. Following the initial opt-out period, enrollees may also request to leave the program based on "good cause," as defined in the RCCO contracts. In the spring of 2012, Colorado Medicaid expanded eligibility to include low-income, nonelderly, childless adults via a Medicaid Section 1115 waiver (these individuals had not previously been eligible for Medicaid coverage). Enrollment in the ACC Program is mandatory for this population (no opt-out period is offered).[12] Colorado Access noted that as its RCCO program has ramped up, its provider network has been able to expand to offer greater geographic choice of providers in terms of location and cultural competencies (e.g., languages spoken). Further, the RCCOs collaborate with regionally based Behavioral Health Organizations.[13]

According to the RCCOs, there has been strong provider participation thus far, with early adopters setting the pace and supporting others in their efforts to improve health care quality and adopt medical home services. Federally qualified health centers

Exhibit 2. Selected Regional Care Collaborative Organization Designs and Key Activities in Colorado, Year 1

	Colorado Access	Rocky Mountain Health Plans
Regions	2,3,5 (includes both Denver and more suburban and rural areas)	1 (Western Colorado, the state's geographically largest and least populous region, which includes Fort Collins, Grand Junction, and many rural areas)
Enrollees	55,000 (in the three Colorado Access regions combined) as of May 2012	15,000 as of May 2012
Launch Date	May 2011 for Region 2; June 2011 for Regions 3 and 5	June 2011
Financing	State funding	State funding and private grants
Key Activities in Year 1	Developing provider network, identifying community champions to participate	"Community leadership teams" of providers organizing themselves to sign agreements to participate/collaborate, and launching using grant funding
Approach to Care Management/ Integration	Directly embeds care managers in practices or, where appropriate, delegates to an organization best positioned to provide it and to collaborate with local primary care physicians	Does not directly embed care managers in practices. Instead, the RCCO pools funding from the state and private grants to fund shared services at the community level. Leadership teams hire and share their own care managers, with varying models in terms of who employs shared staff and where they are based (e.g., a foundation, hospital, other type of provider).
Successes	Provider contracting, broad participation among practices, and successful ramp-up of enrollment over first year of implementation; strong buy-in within regions. Gathering performance data to identify which practices are coordinating care well; pinpoint best practices so others can learn from them.	Convening community leaders to develop/drive local strategies. Focus on metrics including patient contacts, referral activity, and how successfully information is shared among providers.
Challenges	Attributing patients to PCMPs	Engaging/educating patients about the benefits of a medical home to reduce opting out of the RCCO. There have been very few opt-outs thus far (<2%).
Next Steps	Engage hospitals and specialists, obtain timely information on emergency department visits and inpatient admissions so that PCMPs, providers, and RCCOs can collaborate to reduce them	Continued focus on patient engagement, making decisions about care coordination, productivity within teams of providers, care transitions, and broader-based population health and prevention

(FQHCs), in particular, are seen as playing critical roles in the RCCO networks. FQHCs understand the importance of continuous, coordinated, and comprehensive care and tend to have more experience and staff resources to devote to coordinating care than other providers do.

Participating practices and providers have widely varying capacity to serve as medical homes and coordinate care. Colorado Access found that many practices already had National Committee for Quality Assurance medical home certification (or the Colorado equivalent for pediatric practices). But physician practices of different sizes had very different levels of experience and sophistication. One RCCO representative noted that larger practices familiar with the Medicaid system and part of the health care safety net tended to have a better understanding of medical home principles and care management. They were more likely to have experience and expertise in comprehensive care coordination, and were more likely to be prepared to take on care management responsibilities. Smaller practices, particularly solo practitioners, tended to have less care management experience and needed more support from the RCCOs. The capabilities of midsize providers and those with multiple physicians varied considerably. However, these trends

were not universal—the RCCO noted that some smaller practices did have strong medical home capabilities. The RCCOs meet practices wherever they are in medical home capabilities, and help them move toward greater expertise. As a result, RCCOs use a variety of strategies to improve the coordination and quality of care delivered by their network providers—from offering technical assistance to individual providers, to convening providers to share best practices, to developing information technology to help PCMPs better coordinate care in their regions. Examples of activities in one or more RCCOs include:

