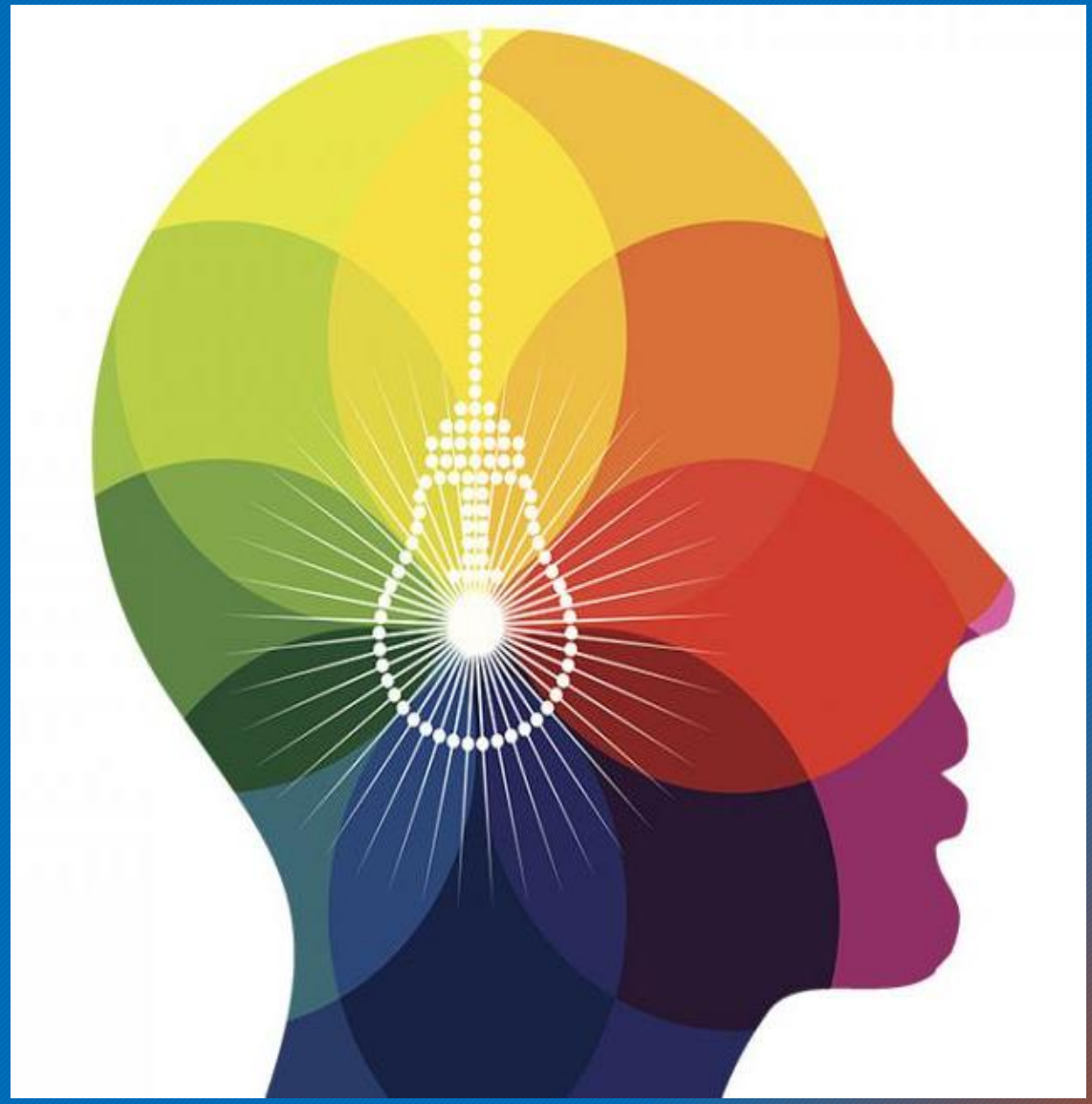
# BH Network Expansion Priorities

1. Improve access to care for services currently unavailable in the region by increasing/enhancing in-region partnerships
2. Improve access to care within existing network providers
3. Expand intensive behavioral health services
4. Expand behavioral health services in non-traditional settings and integrated care setting
5. Expand telehealth utilization throughout the region for specialty services and members located in our rural and frontier areas
6. Expand capacity to serve special populations across the continuum



# 1- Improve Access to Care through Enhanced Regional Partnerships

NORTHEAST HEALTH PARTNERS, LLC

COLLABORATE WITH HCPF, OTHER RAES AND PROVIDERS TO CREATE PARTNERSHIPS FOR SERVICES AVAILABLE IN OTHER REGIONS

WORK WITH PROVIDERS TO ALIGN SERVICES ACROSS ALL LOCATIONS, SPECIFICALLY LOCATIONS WITHIN THE REGION

COMPARE CONTRACTED PROVIDERS IN OTHER REGIONS TO ENSURE SERVICES AND PROVIDERS ARE PART OF THE NETWORK AND AVAILABLE TO MEMBERS.

