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Accountable Care Collaborative could save money and improve quality, but it risks new barriers to care

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With thanks to
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The state's Accountable Care Collaborative (ACC) Program could help contain costs and improve the services Medicaid recipients receive. Without careful implementation, though, the ACC Program risks creating new barriers to care, especially for Colorado's poorest and most vulnerable Medicaid participants.

Colorado is implementing new care coordination mechanisms to serve the hundreds of thousands of residents who participate in the Medicaid program. The state's Accountable Care Collaborative (ACC) Program could help contain costs and improve the services Medicaid recipients receive. Without careful implementation, though, the ACC Program risks creating new barriers to care, especially for Colorado's poorest and most vulnerable Medicaid participants.

The ACC Program's potential to improve health care delivery for Medicaid recipients and contain costs for the state show how vital it is for advocates, policymakers and providers to help make the program's implementation a success. The ACC Program is expected to save the state \$4.9 million this year. The Medicaid program would be under significantly less pressure to control costs by reducing benefits or cutting provider rates if the ACC Program is able to realize that savings goal.

The ACC Program uses multiple layers of administration, including care-coordination organizations and networks of primary care health care providers. The ACC Program divides the state into seven regions to account for the differing health needs of geographically diverse communities. Each region has a Regional Care Collaborative Organization (RCCO) to which the state has delegated responsibility to coordinate Medicaid health care services. Care coordination includes more than ensuring members have access to physical health services. RCCOs are intended to connect members to behavioral health, long-term care, social services and public health systems, and also are responsible for ensuring continuity of care when patients are transferred from institutional settings to their homes or community-based care.

The RCCOs are also responsible for establishing contractual relationships with Primary Care Medical Providers (PCMPs) to deliver primary medical care to Medicaid patients in each region. Primary care providers in the ACC Program serve as medical homes, which are patient-centered practices that focus on building ongoing relationships between patients and their physicians.

At present, medical providers in the ACC Program will continue to be reimbursed through a traditional fee-for-service system. In addition, RCCOs and PCMPs will receive a Per Member Per Month (PMPM) payment for the care-coordination services they provide as part of the ACC program. As more clients are enrolled in the program, RCCOs and PCMPs will also be eligible for incentive payments and shared savings if they meet certain utilization goals.

Initial incentive payments will reward RCCOs and PCMPs that successfully reduce emergency room visits, hospital re-admissions and utilization of medical imaging

Several start-up issues have become apparent as the enrollment process progresses. The first is attribution, or the process of assigning clients enrolled in a RCCO to a specific PCMP. Approximately 20 percent of ACC Program enrollees remain unattributed and unable to access the care coordination services offered by the ACC Program.

Consumers have also expressed concern over the program's feedback process and the lack of consistency in RCCO grievance processes. If the ACC Program is to succeed in its goal of providing patient-centered care, it will be important for the RCCOs and the state to receive and effectively resolve individual grievances and complaints.

Longer-term questions also exist about whether the incentives and payment structure of the ACC Program will succeed in encouraging patient-centered care. Despite the program's commitment to move away from rewarding providers for offering a high volume of services, the state will continue to reimburse ACC providers with the fee-for-service model. It is unclear if this payment structure will motivate providers to focus less on the number of services delivered and more on the quality of care provided to patients.

This payment structure could change after the passage of House Bill 12-1281, which allows the state to consider payment reform pilot projects within the ACC Program. These projects could include a move toward global payment, a system in which a fixed payment covers all of a patient's health care needs.

Payment reform pilots, along with potential future incentives in the state budget, could create barriers to care if not implemented correctly. These incentives include gainsharing programs, which the state put in to its Fiscal Year 2012-13 budget. Gainsharing would allow providers to share in the budget savings from clients enrolled in the ACC Program. While global payment and gainsharing programs have the potential to lower statewide Medicaid costs, they could also create incentives for providers to withhold necessary services to save money. It is vital that cost savings not come at the expense of high quality care for the state's Medicaid recipients.

The ACC Program provides an opportunity to improve Medicaid in Colorado by enhancing the quality of care provided to enrollees and by reducing the cost of the program. The state has already placed over 123,000 Medicaid enrollees into RCCOs and is continuing to rapidly enroll clients. To ensure the health of all Medicaid recipients, the RCCOs must succeed in developing integrated provider networks that can offer high-quality care to all enrollees. It is also crucial that the ACC Program achieve its cost-saving goals. If the RCCOs meet cost reduction goals, the state will be able to realize Medicaid savings through increased efficiency and a decrease in unnecessary and avoidable medical costs, preventing devastating cuts to Medicaid benefits and services.

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