- developing an alert system that provides nearly real-time exchange of information between PCMPs and behavioral health providers so that both parties are kept up to date on patients' use of services and can better integrate care for patients with behavioral health needs;
- convening PCMPs and providers in their networks to provide training on best practices for managing common chronic conditions;
- providing group training for PCMPs, as well as individual technical assistance to specific PCMPs, to further develop their medical home capabilities;
- making resources available electronically, including best-practice guidelines and educational materials for patients;
- working with PCMPs to increase rates of depression screening and to implement a model for substance-abuse screening;
- providing technical assistance to practices on electronic health record adoption and meaningful use certification; and
- offering financial support to clinics that are providing care coordination using their own staff.

The ACC Program is designed to partner with rather than replace existing integrated delivery systems serving Medicaid beneficiaries. For example, Denver Health, an integrated system and major safety-net provider in the Denver area, is participating as a PCMP in the region's RCCO and is also a capitated Medicaid provider.[14] Kaiser Permanente, another integrated delivery system, is working with RCCOs in the areas it serves.

The ACC Program is also envisioned as a platform for other initiatives that will involve and encourage interaction and participation among integrated delivery systems and other providers. For example, the state's Department of Health Care Policy and Financing expects a range of models to be proposed in partnership with RCCOs to pilot innovative payment methodologies.

Stakeholder Activities

Stakeholders have been actively involved in the planning, implementation, and evolution of the ACC Program. During the program's development in 2008, the state sought input from a broad range of stakeholders, including Medicaid enrollees and their advocates, providers, and health plans, through workgroups and public forums. Stakeholders helped create the materials that were used to solicit proposals from organizations applying to serve as the RCCOs.

RCCOs reach out to physical and mental health providers, social services providers, and community-based organizations to educate them about the program and identify opportunities for collaboration. An ACC Program Improvement Advisory Committee includes RCCO staff, PCMPs, other providers, Medicaid enrollees and families, and Medicaid staff. There are also subcommittees on payment reform, provider and community relations, people dually eligible for Medicare and Medicaid, and quality and health improvement.

On their own initiative, the RCCOs decided to meet with each other regularly, separate from their meetings with the Medicaid agency, to discuss issues and best practices. For example, Rocky Mountain Health Plans is gathering information from stakeholders on how best to educate patients about the benefits of having a medical home. Patients occasionally (though very rarely) opt out of the program, perhaps because they are not aware of the potential benefits of having a primary care provider to coordinate their care

and ensure access to the appropriate services. All RCCOs are required to hold quarterly advisory committee meetings that are open to the public, and to provide quarterly reports to the state on the participation and experiences of families, providers, and advocates.

Challenges and Opportunities

According to the RCCOs, the ACC Program's flexibility helped them address operational and implementation challenges that arose during its first year. Some issues required time for the RCCOs to gain a better understanding of how patients were using the health care delivery system. For example, Colorado Access found that some enrollees had been seeing several primary care providers prior to joining the RCCO, instead of relying mainly on one primary care provider as planners had anticipated. In response, the state decided that RCCOs would allow patients to switch PCMPs if their original assignment was not optimal. Planners are also considering whether there are ways to meet the program's goals without having one-to-one relationships between primary care providers and patients in all cases.

The processes of completing contracts with providers and assigning enrollees to PCMPs were more complex than expected. To build support for the program among physicians, the state collaborated extensively with the state medical society and with RCCOs, which in turn worked with providers and other organizations in the regions.