# 2- Expand Intensive Behavioral Health Services

NORTHEAST HEALTH PARTNERS, LLC

## Intensive Outpatient Program (IOP) Medication Assisted Therapy (MAT)

- Leverage appropriate telehealth services
- Support providers with training and technical support
- Conduct effective rate negotiations
- Identify value-based payment opportunities for high quality providers
- Engage and advocate at HCPF's Coding Committee

## Children's Substance Use Disorder (SUD) Services

- Limited state-wide services
- Collaborate with Managed Service Organizations (MSOs) in region(s) to identify local needs and resources available
- Leverage appropriate telehealth services
- Conduct effective rate negotiations
- Identify value-based payment opportunities with SUD providers serving children and adolescents of all levels of care

## Assertive Community Treatment (ACT)

- Development has been challenged, especially with workforce shortages
- Reduced capacity due to COVID-19
- Utilize programs available in larger communities
- Continue to collaborate to explore new opportunities and models

# 3- Improve Access to Care of Existing Network

NORTHEAST HEALTH PARTNERS, LLC

Support providers through:

- Telehealth availability
- Leverage fee schedules/VBP to increase access in areas of need
- Improve workflow to reduce contracting/credentialing timelines
- Monitor access to care to ensure network meets access to care standards

In alignment with department goals, each RAE has the following goals:

- Ensure competitive rates
- Reward quality providers
- Incentivize expansion

Network provider challenges:

- Full caseloads due to reduced capacity and increase of individuals seeking BH services
- In expanding, our goal is to identify if a provider can meet the requirement of offering an intake assessment within 7 days.
- Workforce shortages

# 4- Expand Services in Non-Traditional & Integrated Care Settings

NORTHEAST HEALTH PARTNERS, LLC

Networks already use these modalities effectively

Co-located partnerships with:

- School districts, charters schools
- County Jails, Law enforcement
- Shelters and Housing Programs

***All RAE are continuing to seek and support opportunities for growth***

Integrating physical and behavioral health services:

- Each region has identified integrated partnerships where behavioral health and physical health care are provided seamlessly:

# 5- Expand Telehealth Utilization

NORTHEAST HEALTH PARTNERS, LLC

Goals are to build a sustainable quality telehealth program by:

- Leveraging telehealth to fill gaps in care such as IOP, timely appointments, SUD services
  - Monitor telehealth utilization and quality of care
- Support state efforts for expanded services for telehealth & work with HCPF to incorporate telehealth as part of network adequacy determinations

Successful Modalities of Care Demonstrate:

