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Colorado Hospital Association

White Paper

ACC 3.0

Oct. 25, 2022

As the state enters a multi-year stakeholder process to consider changes to the Medicaid system, the Accountable Care Collaborative (ACC), CHA prepared background on Colorado and national Medicaid trends.

Health First Colorado Overview

The Medicaid program in Colorado, known as Health First Colorado, covers approximately 1.7 million (one in 3.5) Coloradans as of early 2022. In terms of the population enrolled in Health First Colorado, 40% are children and adolescents, 31% are expansion adults, 15% are non-expansion adults, 7% are people with disabilities, 4% are adults 65 and older with full Health First Colorado benefits, and 3% are members with partial Health First Colorado benefits. The program covers 36% of all births in the state of Colorado. In Colorado in 2020, 21.2% of hospital care was provided to Health First Colorado members.

For fiscal year 2019-20, the total spending for Health First Colorado was $10.2 billion – 60.4% of which was federal funds and reappropriated funds, 27.6% of which came from the state general fund, 8.3% of which came from Colorado's hospital affordability and sustainability provider fee, and 3.7% of which came from cash funds. Health First Colorado pays for physical health and behavioral health through a bifurcated payment system. **Physical health services are paid for through the traditional fee-for-service structure through the Colorado Department of Health Care Policy & Financing (HCPF). Meanwhile, HCPF contracts with Regional Accountable Entities (RAEs) to administer the state's capitated behavioral health program.**

Definitions:

- **Accountable Care Organization (ACO):** Organizations aimed at care coordination and value-based delivery. The two most common ACO structures are shared savings arrangements (providers take on downside risk) or global budget model (capitated per payment for the provision of care) (Center for Health Strategies).
- **Regional Accountable Entity (RAE):** Regional entities responsible for coordinating primary and behavioral health services for Health First Colorado members in their regions. RAEs are responsible for increasing quality, reducing cost, and developing financial incentives to increase value (Colorado Health Institute). They:
    - Coordinate care in their region
    - Build provider networks
    - Administer the program through a monthly payment amount per member & reimburse providers
    - Monitor data and metrics
    - Develop population health plans
- **Accountable Care Collaborative (ACC):** Colorado's Medicaid delivery system
- **Medicaid Managed Care:** Per CMS, Managed Care is a health care delivery system organized to manage cost, utilization, and quality through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services (CMS).
- **Fee-for-Services (FFS):** The state pays providers directly for each covered service received by a Medicaid beneficiary **(MACPAC).**

Colorado's Medicaid History (1990s)

Denver Health is Colorado's longest running Managed Care Organization (MCO) program; it began in 1983. In 1995, Colorado implemented the Medicaid Community Mental Health Services program in which Behavioral Health Organizations (BHOs), a mental health PIHP, delivered behavioral health (BH) services to Medicaid enrollees. Also in 1995, the Colorado legislature required 75% Medicaid enrollees be enrolled in a managed care plan. Not long after, MCOs sued, arguing the state wasn't paying them enough. Colorado lost the lawsuit and the experiment ended – around 2000.

Accountable Care Collaborative (2011-now)

The Colorado Accountable Care Collaborative (ACC) is a Managed Care program designed to pay providers for the increasing value they deliver while better cording care for members.

In Colorado, the objectives of ACC per HCPF are to:

