ACC Phase III: Proposed Concepts

Program Improvement Advisory Committee

August 16, 2023

Presented by:

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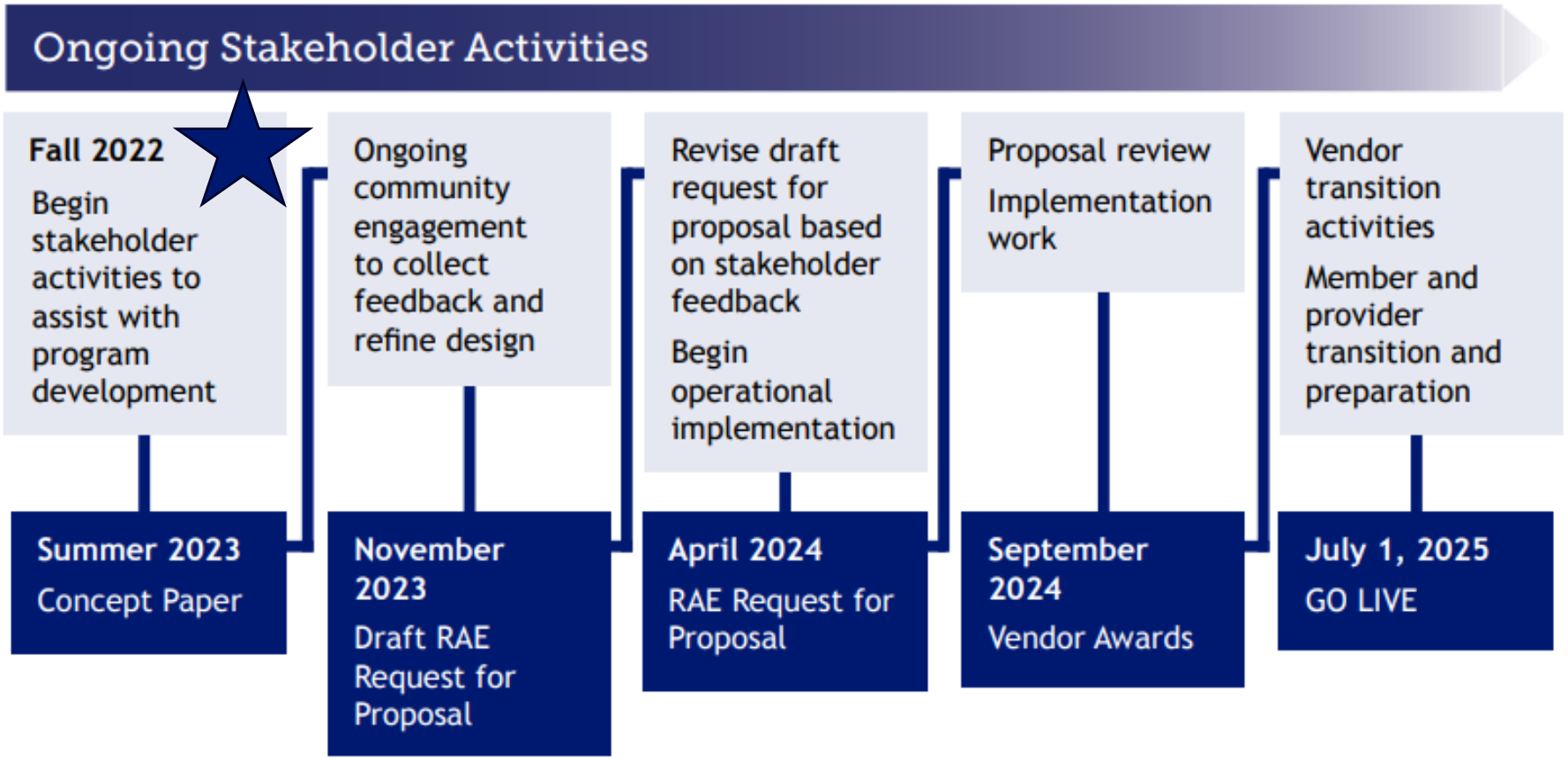
Today's Agenda

- Background
- Phase III Proposals
  - Comments/questions may be shared via chat
- Discussion (PIAC members) – Questions & Answers
  - Please hold verbal comments or questions until this time.
- Next Steps
- Open comment for public attendees (11:45 – 11:50am)