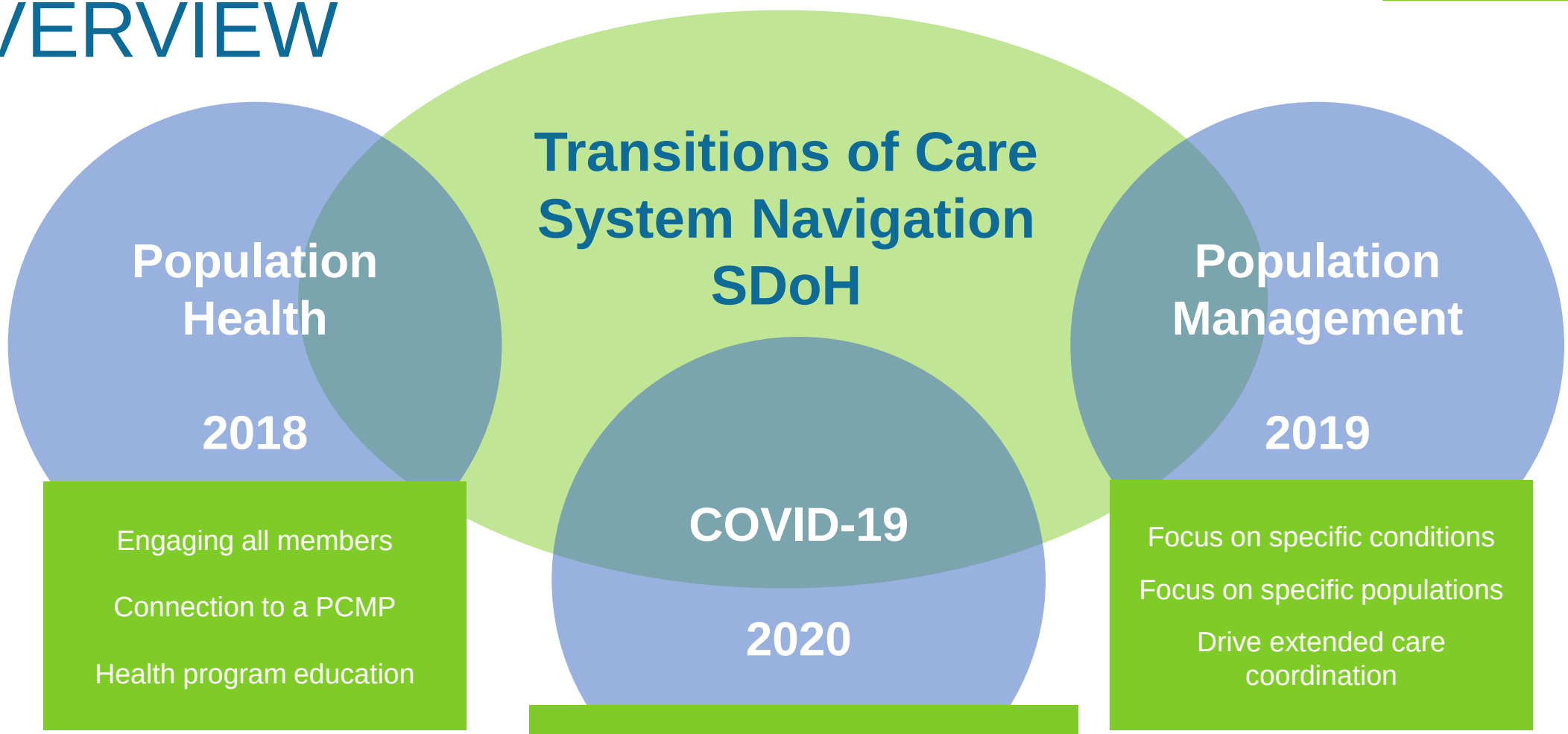
- Decreased no-show rates (reduce geography & time barriers)
- Increased engagement
- Reduced Stigma
- Increased access and member choice

# 6- Expand Capacity to Serve Special Populations across the Continuum

Special Population(s) Focus:

- Members with Intellectual and Developmental Disabilities (I/DD)
- Members involved with the Child Welfare system
- Members involved with the criminal justice system
- Members experiencing housing instability

# CARE MANAGEMENT
## OVERVIEW

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# CARE MANAGEMENT OVERVIEW

## Population Management, Health, Access, and Engagement

- Wellness visits, immunizations, CMS core measures, onboarding and screening, EPSDT, etc.

## Targeted Interventions

- Crisis cases, one-time needs, episodic care management, community-based outreach, etc.

## Condition Management—improving health outcomes

- Diabetes, asthma, maternity, substance use disorders, health disparity opportunities

## High Cost/High Need

- Complex members, Transitions of Care (behavioral and physical health), decreasing inappropriate/avoidable utilization, reducing avoidable ED visits

# CURRENT CARE MANAGEMENT PRIORITIES

## Decreasing inappropriate/avoidable utilization and costs

ED visits, Transitions of Care, targeted condition-specific cohorts (i.e. asthma, diabetes), population-level PMPM

## Driving high-value services

Well visits, immunizations, screenings, CMS core measures, proactive member outreach, reducing health inequities

## Supporting complex members

Engagement in ECC, outreach, supporting the new complex member definition

## Improving health outcomes for targeted population cohorts

Diabetes, Transitions of Care

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# CARE MANAGEMENT CHALLENGES

1. Connecting with members/building trust
2. Multiple programs with multiple care managers
3. Transitions/data sharing across programs, RAEs
4. Timely access to information regarding members in need
5. What is care coordination?