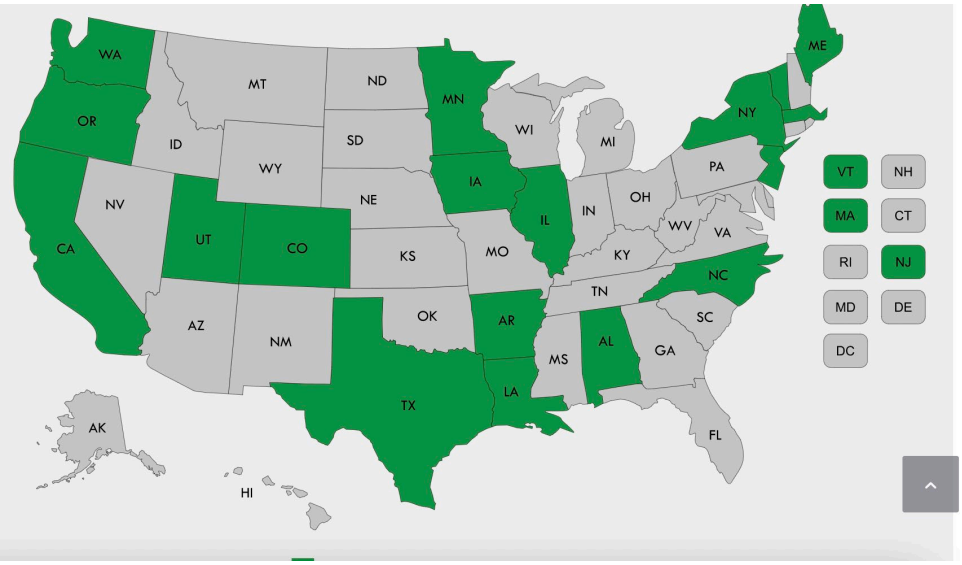
- Join physical and behavioral health under one accountable entity
- Strengthen coordination of services by advancing Team-based Care and Health Neighborhoods
- Promote member choice and engagement
- Pay providers for the increased value they deliver
- Ensure greater accountability and transparency

Seventeen other states have implemented Medicaid Accountable Care Organizations (WA, OR, CA, UT, TX, MN, IA, IL, AR, LA, AL, NC, NY, ME, VT, MA, NJ). The National Academy for State Health Plans (NASHP) classifies states with Medicaid ACOs as programs that have Medicaid program participation, explicit accountable or integrated care models, and dedicated staff. Per NASHP, ACOs follow the below criteria:

1. Organizations or structures should assume responsibility for a defined population of patients across a continuum of care, including across different institutional settings.
    a. *In Colorado, these are the RAEs*
2. Participants should be held accountable through payments linked to value, emphasizing dual goals of improving quality and containing costs.
    a. *Function managed by the RAEs*
3. Accountability should be facilitated by reliable performance measurements that demonstrate savings are achieved in conjunction with improvements in care.
    a. *Function managed by the RAEs*

Interestingly, the National Association of ACO (NAACOS) would classify ACC as a *"more generic value-based payment and quality approach."* They would classify ACC this way due to the RAEs lack of engagement in care coordination of specialty, ancillary, or hospital care beyond their focus on behavioral and primary care integration (NAACOS- Colorado).

Note: states can utilize ACOs in capitated managed care and fee-for-service (FFS) states. For example, VT is a FFS state with value-based add-ons.



NASHP indicates that there are 18 states with active Medicaid ACOs.

Additional Resources & Background

- Center for Health Strategies: Issue Brief on Medicaid ACOs
- Colorado Health Institute: The Way of the RAEs

ACC 1.0 (2011)

The first iteration of the ACC used a network of Regional Care Collaborative Organizations (RCCO) that work with Primary Care Medical Providers (PCMP) to connect Health First Colorado members enrolled in the ACC with medical home providers that will meet their individual needs. The other goals include coordinating medical and non-medical services for patients, improving member and provider experiences, and collecting the necessary data to move the program forward while meeting established benchmarks.

The state previously contracted with five BHOs (Access Behavioral Care, Behavioral HealthCare, Inc., Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership) to provide mental health services in defined geographic areas. The state set rates through a combination of negotiation and an administrative process using actuarial analyses.

ACC 2.0 (2018)

On July 1, 2018, Health First Colorado launched the second phase of its effort to reform Medicaid – ACC 2.0. Phase Two of the ACC aims to control costs in the state government's largest agency while helping Medicaid members improve their health through integrating primary care and behavioral health, which includes mental health and substance use disorder services. Phase Two involved a number of changes aimed at coordinating care and

reducing costs. The biggest development was the launch of seven new organizations – the RAEs.