Restrictions on managed care marketing that were instituted in the 1990s to prevent predatory marketing practices limited the types of outreach and direct contact that RCCOs could use to engage patients. Rocky Mountain Health Plans, for example, noted that the requirement to use a third-party Medicaid enrollment broker created a barrier between the RCCO and patients. For new models of care to be successful, these requirements will need to evolve to reflect innovative models of accountable care that are developing in Medicaid.

RCCO leaders believe that the ACC Program is already improving the value and quality of care, but that legislators' expectations of quick, substantial savings to the state may be unrealistic. Savings may be slow to materialize and not uniform among regions. Interviewees did not expect the program to immediately offset the $20 per member per month costs. Though quantitative metrics are being emphasized, program evaluators are also gathering qualitative information, such as success stories, to demonstrate improvements in the delivery of care.

Measuring Success

The Medicaid program contracts with the SDAC to serve as the ACC Program's data repository; generate reports on the program's effects on health care quality, utilization, and costs; use analytic tools such as predictive modeling to support the RCCOs; and identify opportunities to improve quality and accountability. It is initially focusing on four statewide metrics:

- emergency department utilization;
- hospital readmissions within 30 days;
- use of high-cost imaging; and
- average per member per month cost of care.

The SDAC is currently establishing baseline data and risk-adjustment mechanisms. The state's goals are to achieve 5 percent reductions in the first three metrics, and a reduction in the cost of care that offsets the $20 per member per month fee it is contributing, totaling $2.2 million in savings in FY 2011–12 and $4.9 million in FY 2012–13. As noted above, $1 for RCCO and $1 for the PCMP will be held back for an incentive pool, to be awarded if performance measures are met. The performance measures will be expanded over time, with an increasing portion of the monthly payments to be at risk and a gain-sharing component to be implemented.

The program's first annual report found improvement in the key metrics for the program:

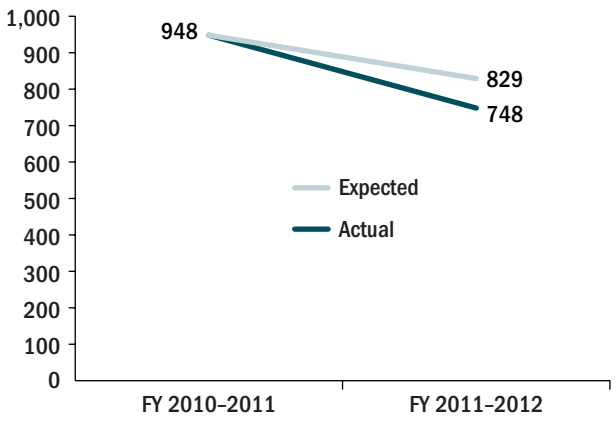
- Although emergency room utilization rates increased by 1 percent across the entire Medicaid program since the ACC Program began, the rate for

ACC Program enrollees grew 1.2 percentage points less than for nonenrollees, an increase of 0.23 percent for the ACC program compared with an increase of 1.47 percent for those not participating.

  - The RCCO in the region with the highest emergency room use prior to the program experienced the greatest decrease, finding a 14 percentage point drop compared with nonparticipants.

- Participants had 8.6 percent fewer hospital readmissions than nonparticipating Medicaid enrollees.
  - Preventable hospitalizations and readmissions for patients with asthma and diabetes were reduced among participants.
  - Within the ACC Program, readmissions fell faster than expected (Exhibit 3).
  - All RCCOs saw increased use of medications to manage hypertension compared with the nonenrolled population, providing additional evidence that the program is helping patients better manage chronic conditions.
- Utilization of high-cost imaging decreased 3.3 percentage points more in the ACC Program population than the nonenrolled Medicaid population, though rates for both groups declined.

Exhibit 3. Hospital Readmissions Among ACC Program Enrollees, FY 2010–2012



Source: Colorado Department of Health Care Policy and Financing, Report to the Joint Budget Committee, Accountable Care Collaborative Annual Report, Nov. 1, 2012.