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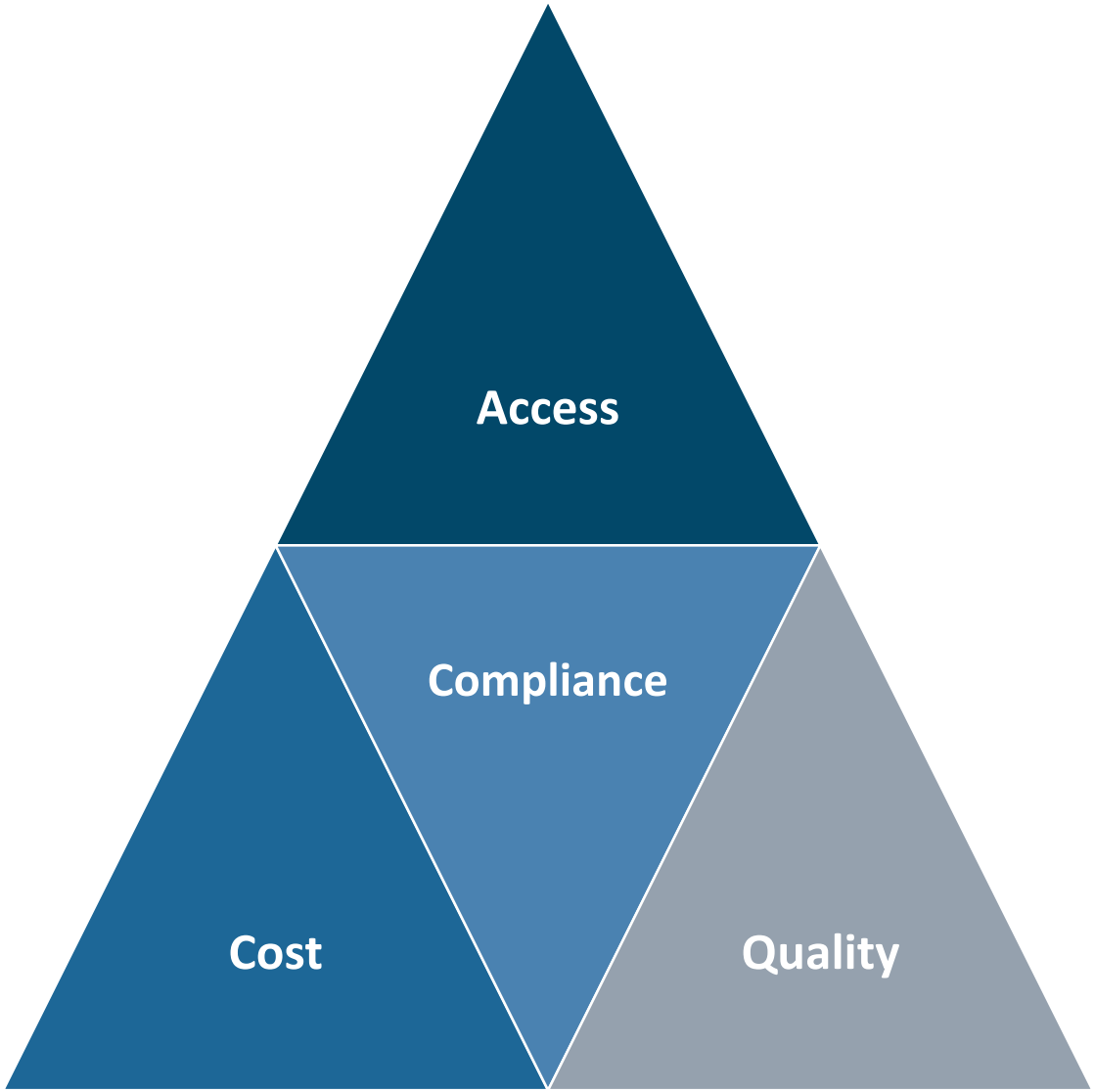
# Key Domains: Performance & Accountability