Ongoing Stakeholder Activities
Fall 2022
Begin stakeholder activities to assist with program development
Summer 2023
Concept Paper
Ongoing community engagement to collect feedback and refine design
November 2023
Draft RAE Request for Proposal
Revise draft request for proposal based on stakeholder feedback
Begin operational implementation
April 2024
RAE Request for Proposal
Proposal review
Implementation work
September 2024
Vendor Awards
Vendor transition activities
Member and provider transition and preparation
July 1, 2025
GO LIVE

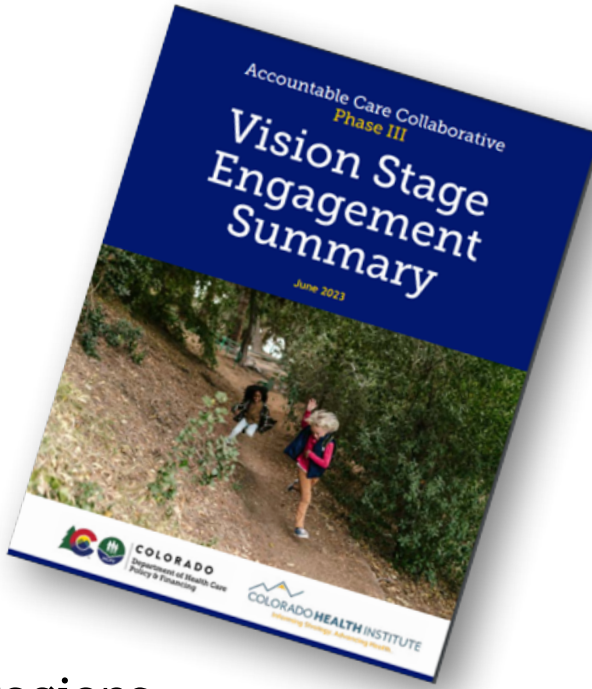
What we've heard:

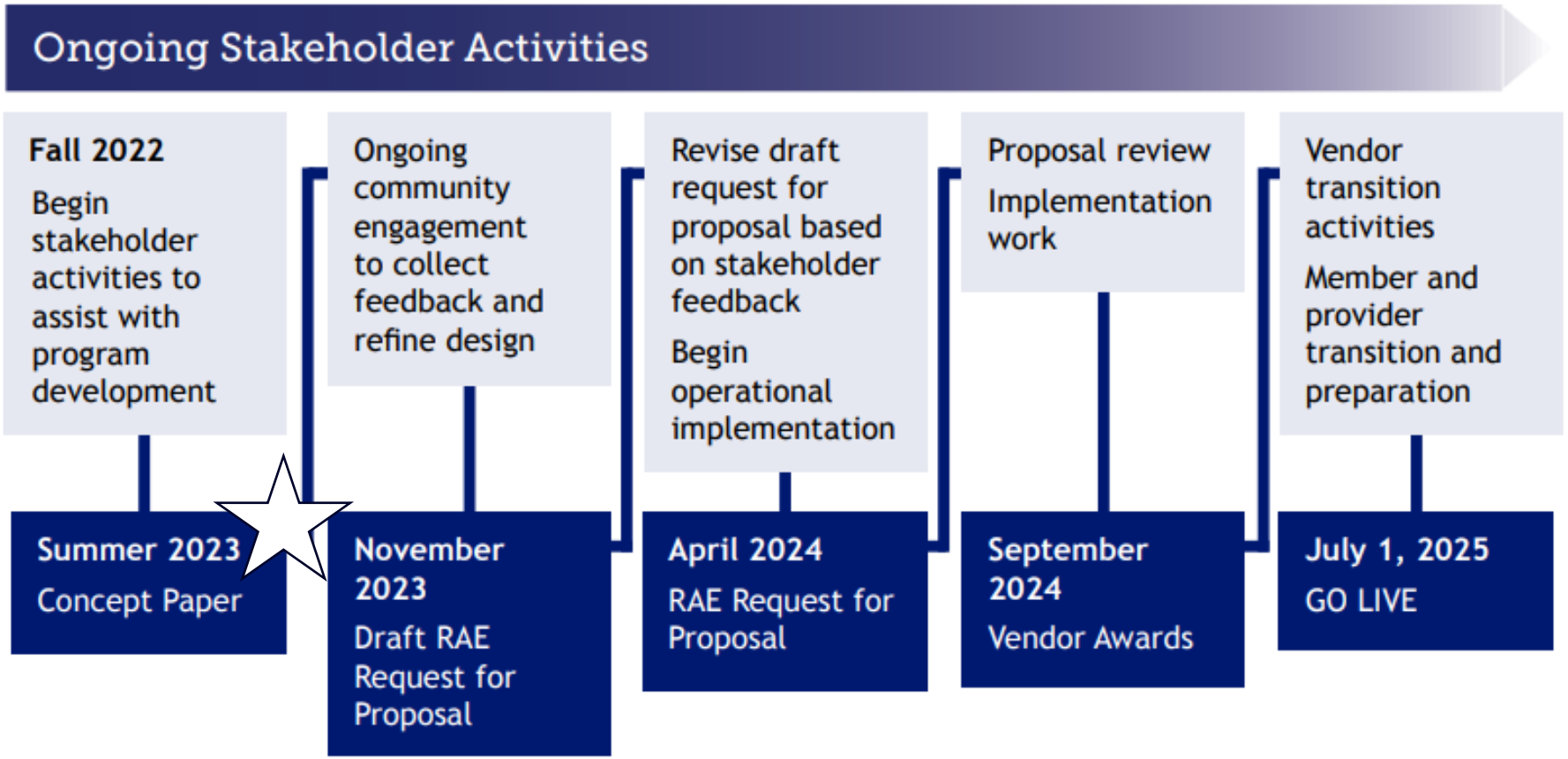
What's working well:

