ACC Phase III: Reading and Responding to the Draft Contract

Program Improvement Advisory Committee

January 17, 2024

Presented by:

Colorado Health Institute

Colorado Department of Health Care Policy and Financing

Today's Agenda

9:55 – 10:00	Introduction
10:00 – 10:10	How to Read the Draft Contract
10:10 – 10:55	Draft Contract: Key Changes for Phase III
11:00 – 11:25	Q & A from the PIAC *Today's session is followed by a public comment period.
11:25 – 11:30	Next Steps

Stakeholder Engagement To Date


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
January 2024
Draft Contract posted for stakeholder review
Revise draft request for proposal based on stakeholder feedback
Begin operational implementation
May 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

Who we've heard from:

- Total ACC Phase III engagements between November 2022 and December 2023:
  - 105+ stakeholder discussions
  - 4,300+ attendees
  - Approximately 400 written comments through various surveys and feedback forms
    - 15+ letters

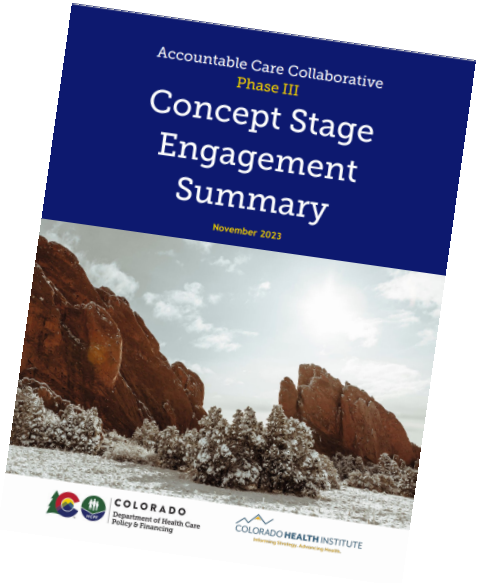
What we've heard:

Proposals with positive feedback:

- Overall focus on stability, process improvement, and accountability
- Alignment of performance and incentive metrics across programs
- Reduction of administrative burden through fewer RAEs
- Increased accountability for care coordination and provision for children and members with complex needs
- Increased emphasis on member engagement, including through member councils

Proposals with mixed feedback:

- Proposed attribution changes
- Exact requirements to assure accountability for health equity
- Need more clarity on care coordination expectations
- Need more clarity on standardized child benefit implementation
- Mixed opinions on expansion of RAE responsibilities



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.

How to Read the Draft Contract

What is the Draft Contract?

- The Draft Contract includes the contractual requirements organizations will be required to follow to serve as Regional Accountable Entities (RAEs) for ACC Phase III.
  - The Request for Proposal (RFP) will include the Contract and additional questions bidders must respond to.
- Organizations interested in becoming RAEs will submit bids that outline their capabilities for meeting the requirements within the Draft Contract.
- The Draft Contract is posted publicly to allow for stakeholder comment and increase transparency of this process.

Draft Contract Sections

1. Regional Accountable Entity	6. Health Neighborhood and Community	11. Data, Analytics, and Claims Processing Systems
2. Member Enrollment and Attribution	7. Care Coordination and Population Management	12. Outcomes, Quality Assessment, and Performance Improvement
3. Member Engagement	8. Provider Support Practice Transformation	13. Compliance and Integrity
4. Grievances and Appeals	9. Capitated Behavioral Health Benefit	14. Compensation and Invoicing
5. Network Development and Access Standards	10. Children and EPSDT	Exhibit E: Administrative Requirements

Tips for Reading the Draft Contract

- Many administrative pieces are functionally the same as in Phase II.
- The contract is over 250 pages. You may want to prioritize sections to read.
- Certain topics may be discussed in multiple sections (e.g., health equity in sections 6, 7, 8, 9, 12, Exhibit E).
- Section titles and the find function can help focus your review to concepts of most interest to you.