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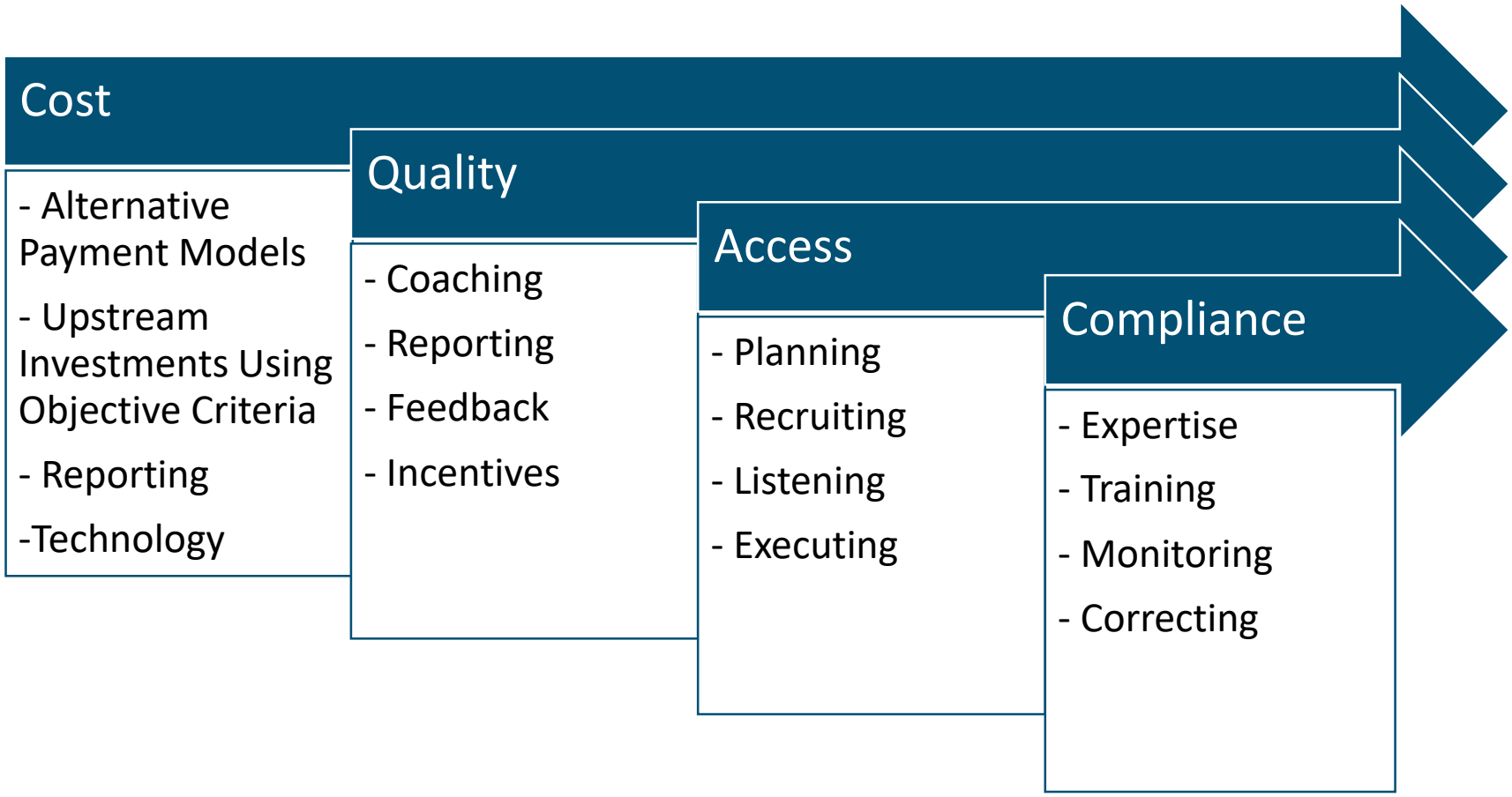
# Key Drivers of Performance




