



COLORADO

Department of Health Care
Policy & Financing

Responses to Questions from the April 21, 2015 ACC Model Details and Policy Decisions Document

JUNE 16, 2015

The next phase of the Accountable Care Collaborative (ACC) seeks to optimize health for those served by Medicaid through accountability for value and client experience at every life stage. Payment is one mechanism to achieve our goals. We have received several questions related to the payment strategy. The Department seeks a payment methodology that is neither complete fee-for-service nor statewide managed care and that incorporates learnings and the best components of both types of systems.

Question 1: What does the Department mean by “capitation” in the phrase “the ACC will continue to pay most behavioral health through a capitated system”?

Answer 1: Capitation means that the payments will be per person rather than per service. The risk structure for the capitation payments (ranging from full to none) has not yet been determined, but could potentially vary by region. Right now, the Behavioral Health Organizations are full risk. This means that they are given a fixed amount of funds per Medicaid enrollee in their geographically defined region. If a client needs services that exceed the amount of funds, the BHO incurs the cost; if a client costs less than the fixed capitation, then the organization retains those additional funds. Capitations can be set up in a variety of different ways. A capitation could be used without including any risk for service costs to the contracted entity. For example, a client needs services that exceeds the fixed price, then the state would provide the organization with more money and if they need fewer services, the organization would have to return funds to the state.

Question 2: Under the “Payment” section, the document [[April 21st ACC Model Details and Policy Decisions](#)] says “At the beginning of the contract, the ACC will continue to pay most physical health through managed fee for service and most behavioral health through a capitated payment structure.” What does “most behavioral health” mean – which services will be provided under capitation and which under a fee-for-service payment model?

Answer 2: Behavioral health, as used here, refers to the set of services that are currently covered by the Behavioral Health Organizations. The specifics of the payment for behavioral health services have not been decided at this time. The Department will determine which services will be in the capitation and which will be outside of the capitation by determining the payment model that will best accomplish the following goals:

1. Accountability for whole-person health outcomes and costs via value based payment
 - a. Supports efficient and innovative interventions
 - b. Supports integrated physical and behavioral health services
2. Appropriate Network
 - a. Appropriate provider mix for client need
 - b. Adequate number of providers

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
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3. Support early behavioral health prevention and intervention
4. Close gaps in coverage and gaps in care for certain populations
5. Flexibility to integrate blended funding (Systems of Care and Corrections)
6. Transparency to the Department and to the public as to how effectively funds are being used

Question 3: Under the “Payment” section, the document says “the Department will create a glide path to better align payment structures to incent value and quality of care.” Does this “glide path” include moving primary care to a risk-based system instead of a fee-for-service payment model?

Answer 3: No. The Department can incent value and quality care through methods other than a risk based system. At this time, the Department is not moving towards full-risk managed care for both physical and behavioral health. The next phase of the ACC may contain multiple payment methodologies for different regional entities, populations, or areas of the state. The Department is interested in stakeholder ideas around innovative payment models that will drive delivery system change, enhance the client experience, and improve health outcomes for those covered by Medicaid.

Question 4: Does “value and quality of care” include integration? What about incentivizing integration of behavioral and physical health?

Answer 4: Yes. Integration of behavioral and physical care is one important method to achieve the Department's value and quality of care goals. The Department will work with State Innovation Model partners and private payors to develop an aligned strategy to support integrated care.

Question 5: Under the “Payment” section, the document says “The applying administrative entity will need to have necessary licensure to manage limited behavioral health risk.” What does “limited” mean?

Answer 5: The Department has indicated that it does not intend to move to full-risk managed care for both physical and behavioral health during the next iteration of the Program. As such, applying entities will not be required to obtain health maintenance organization (HMO) licensure. However, Division of Insurance Limited Service Licensed Provider Network (the current BHO licensure type) may be necessary to manage the services or parts of the scope of work which are at-risk (should any portion of the scope of work retain risk).

Question 6: We assume that there will be 7 ACC regions that mirror the current RCCO regions (with the possible exceptions of Larimer and Elbert counties). Will all of these regions be actuarially sound in terms of establishing a capitated behavioral health payment structure in each?

Answer 6: There will be 7 regions that mirror current RCCO regions (with the possible exceptions of Larimer and Elbert counties). The Department's methodology to determine payments to the regional entities will be actuarially sound commensurate with the level of risk.

Question 7: What's the financing model for integrated care after 2017?



Answer 7: The Department will work with stakeholders to develop a financing model for integrated care after 2017.

Question 8: What does HCPF want to achieve from a combined administrative entity with respect to administrative efficiencies? (i.e., How will the two program contracts be blended administratively?)

Answer 8: The Department intends to contract with a single regional entity. Centralized accountability will produce administrative efficiencies for the Department and providers. Additionally, the Department looks forward to seeing RFP responses that demonstrate:

- A commitment to leveraging opportunities to reduce duplication of administrative efforts and resource utilization that exists in the current bifurcated system
- How entities will leverage economies of scale
- How they will improve overall administrative efficiency relative to the current system

Because price is a consideration in the competitive procurement process, the Department anticipates that a successful bidder would have a robust plan to ensure/maximize administrative efficiency without compromising the comprehensiveness of services.

