



Accountable Care Collaborative Phase II: Frequently Asked Questions

Updated March 2016

ACC Phase II Overview

- **Where can I find a general overview of the ACC Phase II?**
 - The Department has made available the following resources:
 - [ACC Phase II Concept Paper](#)
 - [ACC Phase II Overview Presentation](#)
 - [ACC Phase II Overview of Key Concepts](#)
 - We will also publish brief videos explaining Phase II in the future.
- **Why is the ACC program changing?**
 - The ACC is intended to be an **iterative program**, driving a steady sustainable shift in the delivery system from one that incents volume to one that incents value. In July of 2018, the [Regional Care Collaborative Organizations \(RCCOs\)](#) contracts are scheduled for reprocurement, creating a key opportunity for the Department to evolve the program.
- **What are the key principles of the ACC Phase II?**
 - The Department of Health Care Policy and Financing (Department) is committed to creating a high-performing, cost-effective Medicaid system that delivers quality services and improves the health of Coloradans. Phase II of the Accountable Care Collaborative (ACC) seeks to leverage the program's [proven successes](#) to enhance the Medicaid client and provider experience. The ACC Phase II is based on three key principles:
 - Person- and family-centeredness
 - Delivery of outcomes and value
 - Accountability at every level
 - That means integration within the health care system, integration between medical and non-medical programs, and alignment between efforts to achieve that integration.
- **Where can I find a copy of the ACC Phase II Concept Paper?**
 - In mid-October the Department released the [ACC Phase II Concept Paper](#), welcoming feedback and dialogue from the community. The Concept Paper was shared with the Centers for Medicare and Medicaid Services (CMS), posted to the Department's website, as well as sent to subscribers of the [ACC Phase II Updates list-serve](#). This Concept Paper serves as a request for our federal, state, and local partners to collaborate with the Department. As with all major program changes, the Department must secure approval and support from CMS. Therefore, the proposed changes to the ACC program in the Concept Paper, as well as any ideas developed through the stakeholder process, must be agreed upon by CMS. The Department expects rich and fruitful conversations with our federal partners.

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The Concept Paper is meant to initiate conversations between the Department and the wide variety of stakeholders who deliver and receive services through Colorado Medicaid.

- **Is Centers for Medicare and Medicaid Services (CMS) approval required to extend the current Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) contracts?**
 - Yes, as with all contract amendments, CMS approval is required. The Department will not have to extend the BHO contracts because their original contracting period goes through 2018. The RCCO contracts can be extended on an annual basis with approval from the State Purchasing Director.
- **Does the Department plan to submit an 1115 waiver to implement Accountable Care Collaborative (ACC) Phase II or any specific aspects of ACC Phase II, or will you continue with the program and any changes under the current authority or another type of authority? Are you required to have Centers for Medicare and Medicaid Services (CMS) approval before implementing any part of ACC Phase II under whatever authority you use?**
 - The Department is still in conversations with CMS about what is the appropriate authority needed to implement ACC Phase II. CMS approval is required prior to implementing ACC Phase II.
- **Will the Department release the draft Request for Proposals (RFP) for feedback?**
 - Yes, the Department is committed to sharing the draft RFP with the community. The draft RFP is another opportunity for individuals to look closely at the proposed vendor requirements and provide feedback to the Department.

Regional Accountable Entity

- **What is a Regional Accountable Entity?**
 - The new Regional Accountable Entities (RAEs) will be responsible for coordinating the physical and behavioral health for clients in their region, as well as:
 - Overseeing behavioral and physical health regional networks,
 - Onboarding and activating clients,
 - Developing and supporting Health Teams,
 - Making value-based payments to Health Teams, and
 - Convening Health Neighborhoods.
- **What is a Health Team?**
 - Regional Accountable Entities (RAEs) will have the responsibility for creating and supporting a system of Health Teams. A Health Team, at a minimum, includes the client and Primary Care Medical Provider (PCMP). Health Teams may also include a client's specialty behavioral health practitioner, long-term services and supports case management agency and certain specialists. The Health Teams will utilize:
 - Tele-health,
 - Regional technology solutions for care coordination,
 - Shared client data through the provider portal, and