What is not in the Draft Contract?

- Focused on RAE obligations – policy changes in ACC Phase III are broader than just the contractual obligations.
  - Contract requirements detail what the RAEs will be responsible for, not *how* they complete those requirements.
- Processes primarily managed by HCPF are not detailed in the Draft Contract.
- Challenges that are not part of the RAE role (like the Medicaid unwind and enrollment) are missing, but they are top of mind at HCPF.
- Exhibits referenced in the draft.

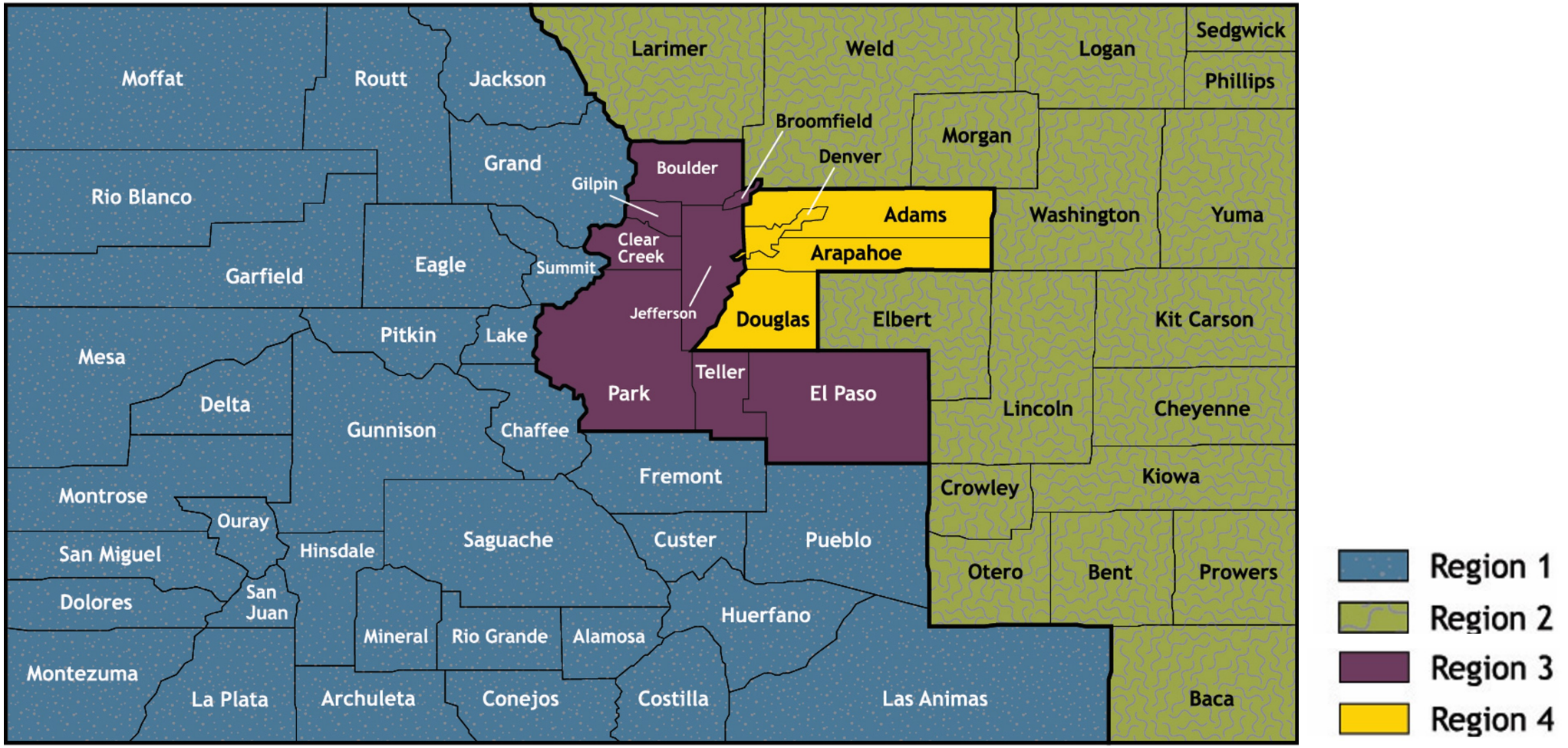
Common Acronyms

- ACC: Accountable Care Collaborative
- BHA: Behavioral Health Administration
- CMS: Centers for Medicare and Medicaid Services
- DOI: Division of Insurance
- EDIA: Equity, Diversity, Inclusion, and Accessibility
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Benefit
- HRSN: Health-Related Social Needs
- MAC/MEAC: Member Advisory Committee/Member Experience Advisory Council
- MCO: Managed Care Organization
- PCMP: Primary Care Medical Provider
- RAE: Regional Accountable Entity
- TOC: Transitions of Care

Draft Contract:
Key Changes for Phase III

RAE Structure & Operations

ACC Phase III Region Map



Managed Care Organizations

- Denver Health MCO will continue in Phase III.

- Bidders for Region 1 can propose an MCO similar to PRIME in the counties where PRIME currently exists.

RAE PIAC and MAC Requirements

- RAEs will be required to convene at least 2 PIACs and 2 Member Advisory Committees (MACs) for each region.
- RAEs must have dedicated budget for a PIAC and MAC.
  - Both must meet at least quarterly.
  - Both must accommodate individuals with disabilities.
  - PIACs must be open to the public.
  - MACs must be chaired by those with experience in member engagement and EDIA.

Where to look for more info?
Section 12.8

Attribution

- Members will be attributed to PCMPs based solely on previous claims history — removing geographic attribution.
  - HCPF will attribute members to the PCMP who provided the two most recent PCMP visits.
- Members without PCMP attribution will be assigned to RAEs based on member address.
- RAEs must support members with seeing their attributed PCMP or recommending reassignment to an appropriate PCMP.

Where to look for more info?
Section 2

Member Support

Member Experience and Incentives

- RAEs must implement specific strategies to improve member communication.
  - Required to co-brand materials and operate a member call center within performance standards.