RAEs are meant to ensure Health First Colorado members have access to primary care and behavioral health services, coordinating members' care and monitoring data to ensure members are receiving quality care. They also have a role in paying providers, including managing payments for behavioral health services and using bonus payments to encourage primary care providers to improve care — responsibilities largely carried out by other entities in Phase One. Five private organizations won a competitive bidding process to take over the coordinating role in the state's seven RAE regions. The RAEs are a mix of established and new organizations with varying previous experience working with HCPF. Three RAEs served as RCCOs in Phase One: Colorado Access, the Colorado Community Health Alliance and Rocky Mountain Health Plans. Colorado Access also served as a BHO. The companies earn revenue from HCPF in a system that encourages them to operate efficiently and is aimed at keeping them accountable for quality.

ACC 3.0

HCPF's current contracts with the RAEs and MCOs will end on June 30, 2025, upon which HCPF intends to implement ACC 3.0 with new contracts that will begin on July 1, 2025. HCPF has started stakeholder activities to assist with program development and plans to release a concept paper in March 2023 and a draft request for proposal in November 2023. There is expected to be an opportunity for stakeholder feedback through ongoing community engagement to refine the design and begin operational implementation with a Request for Proposal in April 2024. In September 2024, vendors will be awarded with contracts and implementation work will continue until the go live date of July 1, 2025.

What is Managed Care?

Per CMS, a Managed Care program is a health care delivery system organized to manage cost, utilization, and quality. The objective of Managed Care is that by contracting with various types of Managed Care Entities (MCEs) states can reduce Medicaid program costs and better manage utilization of health services. Generally, the upside of Managed Care is flexibility whereas the downside can be accountability and consistency.

Federal Managed Care regulations allow four different types of Managed Care Entities (MCEs):

1. Managed Care Organizations (MCOs): MCOs are paid a capitation or per member, per month (PMPM) payment for each enrollee to receive health care services from providers in MCO network. Services included in the capitated payment can include everything (all physical health, BH, RX and LTSS) or a subset of those services. Providers bill MCOs (not the Medicaid department) for care provided.
2. Primary Care Case Management (PCCM) (2 types)

   a. PCCM: Providers are paid a case management fee to coordinate and monitor patients' care, but primary care services are still paid for through FFS. (Colorado – RCCOs in ACC 1.0)
   b. PCCM Entity: Payments are made to an entity to provide case management and other functions (i.e., enrollee outreach and education, call center, contracting with FFS providers). Providers paid FFS. Minimal risk-bearing (or capitated payment); more dollars can be earned through incentive measures.
      i. Colorado has an organizational PCCM Entity structure for physical health care services. Colorado's Regional Accountable Entities (RAE) = PCCM Entity + PIHP
3. Prepaid Inpatient Health Plan (PHIP): PHIPs provide a limited benefit package that includes inpatient hospital or institutional services, such as mental health. The payment may be risk or non-risk.
4. Prepaid Ambulatory Plan (PAHP): PHAPs provide a limited benefit package that does not include inpatient hospital or institutional services, such as dental and transportation. Payment may be risk or non-risk.

Potential Benefits of Managed Care & Drawbacks to FFS

Benefits: Managed Care allows dollars to be used in creative ways beyond traditional FFS programs. Examples include social determinants of health, such as housing or transportation that providers might not have access to. With managed care, the costs for the state are more predictable year to year state agencies are relieved of the obligation to manage networks and conduct utilization management (UM). Additionally, state administrative costs can be lower with Managed Care. The Government Accountability Office cited inadequate data in a 2018 report while a Health Affairs analysis identified a five-fold variation in administrative costs for Managed Care programs, with some states seeing significantly fewer dollars spent on care.

Drawbacks to FFS: In pure FFS without value-based models, there is a lack of accountability for outcomes leading to higher costs. Additionally, FFS models are typically less flexible and responsive to community needs as they are not regional in nature.