- Total reduction in medical spending was estimated at $20 million to $30 million for FY 2011–12, exceeding the cost of the program and in line with the anticipated savings.

Anecdotal evidence also suggests that care is better coordinated under the ACC Program.

One purpose of using outcome-based metrics as opposed to process measures is to allow each RCCO to develop strategies best suited for its region. For example, Colorado Access is testing:

- interventions to identify ACC members in the emergency department and assess whether it is appropriate to redirect them to a PCMP or other type of provider; and
- outreach strategies after hospital discharge to ensure that enrollees make and keep follow-up appointments with a PCMP.

The state's external quality review organization will assess the effectiveness of these and other strategies. The RCCOs are working to identify best practices to achieve improvements on the statewide metrics and other specific areas in need of improvement that they have identified in their regions.

LESSONS

A number of lessons have emerged from the program's early experiences.

Regional Organization Is Important

The ACC Program's regional structure offers flexibility and some independence for RCCOs, thereby promoting community-driven leadership and creating opportunities for innovation and integration. RCCOs have the flexibility to tailor their priorities and approaches to local circumstances, for example for recruiting and training providers, structuring and staffing the care teams, and even in financing (e.g., having the ability to solicit private grants). Rocky Mountain Health Plans, a relatively small RCCO with about 15,000 enrollees, noted that it is not necessary to have huge numbers of enrollees to succeed; efficiencies can

be created by changing the delivery system on a local scale. In the longer term, the state may choose to take a more prescriptive approach to some aspects of the RCCO program, once it has substantial data on which to base recommendations. During the early stages, however, the regions welcome the ability to customize the ACO concept to their needs.

The Need for Robust Data Collection

Robust data collection is critical to support state and local accountability. Interviewees noted that Colorado's SDAC is a key resource, and that the all-payer claims database being developed by the independent Center for Improving Value in Health Care will be useful in delivery system reform. Having "real-time" data on how patients use the delivery system—for example notifying a PCMP when one of its patients receives treatment at an emergency department—will be an important tool to improve the coordination of care across providers and link physical health services with behavioral health and social services.

Community-based health information exchange efforts also can support delivery system reform. Real-time data exchange does exist in some of the state's markets, for example through the Quality Health Network in western Colorado, which receives funding from the Colorado Beacon Consortium. The consortium received $11.8 million in federal funding for a three-year demonstration program to expand health information exchange through the Quality Health Network and to provide a practice transformation team to work with medical practices.[15] Rocky Mountain Health Plans serves as the prime sponsor of the agreement with the Department of Health and Human Services/Office of the National Coordinator for Health Information Technology under which the consortium operates.

Align Quality Measures and Incentives

Even though participants support local flexibility in delivery system design, there is widespread agreement that standards for quality measures are needed to promote performance comparisons, efficiency, and affordability of data collection. Standardization of quality measures also would make data more comparable among all payers to facilitate market efficiency and make data collection more administratively efficient and affordable. States also could consider standardization of quality measures in the interest of collaborating with CMS and other states, which would allow broader performance comparisons and evaluation of system reforms.

Build on What Exists, Without Adding Complexity

Adhering to historical and political factors, Colorado is building on its existing fee-for-service system as the basis for reform. It intends to move away from fee-for-service and toward payment systems that reward value, but the process will be incremental over the coming years. Interviewees commented that delivery system reform needs to be more than just "layering more bureaucracy" on top of the current delivery and payment systems—and that true integration and coordination of services, realignment of incentives for providers, and breaking down of barriers between traditionally separated services is the central goal. Making the administration of programs as simple as possible should be a priority.