- Majority of members are getting the care they need
- Providers engaged with RAEs appreciate resources and support
- Regional model acknowledges that different parts of Colorado have different needs
- Care coordination for those who are actively engaged
- Existing member engagement councils

What needs improvement:

- Process and administrative barriers
- Inconsistency across 7 regions
- Alignment with other entities in midst of statewide changes
- Care capacity and access
  - Services for children and youth

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Goals for ACC Phase III

1. Improve quality care for members.
2. Close health disparities and promote health equity for members.
3. Improve care access for members.
4. Improve the member and provider experience.
5. Manage costs to protect member coverage, benefits, and provider reimbursements.

1. Improve quality care for members.

What does this look like in Phase III?

- Aligned strategic objectives
- Standardize incentive payment measures
- Standardized children's benefit
- Children and youth intensive care coordination
- Behavioral Health Transformation

Implement ACC Phase III Strategic Objectives

Improve follow-up and engagement in treatment for mental health and substance use disorder by 20%

Achieve national average in preventative screenings

Close racial/ethnic disparities for childhood immunizations and well-child visits by 30%

Reduce maternal racial/ethnic disparity gaps between highest and lowest performing populations for birthing people by 50%

Improve care for people with diabetes and hypertension by 50%

Fiscal goal under development

Standardize incentive payment measures

- CMS core measures
- Align with:
  - Division of Insurance's implementation of House Bill 22-1325, Primary Care Alternative Payment Models
  - Center for Medicare and Medicaid Innovation's Making Care Primary model

Standardize children's benefits to assure access to needed services across a continuum of care

Entry to Care	Determine access points for different tiers [e.g., PHQ-9 in PCP; CANS with IA through CW]			
Level of Care	1	2	3	4
Service Category	Low	Medium	High	Inpatient
Services Available	Targeted services for each acuity/complexity TBD through engagement with you			
Care Coordination Level	Tiered care coordination associated with evidence-based practice for different levels			

Implement programs for children with highest acuity and multi-agency involvement.

- High-Fidelity Wraparound
- Establish new intensive care coordination model

Reference: Senate Bill 19-195

Implement behavioral health transformation efforts

- Expand provider network and strengthen crisis continuum of services
- Explore innovations to current funding system such as prospective payments and directed payments
- Fill gaps in continuum of care
- Align with BHA
- Reduce administrative burden

Explore development of a distinct Integrated Care Benefit

- Apply to integrated care in both physical health or behavioral health setting

- Align and advance various efforts around integrated care:
  - SIM
  - Six-visit benefit
  - Grant pilot

Reference: House Bill 22-1302

2. Close health disparities and promote health equity for members.

What does this look like in Phase III?

- Implement existing regional health equity plans
- Use equity-focused metrics
- Equity requirements for RAEs
- Explore expansion of permanent supportive housing services
- Explore providing food related assistance and pre-release services for incarcerated individuals
- Leverage social health information exchange tools

Develop requirements for RAEs to address health equity within their regions.

- Implement a regional health equity plan
- Create an equity key personnel position
- Complete health equity trainings
- Create an equity taskforce

Explore opportunities to address members' health-related social needs

- Support connection to food-related assistance
  - Support member enrollment in SNAP and WIC
  - Explore other opportunities (e.g., medically tailored meals)
- Explore new federal (CMS) opportunities:
  - Expand permanent supportive housing services
  - Expanding continuous coverage for eligible children and adults
  - Pre-release services for incarcerated individuals
- Leverage social health information exchange tools

Reference: House Bill 23-1300, Senate Bill 23-174, Senate Bill 22-196

3. Improve care access for members.

What does this look like in Phase III?