- RAEs must develop and report on a member experience of care strategy as part of continuous process improvement.
  - They will focus on hearing from recent utilizers and new members.
- RAEs must develop and implement a member incentive program promoting HCPF identified health behaviors (e.g., prenatal care).

Where to look for more info?
Sections 3.3, 3.7, 12.5

Member Experience Strategy Requirements

- RAEs must report on members' experience of care annually and must:
  - Utilize multiple sources of information (e.g., call center information, surveys, grievances).
  - Develop interventions to address areas identified for improvement based on member response patterns.
  - Implement provider corrective action plans for patterns of complaint with a specific provider.

Health-Related Social Needs

- RAEs must create formal partnerships with community partners.
  - Establish formal partnerships with community organizations to refer to food resources and to help with SNAP and WIC enrollment.
  - Provide referrals and coordination for members experiencing housing instability and working with permanent supportive housing providers.
- RAEs will help provide pre-release services to eligible incarcerated individuals.

Where to look for more info?
Sections 6.3, 7.6, 9.8

Food Security Requirements

- RAEs must establish formal partnerships with community organizations to refer to food resources and to help with SNAP and WIC enrollment.
  - RAEs must report the number of referrals made to SNAP outreach and application organizations.
- RAEs must train network providers on WIC referral process and create streamlined processes for sharing member data for WIC enrollment.
- RAEs must participate and align with existing programs, advisory groups and statewide initiatives.

Supportive Housing Requirements

- To support members who are homeless or at risk of homelessness, RAEs must:
  - Form partnerships with other organizations (including Continuums of Care).
  - Conduct additional outreach to members identified as homeless or at risk of homelessness.
  - With partners, identify housing options, assist members in filing housing applications, and coordinate provision of supportive housing and related services.
- RAEs must build a network of permanent supportive housing (PSH) providers, support enrollment of PSH providers, and coordinate care for those eligible for and enrolled in PSH.