Broaden the Scope of Care Integration

Colorado is searching for opportunities to further integrate care for people who incur the highest costs, regardless of the type of coverage they have. The state is considering how best to integrate its behavioral health and long-term care programs with physical health care. RCCOs are already working with regional behavioral health organizations, and the state enacted legislation that will enable long-term care providers to serve as health homes, though making these health homes financially sustainable could be a challenge.[16]

Incorporating those who receive both Medicare and Medicaid coverage (known as "dual eligibles") into state payment reform efforts will be important. Colorado is currently pursuing a separate pilot with CMS to integrate care for this population,

though it has proposed that the ACC Program will be the vehicle to integrate care for dual eligibles starting in 2013. A truly integrated system would hold providers accountable for discharging people into the community, i.e., coordinating a successful transition to the appropriate outpatient services to reduce unnecessary readmissions, and ideally Medicaid would have an opportunity to share in the savings from having reduced the need for institutional care.

Payment Reform Alone Does Not Lead to Care Integration

Payment reforms alone, for example shifting from fee-for-service payments to capitation, are not sufficient to change the way that care is delivered or the way patients use the health care system. Instead, locally tailored care management can help break down traditional silos among services. Colorado's RCCOs build providers' competence in serving as a medical home and coordinating care through training and technical assistance, and by gathering information and disseminating best practices. Federally qualified health centers have experience in coordinating care for vulnerable populations and can help bring other providers along. RCCO advisory committees are developing mechanisms to engage and educate patients about the benefits of having a medical home and about their responsibilities in realizing those benefits.

The Importance of Leadership, Communication, and Willingness to Take Risks

Colorado's experience underscores the importance of leadership to avoid what one interviewee called "paralysis by analysis." Though preparation and stakeholder input are critical steps in planning reform efforts, leaders must be willing to move past those steps to implement changes, adjusting policies in response to new experiences while using metrics to measure progress. Interviewees also said they had to challenge their pre-existing assumptions, for example about how patients served by the RCCOs had been using primary care.

Strong communication is key to the success of reforms as they continue to evolve, including in making the case to legislators that the care delivery changes are worth the continuing investment even when savings may be slow, uncertain, and variable by region. RCCOs are playing a crucial role as "boots on the ground," relaying to Medicaid what is happening across the state and reporting on progress and challenges.

HOW CMS CAN SUPPORT STATE PIONEERS

Data-Sharing

The need for robust measurement as a necessary component of payment reform was a major theme in Colorado. Practices have enthusiastically embraced the use of performance data and the CMS framework of the triple aim—improving people's experience of care, improving population health, and reducing the cost of care. These goals are well aligned with the major metrics Colorado chose to prioritize, now being collected and analyzed by SDAC.

Colorado's development of an all-payer claims database is a potentially powerful tool in reform. CMS could offer technical assistance to states on the best ways to establish and use such databases, as well as provide states with Medicare data quickly and efficiently. The agency also could offer guidance to states on ways to pursue enhanced federal matching funds for data-related activities.

Participation in data exchange by private payers is also important, and states would welcome greater assistance from CMS in promoting real-time exchange of health data. CMS could intensify its exploration with states on ways to reduce barriers to information-sharing related to state and federal privacy laws such as HIPAA or restrictions related to substance-abuse information.

Establishment of Quality Standards

There was some support among interviewees for the development by CMS of standard, well-validated, actionable quality measures to assess the effects of state Medicaid reforms and facilitate performance

comparisons across regions and states. Interviewees emphasized that the measure set should be small so as not to be burdensome to providers and administrators.

Adjustments to Address States' Continued Financial Pressures

CMS should keep in mind that states continue to experience severe budget shortfalls; finding resources—even when the federal government is offering 90 percent matching funds for certain activities—can be a challenge. In particular, it can be a political challenge to find funds for administrative costs. Further, funding sources for health homes or other delivery system innovations need to be sustainable. Instituting a more gradual step-down of federal enhanced matching funds would help states shift short-term programs into longer-term models and encourage their reform efforts.

Payment Flexibility

States would value additional flexibility to test alternatives to fee-for-service payments and other reforms, for example to blend state funding for behavioral and physical health sources. Opportunities to experiment on a small scale (without the need for statewide waivers) could promote innovation. Colorado's State Innovation Models Initiative grant is a promising example of how such flexibility can be offered.