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- Agreed upon and streamlined referral expectations between primary care medical providers and specialists.
- **How will the Department pay for services?**
 - The Department seeks to improve tools and strategies that ensure accountability for the full range of services provided to Medicaid clients and the total cost of care for clients. Regional Accountable Entities will be held accountable by the Department for improved health outcomes and cost efficiencies by tying a greater proportion of the administrative payment to quality-based measures and shared savings. The Department will continue to pay physical providers directly for the clinical services they offer in a way that promotes value. A capitation payment methodology will be retained for core behavioral health services that will be paid directly to the RAEs. The capitation will differ from the current capitation administered by the Behavioral Health Organizations in order to better support whole person accountability.
- **Will the RAEs be responsible for creating a regional care coordination tool? Or will the Department provide one, standard tool to be used by all RAEs and regions?**
 - Based on feedback the Department has received to date, the Department does not intend to offer one statewide solution. Many communities across the state have already invested in tools to help share information; the Department does not want to take-away from that work. The Department plans to set basic parameters around what information needs to be able to be collected and shared, and then allow the RAE and community develop a solution that works for them.
- **Will Medicaid client be automatically enrolled in the ACC?**
 - Yes. Medicaid clients will be automatically enrolled in the ACC and immediately connected with a PCMP. Automatic enrollment gives clients access to support from their RAE and the provider network upon Medicaid approval.
- **Will physical health payments still be fee-for-service through the Department, or will the Regional Accountable Entities (RAEs) also receive capitation for physical health services?**
 - Providers who are delivering physical health services will still bill the Department directly on a fee-for-service basis for the delivery of those physical health services. The RAEs will not receive a capitation for physical health services. For additional information, please see the [October 20, 2015 ACC Phase II Concept Paper](#).
- **Will Regional Accountable Entities (RAEs) be required to have an insurance license in order to accept behavioral health capitation?**
 - Yes, at a minimum RAEs will be required to have a Division of Insurance Limited Service Licensed Provider Network license in order to manage limited risk. This is the current requirement of all Behavioral Health Organizations (BHOs). A Health Maintenance Organization (HMO) license is also acceptable because it allows vendors to hold a greater degree of risk for comprehensive services, but an HMO license is not required.
- **Will the Regional Accountable Entities (RAEs) have flexibility to sub capitate qualified providers, and to which entity will encounter data be sent?**

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- The only capitation that will be paid to the RAEs is for those core behavioral health services. The RAE will then have the flexibility to pay a portion of that capitation to another entity and sub capitate them. All behavioral health encounter data will need to be sent to the RAE administering the capitation.

Physical health care services will continue to be billed by providers directly to the Department. There will not be the opportunity for the RAEs to capitate physical health services, except through existing managed care contracts and the limited implementation of special outpatient professional capitation models. (For more information see the [October 20, 2015 ACC Phase II Concept Paper](#).)

Behavioral Health

- **What changes are being made as of the ACC Phase II to Behavioral Health Organizations?**
 - The Department will contract with one administrative entity in each region of the state to be responsible for the duties traditionally performed by the Regional Care Collaborative Organizations (RCCO) and Behavioral Health Organizations (BHO). This change will improve the client experience by creating one point of contact and clear accountability for whole person care. For additional information please see the [April 2015 ACC Model Details and Policy Decision paper](#).
- **What will the capitated core behavioral health services include?**
 - The primary focus will be retaining services that are currently available only through the state's 1915(b)(3) waiver with the Centers for Medicare and Medicaid Services (CMS). Specifically, the waiver enables the Department to pay for services that are not allowed under fee for service, such as inpatient hospitalizations as an "in lieu of" service, vocational services, intensive case management, clubhouse and drop-in centers, and Assertive Community Treatment among others. The Department also envisions including basic behavioral health therapies such as medication management and individual, group, and family therapy within the capitation.
- **Can you offer any specifics at this point about what, if anything, will be moved out of capitation?**
 - The Department is seeking to achieve the appropriate balance between retaining the flexibility of a capitated system in order to effectively care for individuals with severe and persistent mental illness, and adjusting the current capitation to increase access for individuals who the current system is not serving as well as it potentially could. As a result, the capitation will support the continuum of core behavioral health services, but the Department will reduce the use of covered diagnoses where possible. In addition, the Department will move money outside of the capitation to pay for integrated care and brief behavioral health therapy in the primary care setting.
- **Are you considering eliminating covered diagnosis or adding additional diagnoses?**