Pre-Release Services

- RAEs will support care coordination, including care transition support pre-release.
  - One potential example: Supporting continued access to medications, such as methadone and suboxone.
- RAEs will outreach individuals assigned to their region pre- and post-release to support their transition to the community.
- Implementation will depend on legislative and CMS approval.

Health Equity

- RAEs must:
  - Develop annual health equity plans with measurable goals and submit data on their performance.
  - Establish a Regional Health Equity Committee to help with development of plan and oversee performance.
  - Make trainings available to staff and network providers on cultural responsiveness and EDIA.
  - Hire an EDIA Officer Key Personnel position that serves as the point for all health equity activities.
  - Analyze performance and utilization data through an equity lens.

Where to look for more info?
Sections 6.3, 12.8, 3.2, Exhibit E

Provider Support

Provider Support

- RAEs must provide supports and services to providers participating in value-based payments (VBPs), so that providers reach quality outcomes.
- Phase III Payment Structure is designed to allow for flexibility in how RAES work with providers to offer comprehensive supportive services based on provider capabilities.
  - Encourages RAEs to provide actionable and timely data so that providers can be successful in delivering quality care for members, achieving metrics, and participating in VBPs.

Where to look for more info?
Sections 8, 11.2

Value-Based Payment Strategy

- RAE PCMP Payment Programs must be designed to achieve the following:
  - Invest in primary care
  - Increase member access to care
  - Support PCMP adoption and ongoing implementation of advanced primary care in alignment with Division of Insurance
  - Support effective and appropriate delivery of Care Coordination Program activities
  - Reduce health disparities
  - Enable PCMPs to care for members with high acuity
  - Reward PCMPs for achieving HCPF population health goals
  - Incentivize PCMP adoption of HCPF and state supported health technologies (e.g., eConsult, Prescriber Tool, etc.)

Three-Tier Payment Framework

- RAEs must design their payment programs to support and incentivize PCMPs' progress along the continuum of advanced primary care
  - Level 1: focused on creating a foundation for excellent primary care
  - Level 2: focused on population management tools, evaluating continuity of care, and developing care coordination services
  - Level 3: focused on payment models that support the sustainability of advanced models of care delivery (e.g., integrated behavioral health care)
- This framework is aligned with DOI Primary Care Alternative Payment Model and CMMI's Making Care Primary

Provider Network

- In alignment with the DOI, Phase III expands network time and distance standards from three county types to five county types.
- RAEs must collaborate with HCPF on a process to monitor timeliness standards within provider network.
  - In Phase III, addition of standards related to medication assisted treatment.
- RAEs must meet requirements for timely response and resolution to issues and complaints from providers.

Where to look for more info?
Sections 5.4, 8.2

Data and Technology

- RAEs must identify strategies to improve data sharing throughout the Health Neighborhood.
- RAEs must provide support to the following programs:
  - eConsult: RAEs will promote among specialty providers and support primary care medical providers on using it.
  - Social Health Information Exchange: RAEs will participate in development and use for HRSN and will support providers in using it.

Where to look for more info?
Sections 8.5, 8.6

Behavioral Health Improvements

- RAEs must work on process improvements, both individually and in collaboration with the BHA.
  - Ensuring all providers are credentialed by one HCPF contractor
  - Using and helping implement universal contract provisions
  - Standardizing utilization management and RAE reporting to improve provider experience and increase access to services
- RAEs will be held accountable to additional behavioral health performance standards including:
  - Timely payment
  - Timely authorizations
  - Continuity of care