CONCLUSION

Colorado is building its delivery system and payment reforms by integrating care at the local and regional levels and depending on providers' commitment to participate. The state has prioritized robust quality measurement and data-sharing, reflected in its creation of an entity to gather and disseminate data and its establishment of an all-payer claims database. The Accountable Care Collaborative Program is a starting point in what is intended to be an incremental transition away from fee-for-service reimbursement toward paying for better health outcomes. Colorado has been willing to take on the challenge of health reform, learning by doing and making adjustments over time. The state's experiences can provide lessons to other states and federal policymakers.

NOTES

[1] See the Accountable Care Collaborative Annual Report at http://www.colorado.gov/cs/Satellite?c=Document_C&childpagename=HCPF%2FDocument_C%2FHCPFAddLink&cid=1251633513486&pagename=HCPFWrapper.

[2] The Medicare-funded per member per month fee will total about $20. See http://www.civhc.org/CIVHC-Initiatives/CIVHC-Payment-Reform-Initiatives/Colorado-Primary-Care-Initiative.aspx.

[3] This effort is organized by HealthTeamWorks, which provides coaching and technology support to participants. Sixteen primary care and internal medicine practices in Colorado are participating, along with practices at partner sites in Cincinnati, Ohio. See http://www.healthteamworks.org/medical-home/pcmh-pilot.html. The measures for this project are similar to those of the ACC Program.

[4] See http://www.coloradobeaconconsortium.org/about/.

[5] See http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1246453720972.

[6] Colorado's two traditional Medicaid managed care contracts are continuing during the ACC's initial stages.

[7] See http://www.leg.state.co.us/clics/clics2012a/csl.nsf/fsbillcont3/28EE8C6A74A071988725798100 7F12EC?open&file=1281_enr.pdf and http://www.leg.state.co.us/clics/clics2012a/csl.nsf/billcontainers/7D30A365145E025787 25798900551654/$FILE/127_01.pdf.

[8] "Understanding the ACC Program," Colorado Department of Health Care Policy and Financing; and discussions with state contacts, April–May 2012.

[9] The SDAC contract is for a fixed price that averages $3 per member per month, but is not technically a per member per month payment.

[10] See http://www.leg.state.co.us/clics/clics2012a/csl.nsf/fsbillcont3/28EE8C6A74A071988725798100 7F12EC?open&file=1281_enr.pdf.

[11] This is a multipayer initiative through the federal Center for Medicare and Medicaid Innovation in which Medicare will work with public and private payers and offer bonus payments to 500 primary care practices in eight states if they can better coordinate care for their patients. See http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html.

[12] Although individuals may opt out for good cause, the opt-out rate for this population has been very low. People eligible for both Medicare and Medicaid are not being enrolled yet because the state is pursuing a demonstration program in which they would be served through the ACC Program starting in 2013. The Colorado State Demonstration to Integrate Care for Dual Eligible Individuals, one of 15 such programs that states are launching to better integrate care for this population, is described in greater detail at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251610502140.

[13] Prior to the ACC Program, Colorado had five regionally based Behavioral Health Organizations operating its mental health program. The state based the RCCO regions on these groupings. See Kaiser Commission on Medicaid and the Uninsured, "Emerging Medicaid Accountable Care Organizations: The Role of Managed Care," Issue Brief, May 2012, http://www.kff.org/medicaid/upload/8319.pdf.

[14] In the Denver region, Medicaid enrollees are initially assigned to Denver Health as a managed care provider; if they opt out, they are assigned to a PCMP (which may be Denver Health or another provider) through the RCCO.

[15] See http://www.coloradobeaconconsortium.org/about/.

[16] Medicaid enrollees living in nursing facilities or state psychiatric institutions were also initially excluded. See Kaiser Commission, "Emerging Medicaid," 2012.

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