Potential Drawbacks of Managed Care & Benefits to FFS

Drawbacks to Managed Care: Critics of Managed Care say that MCOs have a strong incentive to contain costs, which can lead to a reduction in provider payments and patient care denials. Concerns with Managed Care include low provider payments and significant administrative burden. Additionally, for providers that serve multiple regions, coordination with separate RAEs can be difficult.

Benefits of FFS: In a FFS model, while the state can contract with outside entities for administrative functions, there is typically only one entity to work with on payment policies and appeals. There is also not a middle-entity with an incentive to decrease or reduce payment.

Deep Dive on Other States

As of July 2021, 41 states contract with some comprehensive, risk-based Managed Care plan to provide care to Medicaid beneficiaries (including Colorado) (*Kaiser Health News*). In most states, MCOs are statewide health plans and are administered by commercial insurers, such as United, Anthem, Cigna, Aetna, etc. Except for certain special populations, Medicaid enrollees generally have a set number of MCOs to choose from upon enrollment in Medicaid. Of states with MCOs, Colorado has the lowest percentage of Medicaid spending in Managed Care – 4.5% compared to 52% for U.S. average and 88.8% in IA. Only four states have no Medicaid managed care – Alaska, Wyoming, Connecticut, and Vermont.

Oregon: Regional Coordinated Care Organizations

Oregon's Medicaid Program, Oregon Health Plan, enrolls nearly all Medicaid beneficiaries in fully capitated Managed Care plans that operate as regional MCO-like entities known as "coordinated care organizations." These entities were first formed in 2012 through an 1115 waiver and include 16 provider networks within a geographic area, providing physical, dental, and behavioral services. The primary goals of the CCOs are to limit increases in per capita spending and improve health care access and quality (NASHP).

Each CCO operates with a global budget and is responsible for all behavioral health, physical health, and oral health services with the added flexibility to provide services outside traditional medical services. In the first five years of the CCO program, 2.2 billion in costs were avoided. CCOs have also improved health care quality and other health indicators, especially in areas tied to incentive care. In addition, an evaluation of Oregon's 1115 waiver found an improved experience of care, improved self-reported health status, and a strong association between financial incentives and improvements in CCO metric performance (Center for Health Care Strategies).

Starting in 2020, Oregon required CCOs pay providers using Value-Based Payment (VBP) models and will expect CCOs to have a larger proportion of payments tied to VBP over time, moving away from the fee-for-service payment model toward annually increasing paying providers for quality of care and improved health outcomes. By 2024, CCOs will require 75% of payments to be VBP (Oregon Health Authority).

Arizona: Managed Care Organizations with Value Based Payments

Arizona's Medicaid Program resides in the Arizona Health Care Cost Containment System (AHCCCS) and the vast majority of beneficiaries receive services through MCOs. As of 2022, Arizona has contracted with eight managed care plans, which are paid a PMPM for each enrollee. Prior to 2015, the state regulated behavioral and physical services under two separate agencies; however, in a push towards integrated care, they unified those services under AHCCS and, starting in 2018, physical and behavioral health were fully integrated in Managed Care contracts.

AHCCCS is incredibly efficient in its provision of care, with lower Medicaid spending per beneficiary than other states ($5,821, versus a national average of $7,766). Arizona has

been one of the most innovative states within their Medicaid program. They are testing new models to improve quality of care through value-based payment. in 2019, MCOs in Arizona were required to have 50% of all payments to providers subject to value-based payment. According to the state, MCOs have implemented pay-for-performance (P4P), PCMH, shared savings, and bundled payment programs as a result of this flexible value-based payment requirement (Center on Budget and Policy Priorities).