- Clarify care coordination roles and responsibilities
- Create tiered model for care coordination
- Strengthen requirements for RAEs to partner with community-based organizations (CBOs)
- Explore innovations to current behavioral health funding system to fill gaps in care (Behavioral Health Transformation)

Reference: Senate Bill 23-174

Create a 3-tier care coordination model, aligned with the BHA, to improve quality, consistency, and measurability of interventions

Tier	Target Population	Care Coordinator	Activities
Level 3	• Uncontrolled conditions • Multiple diagnoses • Multi-system involvement • Difficult to place • PDN • COUP	Clinical Care Coordinator Maybe in-house HCPF clinicians for specific populations (e.g., transplants)	• Care plan • Specific assessments based on population type/need • Monthly coordination with Member/treatment team • Long-term monitoring and follow up
Level 2	Condition management (heart disease, diabetes, depression/ anxiety, asthma/COPD, maternity)	Clinical Care Coordinator	• Care plan/assessments TBD (possibly just pull from their provider) • Quarterly coordination with member/treatment team • Long term monitoring and follow up
Level 1	Anyone	Not clinical, no staffing ratio	• Brief needs screening (Health Needs Survey) • Support accessing services and benefits • Determining need for higher level of care coordination • Brief monitoring and follow up

Increase equitable access to care coordination

- Require RAEs to develop a network of community-based organizations to reach and educate members

4. Improve the member and provider experience.

What does this look like in Phase III?

- Enhance Member Attribution process to increase accuracy and timeliness
- Increase the visibility of and clarify role of the RAE
- Reduce administrative burden on providers through BH transformation efforts
- Reduce total number of regions

Enhance Member Attribution process to increase accuracy and timeliness

- Members without existing PCMP relationship assigned to RAE only based on their address
- RAEs support members in establishing care with PCMP or with engaging in preventive services
- Expand provider types that can serve as PCMPs (such as Comprehensive Safety Net Providers)

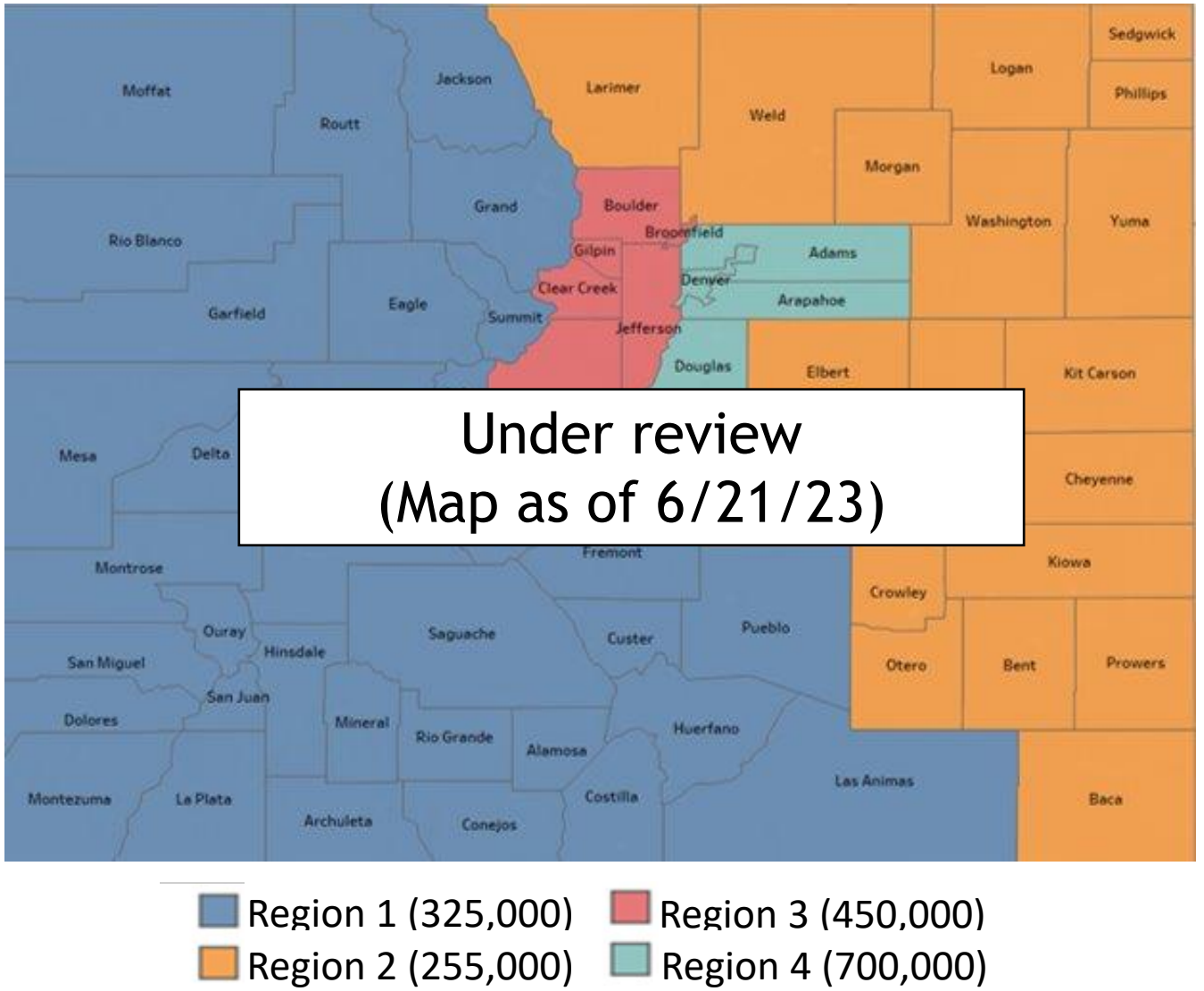
Increase the visibility and clarify roles of RAE and HCPF to members