Overall Performance / Measured Outcomes

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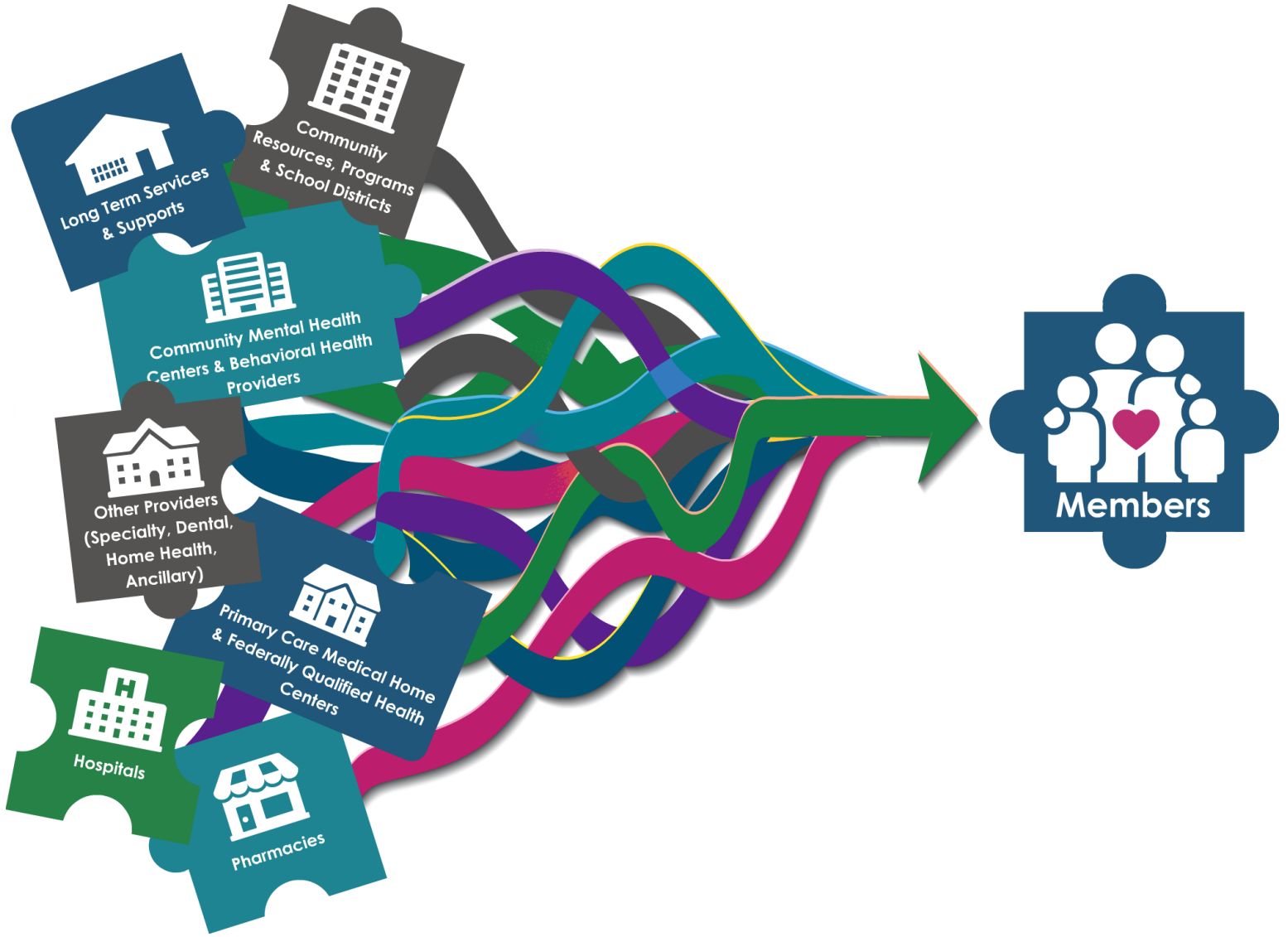
# Heath Neighborhood & Community

## *HCPF's ACC 2.0 Vision*

A connected and engaged community, efficiently utilizing public resources, will ultimately optimize the physical and behavioral health of its members.

# Coordinating for Members



# Health Neighborhood & Community

# Why: An engaged community successfully engages its members

- All health care is local
- Our members are active in our regions, we need to partner with the entities who touch our members
- Our members often prefer information from a trusted source
- Our members want to tell their story once, so we need to create common platforms for information sharing
- Our members trust information provided to them closer to home

# How the RAEs support engagement

- Forums - Regional PIACs, Member Advisory Committees, Health Alliances & cross sector collaborative meetings

- Education - Member materials, newsletters, webinars, practice transformation with network providers

- Collaboration – Relationship development, create referral processes, case consults

- Data Sharing – Helps identify shared members & transmit relevant information

- Financial Incentives/Support – Each RAE has a unique approach

# Health Neighborhood & Community funding in ACC 2.0

- RAE Contract Language: *The Contractor shall distribute, in aggregate, at least thirty-three percent (33%) of the Contractor's administrative PMPM payments received from the Department to their PCMP network.*
- Outside of this requirement, RAEs have been provided the flexibility to customize their funding distribution strategy to meet the needs of their region.
- Each region's allocated funding is relative to the number of attributed members they serve.
- RAE network providers, to include providers with "add on services" like delegated care coordination, receive payment via claims or from their RAE via a PMPM for these services.
- These next slides show investments the RAEs have made outside of these types of payments.

