

ACC Phase III Planning

April 27, 2023

County Directors Leadership Meeting



COLORADO

Department of Health Care
Policy & Financing

Agenda

- Overview of ACC Phase III
- Behavioral Health Integrated Care Benefit Proposal
- Aligning RAE & BHASO Regions

ACC Phase III Vision for July 2025

Why: Goals

- ★ Improve quality care for members
- ★ Close health disparities and promote health equity for members
- ★ Improve care access for members
- ★ Improve the member and provider service experience
- ★ Manage costs to protect member coverage, benefits, and provider reimbursements

What: Priority Initiatives

-  Improved Member Experience
-  Accountability for Equity and Quality
-  Referrals to Community Partners
-  Alternative Payment
-  Care Coordination
-  Children and Youth
-  Behavioral Health Transformation
-  Technology and Data Sharing

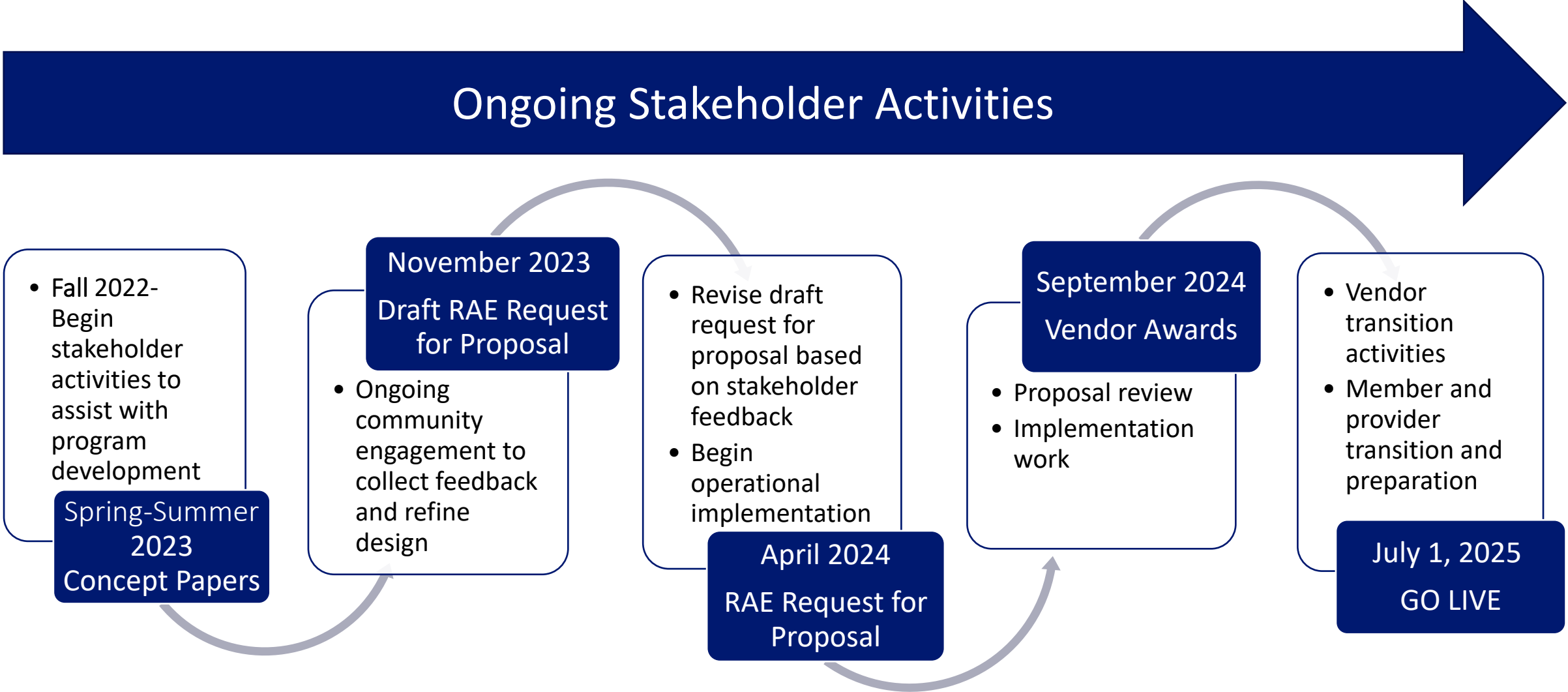
How: Pathways to Success

Simplifying Systems

Incentivizing Better Outcomes

Timeline

Ongoing Stakeholder Activities



ACC Phase III Integrated Care Benefit Concept Proposal

Presented by: John Laukkanen

Problem Statement

- The Dept is committed to advancing the integration of member care for physical health (PH) and behavioral health (BH) to provide whole-person care in ACC Phase 3.
- The Dept would like to see distinct care considerations for members with higher acuity conditions (SMI/SUD)

Proposal

HCPF is looking to design a distinct Integrated Care Benefit (ICB) that considers the current reimbursement structures of key PH and BH providers (i.e. FQHCs, CMHCs, PCPs, etc.). This new benefit will fold in the current Short-Term Behavioral Health (STBH) benefit.

