



Accountable Care Collaborative Fact Sheet

The Accountable Care Collaborative (ACC) is a Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC receive the regular Medicaid benefit package, and belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP).

The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes.

ACC History

The program began in the spring of 2011 and enrollment has reached more than 662,000 Medicaid clients statewide.

Central Goals:

- Improve health outcomes through a coordinated, client-centered system; and
- Control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

Key Components:

- Seven Regional Care Collaborative Organizations (RCCOs) provide:
 - Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
 - Care coordination among providers and with other services such as behavioral health, long-term supports and services, Single Entry Point (SEP) programs and other government social services such as food, transportation and nutrition; and
 - Provider support such as assistance with care coordination, referrals, clinical performance and practice improvement and redesign.
- The Statewide Data and Analytics Organization (Treo Solutions):
 - Builds and implements the ACC data repository;
 - Creates reports using advanced health care analytics;
 - Hosts and maintains a Web portal;
 - Provides a continuous feedback loop of critical information;
 - Fosters accountability and ongoing improvement among RCCOs & providers; and
 - Identifies data-driven opportunities to improve care and outcomes.

Primary Care Medical Providers (PCMPs) are affiliated with a RCCO, and act as “medical homes” for clients. As a medical home, the PCMP will coordinate and manage a client’s health needs across specialties and along the continuum of care.

Colorado has received national attention due to the progress and composition of the ACC program. Many states are watching and monitoring Colorado’s implementation of the program.