- Increase member education and awareness of RAEs
- Require all RAEs to establish and regularly meet with Member Engagement Advisory Councils for ongoing trust building and engagement
- Create a seamless experience for members by promoting HCPF member call center as primary point of contact

Reduce administrative burden on providers through Behavioral Health Transformation efforts

- Centralized provider credentialing
- Explore directed payments
- Standardized utilization management
- Universal contracting provisions

Reduce the total number of RAE regions



5. Manage costs to protect member coverage, benefits, and provider reimbursements.

What does this look like in Phase III?

- Improve administration of behavioral health capitation payment
- Improve alignment between ACC and Alternative Payment Models
- Implement new Alternative Payment Models

Improve administration of behavioral health capitated payment

Address:

- Regional variations in rates and UM practices
- Transparency
- Administrative burden for providers
- Reporting requirements and oversight capabilities

Improve alignment between ACC and Alternative Payment Models

- Payment
  - ACC Incentive Payments
  - ACC administrative payments to PCMPs
  - Behavioral health capitation
  - Shared Savings
- Practice support
- Data sharing

Explore ACC alignment with new APM programs

APM 2	• Providers receive 100% of Medicare rates for services under APM 2 and eligible to receive shared savings from improved chronic care management • FQHC subset that allows more flexibility for participation
PACK	• Address specific needs of pediatric primary care providers • Incentivize quality care specific to pediatric population
Maternity Bundled Payment	• Providers eligible to receive incentive payments depending on cost of each episode • Allows providers to make choices about care delivery and related investments to improve quality and health equity outcomes
Behavioral Health APMs	• Designed in collaboration with BHA • Cost-based prospective payment model for safety net providers • Enhanced payment for essential safety net providers
Prescriber Tool APM	• Incentivize use of the Real Time Benefits Inquiry (RTBI) module to promote Medicaid pharmacy benefit compliance and cost efficiency in pharmacy utilization

Reference: House Bill 22-1325

Discussion

Discussion

- CHI will prioritize questions from PIAC members in the chat. All chat comments will be shared out with the slides.

- **PIAC Voting Members:** Please raise your hand using the "Reactions" feature in Zoom.
  - CHI staff will call on speakers based on the speakers' queue
  - Please limit your comment to 2 minutes to ensure time for others to speak.
  - Longer comments may be submitted in writing via the chat, or through the survey link shared at the end of today's meeting.

- **Members of the public:** Please hold verbal comments until the Open Comment session immediately following this presentation

Thank you for your patience and your participation!

Next Steps

Provide additional feedback:

- Full concept paper to be posted soon
- Online survey — responses will be made publicly available (without names)
- Open feedback form will remain open

Upcoming Public Meetings

- **Virtual Public Listening Session (all welcome):** 8/21 from 12 to 1:30 pm
- **Primary Care Medical Providers:** 8/31 from 8 to 9:30am
- **Advocates and CBO representatives:** 9/6 from 12 to 1:30 p.m.
- **Behavioral Health Providers:** 9/14 from 5 to 6:30 pm
- **All providers welcome:** 9/26 from 8 to 9:30 a.m.

Additional members-only sessions are in the process of being scheduled.

Thank you!

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