Options Considered

- 2703 Health homes for SUD
- 2703 Health homes for both SMI/SUD
- ACC Phase 2 merged PH and BH under the RAEs
- The state's participation with the State Innovation Model (SIM)
- The implementation of the 6 Short Term Behavioral Health (STBH) benefit
- 1302 grant pilot funding to promote PH and BH integration
- Specific care considerations for high acuity conditions, serious mental illness/substance use disorder (SMI/SUD)



Proposed Approach for ICB

The ICB will start with a mechanism to identify PH settings who are operating as IC providers

- 1) Behavioral Health Entities (BHEs) would stand up a PH clinic onsite/embedded in their practice (as done in SIM).
 - Address the specific care needs of the SUD/SMI populations where BHE is the primary provider connected to members.
 - Consider the scope of BH services on member attribution here, which would give us the outcome of a health home.
 - We could design distinct metrics/outcomes for PMPM or incentives related to members with high-acuity BH conditions
- 2) There are multiple models of integration when adding behavioral health services to medical settings. Distinct BH services would be added/billed in this setting and require a licensed BH practitioner who is enrolled with Medicaid be employed or contracted by the IC location.



Proposed Approach for ICB

Policy Parameters:

1. The ICB is intended for early intervention, pre-diagnosis, lower acuity, and maintenance level encounters.
2. There would be no limit to contacts per year. The number of contacts with a member would be determined by the member, the Integrated Practitioner, the condition being treated, and the business model of the IC setting.
3. The Integrated Practitioner (medical staff or BH staff) would only see patients established at the host agency (i.e. PH clinic/setting or BHE).
4. MAT services should be encouraged and incentivized in practices where it is appropriate.

Proposed Approach for ICB

Payment Components

1. The Integrated Practitioner would bill codes for each encounter. RECOMMEND SUNSETTING THE STBH BENEFIT FOR PCMPS. Replace with a full bundle of codes designed for Integrated Care Models.
 - a) Adding a distinct line of business (BH) to a PH setting requires more than a PMPM or APM financial investment. This needs a distinct set of codes and a clear, identifiable billing pathway.
 - b) Using billable codes directly links payment to a service provided that is trackable and has a direct financial impact to the location for those services. PMPMs alone risk being absorbed by unrelated business expenses.
2. IC Providers would participate in a PMPM for additional resources, which is linked to established care metrics.
3. HCPF would design data, metric, and outcome measures for these providers [before the benefit is created in order to determine ROI and value, etc.] and in both contexts: PCMP with BH or within BH.
4. HCPF would offer incentives (BHIP?) for the RAEs to recruit/contract with a certain percentage of IC practices.

Decisions

1. Since these services will be provided in physical health settings, the medical services will be billed FFS [current process]. Would it be better (for cost, care, administrative burden, etc.) to allow the ICB codes to also be billed FFS? If we wanted the distinct BH encounters billed under the Cap, RAEs could be required to automatically include the ICB codes in the IC contracts. If we wanted some services covered under each (FFS/CAP) we could develop a “staircase” for this benefit to identify what and when a service is billed to each.
2. How to address providers who have a cost-based reimbursement structure (i.e. FQHCs - already have a staffing and billing model for both their PH/BH encounters)



Questions?



Thank you!
john.laukkanen@state.co.us

Aligning RAE and BHASO Regions



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Level-setting

- Today we will be discussing geographic alignment of the following two entities:
 - **Regional Accountable Entities (RAEs)** – managed by the Department of Health Care Policy & Financing, new RAE contracts go live 7/2025.
 - **Behavioral Health Administrative Service Organizations (BHASOs)** – managed by the Behavioral Health Administration, go live 7/2024.

Level-setting

- The Department of Health Care Policy & Financing and the Behavioral Health Administration are committed to being thoughtful about how the RAEs and BHASOs might align. **The shared map is created in that spirit.**
- The final map has not yet been decided.
- We are moving quickly to do our best to support the BHASO timeline for RFP, given their 7/1/24 legislative effective date.


Behavioral Health Administrative Services (BHASO) Overview

- C.R.S. 27-50-401 established the newly proposed safety net system that creates regional Behavioral Health Administrative Services Organizations (BHASOs).
- The BHASOs must be established no later than July 1, 2024.
- BHASOs must accept and provide behavioral health safety net services to individuals outside of their own region.
- BHASOs will operate on a regional basis.
- Entities will participate in a competitive process (RFP) to become a BHASO.

The BHASOs will:




Help individuals and families initiate behavioral health care and ensure timely access to service.



Provide a continuum of behavioral health safety net services and care coordination.



Consolidate MSOs, ASOs, and services offered by CMHCs.



Interface and align with the RAEs that manage services and provide care coordination for Medicaid members.