There are a number of innovative programs within Arizona's Medicaid program, a few of which are highlighted below:

- **Persons with Serious Mental Illness**: Most Medicaid enrollees receive services through their chosen MCO plan but, starting Oct. 1, 2022, AHCCS has contracted with three Regional Behavioral Health Authorities (RBHAs) that operate statewide through a specialty managed care arrangement to provide integrated behavioral and physical health services to Medicaid enrollees with serious mental illness (SMI). Additionally, AHCCS has partnered with two collaborative vendors to provide housing and health care services in a new transitional housing facility for individuals experiencing homelessness and living with a SMI designation (AHCCS).
- **Whole Person Care Initiative**: Offers a range of support services to enrollees including transitional housing; referrals for and transportation to community-based services such as employment and food assistance; and long-term care services to reduce social isolation (AHCCS).
- **Opioid Services Locator**: AHCCS launched a web-based opioid services locator that is a location-based search engine featuring real-time services, by health plan network, distance, and type of services offered. Users can find certified opioid treatment programs, office-based treatment, residential services, and where to obtain Naloxone (State of Reform).

Washington: Regional Approach to Integrated Managed Care

Washington's Medicaid Program, Apple Health, contracts with MCOs to provide physical and behavioral health services. Prior to 2016, Washington Medicaid enrollees had to navigate separate systems to access physical and behavioral health services. In transitioning to a fully integrated system, Washington put emphasis on different regional approaches and allowed 10 designated regions to transition on their own timeline and the role of each regional/county behavioral health entity. Each region contracts with between three and five MCOs, chosen from a competitive bidding process among the existing Medicaid MCOs. The state also contracts with one Behavioral Health Administrative Services Organization (BH-ASO) in each region to manage crisis services regardless of insurance status. Preliminary evaluations of early and mid-adopting regions have shown positive impacts for Medicaid enrollees, particular for those with behavioral health conditions (Center for Health Care Strategies).

Connecticut: Fee-for-Service with an ASO Model or "Managed Fee-for-Service"
Connecticut utilized Managed Care to serve the majority of its Medicaid beneficiaries before transitioning to a FFS model in 2010. Connecticut is in the minority of states that utilize a pure FFS system. Connecticut's original Managed Care program saw high satisfaction with their plans, but faced provider network adequacy and target population screening deficits. Ultimately, the governor of CT terminated the contracts with the state's MCOs in 2008, at which point the state government took over the functions for provider rates, prior authorization criteria, and provider enrollment criteria. Connecticut contracts with an administrative service organization (ASO) for member services, provider enrollment, claims processing, case management, outreach and education. Ultimately, CT officially began to transition to FFS with ASOs handling administrative components in 2010 due to loss of confidence in the MCOs (CT Managed Care Background). Per CT, their shift led to a reduction in costs an increase in providers willing to treat Medicaid patients and a reduction in ED visits (*Fierce Healthcare*).

Vermont: Fee-for-Service that operates like Managed Care
Like CT, Vermont was previously a predominantly Managed Care state. In 2005, Vermont received approval for a unique 1115 demonstration waiver to affirm that the state will comply with all Managed Care regulations in administration of their Medicaid program. The waiver imposes a cap on the amount of federal Medicaid funding available to Vermont to provide acute care services to its Medicaid population. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the only state in the nation facing a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, creating a fiscal windfall for the state. It also gives Vermont new flexibility to reduce benefits, increase cost sharing, and cap enrollment for many Medicaid beneficiaries (Kaiser Family Foundation Issue Brief).

The Department of Vermont Health Access (AHS) technically operates as the managed care entity and through intergovernmental agreements they contract with other Vermont Agency for Human Services (AHS) departments for administrative and service management functions. CMS classifies the Vermont model as FFS with the dollars flowing through government agencies to providers based on value-based methodologies (CMS).

In Vermont, the AHS Department of Vermont Health Access (DVHA) serves as the managed care entity, and must adhere to both state and federal Medicaid managed care regulations. The state, therefore, does not contract directly with plans to manage care. AHS pays Department of Vermont Health Access (DVHA) a capitated per member per month rate similar to the way other state Medicaid agencies pay Mmanaged Rates are set prospectively using an actuarial process for the waiver year. For Medicaid, DVHA will "contract" with two ACOs (OneCare Vermont and Community Health Accountable Care). Green Mountain is a commercial plan that is for Medicare. All three are a part of a Shared Savings plan with savings generated through the "value-based payment methodologies."