Where to look for more info?
Sections 9.5, 9.6, 5.3, 5.3

Care Coordination and Support for Children and Youth

Care Coordination

- RAEs must create a program that supports the full continuum of care coordination, including:
  - Implementing a 3-tier model that allows for person-centered care and consistency across RAEs
  - Creating a care coordination policy guide for children and adults
  - Coordinating and collaborating with community-based organizations and other agencies serving members
  - Establishing requirements, specifically for members with complex needs and members going through transitions of care

Where to look for more info?
Section 7

Continuum of Care Coordination Program Activities

- General outreach and health promotion
- Efforts to screen members for both short and long-term health needs
- Targeted outreach to promote preventive care
- Proactive outreach to members with diagnosed conditions
- Coordination of Transitions of Care from clinical settings
- Medication reconciliation for members in the Complex Health Management tier
- Effective collaboration with multi-provider and agency care teams
- Address health-related social needs
- Utilization of the social health information exchange and related systems
- Support a network of community-based organizations
- Connect members with appropriate entities for enrollment in other state benefits (SNAP, WIC, etc.)

Care Coordination Tiers

Tier	Activities at a Minimum Must Include	Minimum Populations that Must Be in This Tier (RAEs have discretion to add more but not to remove)		
		Adults	Children	Both

Tier 3: Complex Health Management	• Comprehensive needs assessment
	• Comprehensive care plan
	• Minimum monthly coordination with member and treatment team
	• Long-term monitoring/support
		• Chronic Over-Utilization Program
		• Individuals involved in Complex Solutions Meetings
		• Deemed ITP in previous year
			• CANS Assessment indicating high needs
			• Individuals involved in Creative Solutions Meetings
			• Child welfare and foster care emancipation
				• 2+ uncontrolled physical and/or behavioral health conditions
				• Multi-system involvement (e.g., child welfare, juvenile justice)
				• Denied Private Duty Nursing
				• Utilization (in previous 6 months):
				  • 2+ Hospital Readmissions
				  • 30+ Days Inpatient
				  • 3+ Crisis Contacts
				  • 3+ ED Visits

Tier 2: Condition Management	• Assessment based on population/need • Condition-based care plan (may pull from a provider as appropriate) • Minimum quarterly meeting with member and treatment team • Condition management • Long-term monitoring/support	• Value-based payment identified conditions not already listed under "Both" category	• CANS Assessment indicating moderate needs • Obesity • Pervasive Developmental Disorder	• Diabetes • Asthma • Pregnancy (peri- & post-natal) • Substance Use Disorder • Depression/Anxiety
Tier 1: Prevention	• Brief needs screen • Short-term monitoring/support • Prevention outreach and education	• Adult preventative screenings	• Well child visits • Child immunizations	• Dental visits

Care Coordination Collaboration

- RAEs must collaborate with the following types of organizations for care coordination:
  - Community-Based Organizations (CBOs)
  - Case Management Agencies (CMAs)
  - Dual Special Needs Plans (D-SNPs)
  - Behavioral Health Administrative Service Organizations (BHASOs)
  - Foster Care
  - Emancipated Foster Care
  - Criminal/Juvenile Justice