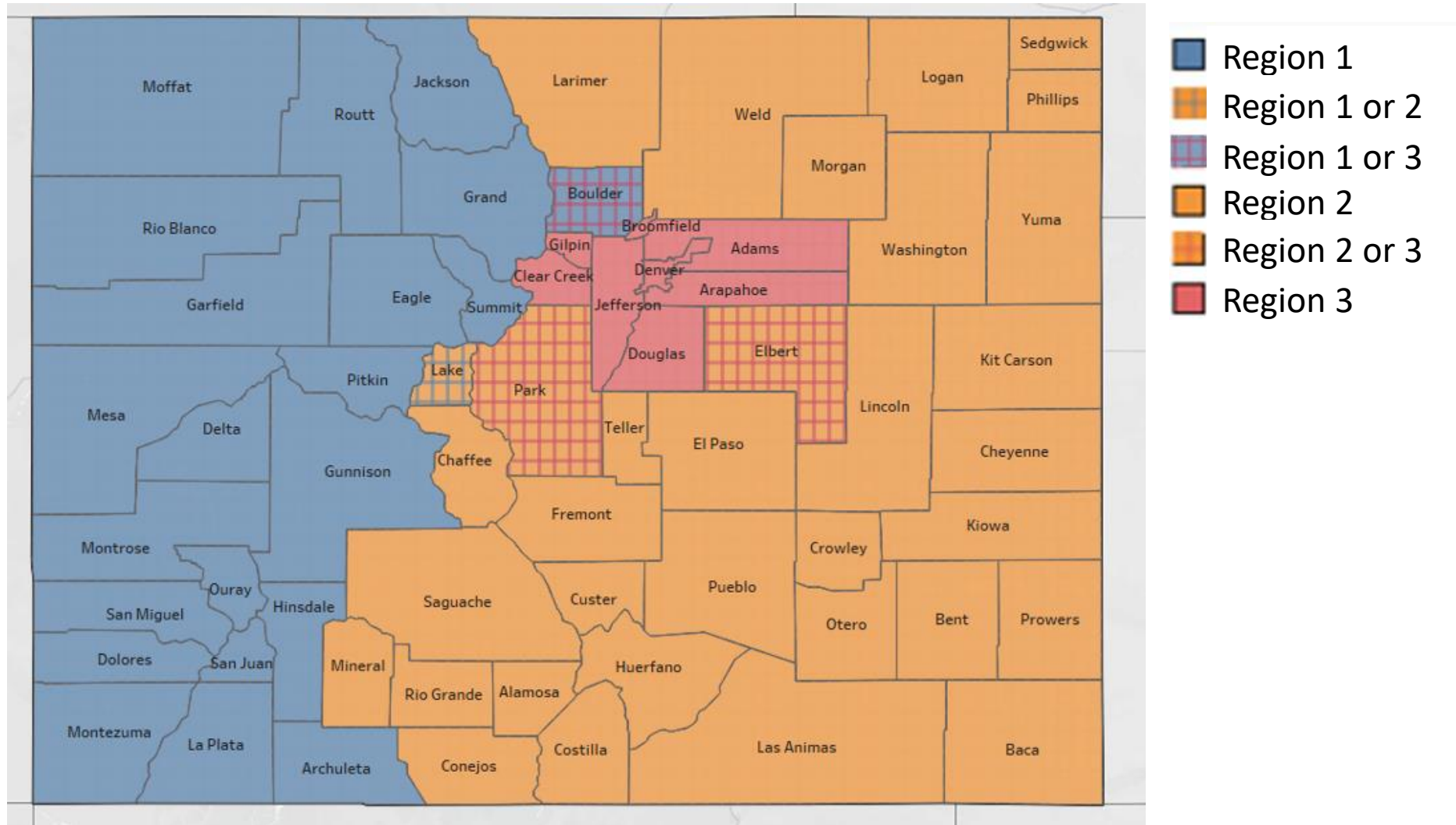
Guiding Principles

- Ensure populations are large enough to effectively manage risk
 - Include at least 2 population centers
- Support and promote existing member utilization patterns and existing care infrastructure
 - Minimize disruption to providers and Medicaid members
- Support value of community-based care

Factors Considered

- Geography/number of counties
- Population demographics
- Behavioral health needs
- Continuum of behavioral health services
- Medicaid utilization patterns
 - Utilization in member's home county vs adjacent counties
- Provider networks
- Stakeholder feedback

Three-Region Proposal for BHASOs and RAEs



Discussion

Future Considerations

- Understanding how new regional boundaries will impact the number of RAEs and contractual responsibilities
- Understanding how to ensure a regional focus on care within larger boundaries

Stakeholder Questions

- Are there any data points or key considerations that we've missed that should be examined in the process of determining these regions?
- Should any of the regions be further subdivided to include multiple RAE regions?

Upcoming Stakeholder Meetings

- Additional meetings are being scheduled, look out for email announcements or check our website for updates

**Regional meetings were held with Larimer, Weld, and Elbert county stakeholders the week of April 10, Park and Lake counties April 19, and Boulder county April 25.*