Vermont also participates in a five- year CMS All-Payer Model demonstration that began in January 2017 across Medicare, Medicaid, and commercial insurance. During COVID-19, small hospitals struggled with the upside risk component in the Medicare population.

Additional Resources on Medicaid Managed Care

- *American Journal of Managed Care*: Variation in Network Adequacy Standards in Medicaid Managed Care, 2022
- National Council of State Legislatures: How States are Making the Most of Medicaid
- Institute for Medicaid Innovation: Medicaid MCO Best Practices & Innovative Initiatives
- CMS Value-Based Care Opportunities in Medicaid

Appendix

MACPAC Managed Care Overview- Federal Medicaid Managed Care Authorities

Section 1932(a) state plan authority	Allows states to enroll Medicaid beneficiaries in managed care on a mandatory basis without obtaining a waiver. Certain groups are exempted from mandatory enrollment (e.g., beneficiaries who are dually eligible for Medicare and Medicaid, Native Americans and children with special health care needs). The state must offer enrollees a choice of at least two managed care plans except in rural areas, where states can mandate enrollment into a single plan.
Section 1915(b) managed care/freedom of choice waivers	Allows states to implement managed care and to limit individuals' choice of providers under Medicaid. States can also: • waive state-wideness requirements (e.g., provide primary care case management or comprehensive risk-based managed care in a limited geographic area); and • waive comparability requirements (e.g., provide enhanced benefits to managed care enrollees).
Section 1115 research and demonstration waivers	Allows states to test an "experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs" covered by the Social Security Act, including:

	• waiving state wideness requirements related to eligibility, benefits, and service delivery and payment methods used by the state to administer the managed care program, and • identifying savings in the demonstrations to offset the cost of any program change, which can include managed care savings, to maintain budget neutrality.

MACPAC Types of Managed Care Arrangements

Key system features	FFS	Comprehensive risk-based plans	PCCM	Limited-benefit plans
Provider participation requirements	Any willing provider licensed by the state who agrees to accept Medicaid rates as payment in full can participate.	Plans must meet network size and location standards. Plans are permitted to limit the number of providers in their network and generally must credential providers before accepting them into the network.	PCCM programs may have to meet additional state requirements and agree to certain service policies.	Plans contract with a network of providers, similar to the process for comprehensive risk-based managed care plans, and may also need to meet network requirements.
Enrollee care-seeking rules	Typically, enrollees may receive care from any participating provider.	Plans set the rules on non-emergency referrals and care management, subject to state requirements and oversight. Services must be received from participating	Enrollees may need referral by the PCP to see various kinds of specialists, except in emergencies.	Plans set the rules on non-emergency referrals and care management, subject to state requirements and oversight. Services typically must be received from

		network providers, except in emergencies.		participating network providers, except in emergencies.
Navigation support for enrollees	Open access; enrollees may or may not have rules or guidance on how or where to seek appropriate available services.	Plans typically must provide enrollees with a member handbook and conduct an initial health assessment to determine enrollee needs. Many also provide disease management and care coordination services.	PCCM programs may provide additional navigation support and ways of identifying appropriate providers.	Depending on the type of services provided, plans may provide navigation support for enrollees similar to comprehensive risk-based plans.
Performance monitoring and quality oversight	Provider accountability for outcomes for individual enrollees is not typically formalized. For example, most states do not require providers to report HEDIS data.	Plans must conduct external quality reviews and must report specific performance data (e.g., HEDIS) and undertake specific quality improvement activities. Some states require external accreditation (e.g., NCQA and URAC).	Same as FFS; potentially specific metrics associated with monitoring PCCM performance.	PIHPs must conduct annual external quality reviews, may be required to report performance data applicable to the services delivered, and undertake specific quality improvement activities. External accreditation may be required.