Transitions of Care

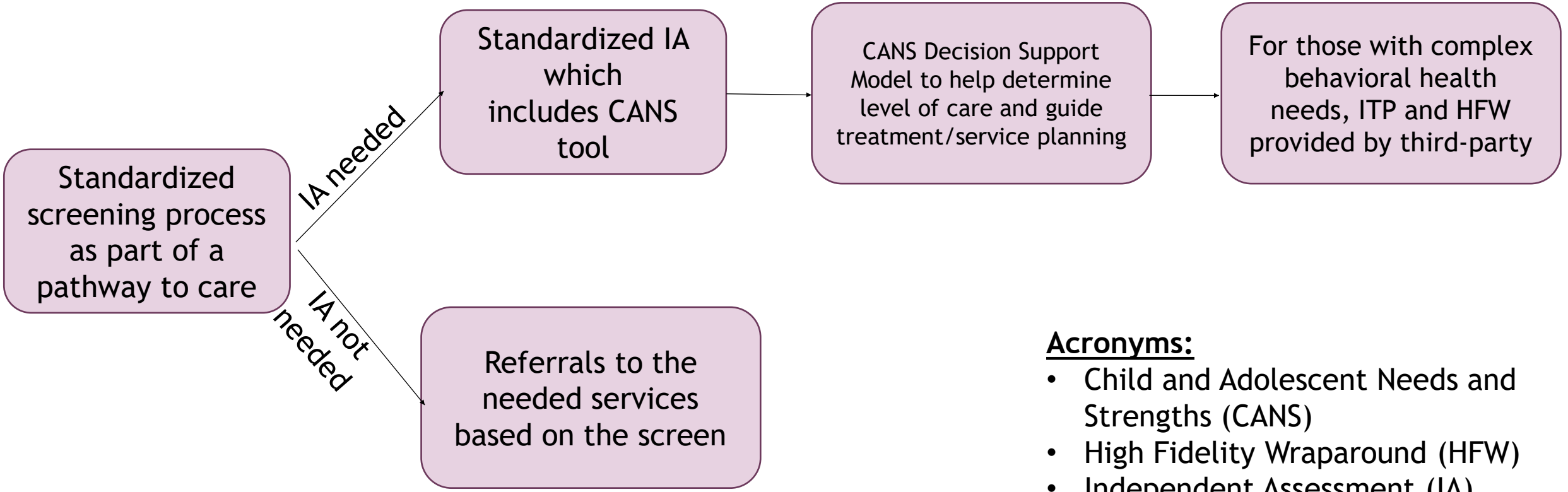
- Phase III includes additional focus on transitions of care (e.g. inpatient hospital review program, emergency department, mental health facilities, crisis systems, Creative Solutions/Complex Solutions).
- RAEs must help develop and meet additional requirements focused on transitions of care.
- RAEs must meet the following performance standards:
  - 30 day follow up for physical health inpatient stay. Target is achieving the national average over the term of the contract.
  - 7 day follow up for behavioral health inpatient discharge. Target is achieving the national average over the term of the contract.

Standardized Child and Youth Benefit

- New RAE requirements to improve screening of EPSDT eligible populations
- RAEs must collaborate with HCPF to create EPSDT Uniform Accountability Strategy describing best practices for all Managed Care Entities to follow to ensure state compliance with EPSDT
  - Training and outreach
  - Promote early identification of children across places of service
  - Processes to track positive screens and referrals

Where to look for more info?
Section 10

STANDARDIZED CHILD AND YOUTH BENEFIT



Acronyms:

- Child and Adolescent Needs and Strengths (CANS)
- High Fidelity Wraparound (HFW)
- Independent Assessment (IA)
- Intensive Treatment Planning (ITP)

Standardized Child and Youth Benefit Pathway to Care Example

Accountability

Accountability

- RAEs will be incentivized to meet operational performance standards through new Commitment to Quality program.
- RAEs will be incentivized to meet key performance indicators, which will be aligned with Division of Insurance metrics and with CMS Core Metrics.
- RAEs must develop and report annually on plans or strategies:
  - Annual health equity plan
  - Member experience of care strategy
- RAEs and providers will have opportunity to earn value-based payment shared savings.
- RAEs will have deliverable requirements due to HCPF.
- HCPF will update ACC Evaluation Strategy for Phase III.

Where to look for more info?
Sections 12.4, 6.3, 12.5

Q and A

Next Steps

PIAC Involvement

- **February meeting:**
  - Further discussion of draft contract content
  - Procurement and evaluation process feedback

Upcoming Stakeholder Engagement

- Public meetings through February
  - 2 Informational Meetings
  - Audience-specific: PH providers, BH providers, CBO/Advocates, Members
- Topic-specific fact sheets
- Online survey and open feedback form

Dates and materials to be posted online soon!

Thank you!

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