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- Covered diagnosis requirements will not be eliminated completely; instead, the Department is considering appropriate ways to limit the covered diagnosis requirements where possible. By limiting the covered diagnosis requirements the Department will rely more on clients meeting standards of medical necessity in order to access capitated services. At a minimum, covered diagnoses will still be required for reimbursement of emergency department visits, inpatient hospitalizations, and laboratory tests.
- **Will there be a change to the substance abuse benefit?**
 - In January 2014 the Department added substance use disorder diagnoses to the Behavioral Health Organizations (BHOs) contract, removing barriers to payment. Based on feedback during the [RFI process](#), the Department, along with stakeholders, are exploring how best to ensure increased access to substance use disorder services in Phase II. No decisions have been made at this time about the benefit and if there will be changes. For more information about what substance use treatments are currently reimbursed, please see the [2015 Uniform Service Coding Standards Manual](#).
- **What suggestions do you have for providers working to recover costs for Medicaid services for behavioral health clients?**
 - Providers should reach out to their Behavioral Health Organization (BHO) directly to identify solutions. If the provider and BHO are unable to reach a solution, they should contact the BHO contract manager at the Department. In addition, a cross-agency working group currently exists between the Department and the Department of Human Services. The working group is tasked with working with BHOs to identify how to define and support more integrated care under current contracts.
- **Currently a primary care provider can only bill a primary behavioral health diagnosis through the Behavioral Health Organizations (BHOs). Will that policy continue?**
 - The statement above is not correct. The current policy is that primary care providers (MD, DO, NP, etc.) do NOT have to submit claims for Evaluation and Management (E&M) procedure codes to the BHOs for clients with a primary behavioral health diagnosis. Rendering primary care providers may submit all E&M claims to the Medicaid Management Information System (MMIS) for fee-for-service reimbursement. The Department will not change this policy in ACC Phase II.
- **Will Regional Accountable Entities (RAEs) be responsible for the utilization management for the core behavioral health services?**
 - Yes, the RAE will be responsible for utilization management of core behavioral health services and will authorize services. The RAE will also be responsible for ensuring increased access to services.
- **It will be helpful to have conversation about what is needed in integrated care settings that are actually based in the Community Mental Health Centers (CMHCs) (health homes)- rather than talking about integrated care as if it is all the same and just about bringing a BHP into primary care.**
 - The Department acknowledges that there are different needs and requirements related to the integration of primary care services within Community Mental

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Health Centers (CMHCs). At this time the Department is allowing the models funded through the State Innovation Model to evolve and will work to align ACC Phase II with the findings that arise from these models. In the meantime, the Department did provide guidance to CMHCs in November 2014 on methods they could implement in order to be eligible for reimbursement for primary care services delivered within the CMHC. Please contact your BHO for assistance with this guidance.

- **Does HCPF plan to make any incremental changes in the current Accountable Care Collaborative (ACC) or with the current Regional Care Collaborative Organizations (RCCOs)/Behavioral Health Organization (BHOs) contracts in the interim before the rebid and change to Regional Accountable Entities (RAEs)?**
 - The Department is committed to continuing delivery system innovation as it works towards Phase II. Over the next two years, the Department will work with providers and the current RCCOs and BHOs to innovate and transform the delivery system, including further implementation of:
 - Cost savings measures,
 - Financial transparency,
 - Pay for performance and alternative payment methodologies,
 - Integrated care,
 - Learnings from projects and pilots including the State Innovation Model (SIM), Comprehensive Primary Care Initiative (CPCI), 1281 Payment Reform Pilots, and Medicare Access & CHIP Reauthorization Act (MACRA),
 - Local public health agency partnerships, and
 - Systems to support innovation.

The Department is confident these ongoing innovations and the revised procurement timeline will help better meet the needs of the community.

How to Stay Informed

- **Where can I find information on upcoming stakeholder meetings that are open to the public?**
 - The current list of public meetings can be viewed in the [Stakeholder Opportunities section of this page](#).
- **What steps is the Department taking to solicit Medicaid client input on Phase II development?**
 - The Department plans to solicit feedback from its [Person- and Family-Centeredness Advisory Councils](#) on key topics related to Phase II development.
- **How can I sign up for the ACC Phase II Updates?**
 - You can [sign up for our regular ACC Phase II Updates here](#). We also encourage you to sign up for the other Department publications listed.

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