# CCHA Funding Strategy

## PROVIDER INCENTIVE PROGRAM – 75%

- Practice transformation – 10%
  - Participation in 10 Quality improvement Meetings annually
- Key Performance Indicators – 60%
  - Well visits (2 measures, three parts), prenatal care, dental visits, emergency room utilization
- Cost and Utilization – 30%
  - Inpatient readmissions, ED PKPY, and COVID vaccination percentage

## COMMUNITY INCENTIVE PROGRAM – 25%

- Annually organizations apply by proposing a program/pilot not covered by Medicaid benefits yet promoting positive outcomes for members
- Regional PIAC stakeholders take on the responsibility of scoring, voting and selecting each year's awardees
- CCHA manages the contracts, funding and performance throughout the year

## PERFORMANCE POOL DOLLARS

- Intended for Community Innovation pilots/programs focusing on positive impact for high-cost/complex members.
- 17 different pilots/programs across both regions in CY20 were selected with a few examples including CARES, Project Angel Heart, Lift, YMCA
- The SEP/CCB program has continued and CY22 began Year 3

## BEHAVIORAL HEALTH INCENTIVE PROGRAM

- Social Determinants of Health Provider Incentive Program
  - Incents BH providers to connect members to resources by means of a designated platform
- Behavioral Health Quality Incentive Program
  - Measures year-over-year improvement for BH providers on quality metrics
- Performance Improvement Participants
  - Incents both PH and BH providers to perform on BHIP metrics by means of Process Improvement Projects

# CCHA - Dollars Distributed

**$34,086,442.20 Dollars Distributed Since 2019**

| | |
|---|---|
| **Community Innovation** | • Since 2019, CCHA has allocated over **$2,650,980.59** Performance Pool Dollars towards pilots and programs that focus on high cost/complex members. |
| **COVID Support** | • In 2020 alone, CCHA distributed over **$4,840,312.36** to providers across both regions as a COVID Support Fund and an additional **$2,432,900** to providers and the community to promote vaccinations in 2021. |
| **Provider Incentive Program** | • Since 2019, CCHA has distributed 75% of the KPI dollars earned totaling **$17,159,695.90** to the primary care provider network. |
| **Community Incentive Program** | • Over the last three years CCHA has allocated 25% of all KPI funds, totaling **$3,930,064.35** to community entities to address barriers to care such as transportation, mental health and access. |
| **Behavioral Health Incentive Program** | • In 2021 CCHA paid BH providers **$1,992,156** based on performance with an allocated additional **$1,080,333** for SDOH related programs. |

# Community Incentive Program
# Region 6 2021 Highlights

Funding awarded to 7 awardees across Region 6 — $700K

2,243 — Members impacted through innovative programs

Referrals and consultations for PH, BH, and SDOH — 2,630

202 — Families served through programs focused on children and maternity

Low income/homeless members connected to services and safe parking/housing — 2,099

$79K — Member expenses ranging from food provision, vehicle related, rent/mortgage assistance, etc.

Surveys administered to members in Gilpin County to gauge medical and behavioral needs — 539+

# Community Incentive Program
# Region 7 2021 Highlights

Funding awarded to 9 awardees across Region 7 — $690.5K

8,337 — Members impacted through innovative programs

Educational hours completed by organization staff and HFC members — 3,259

395 — Social determinates of health rides provided in Teller & El Paso Counties

Screened for Diabetes and enrolled in 16-week chronic condition management program — 350

41 — Families completed SUD screening and enrolled in programming

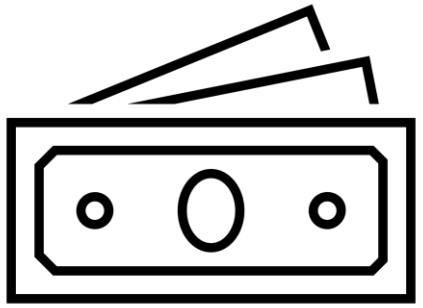
Resource Hutches built and placed in Park County with items such as hygiene kits & winter items — 7

# NHP (RAE 2) Dollars Distributed: $13,918,110*

| | |
|---|---|
| **Community Innovation** | $330,000 Diabetes Programs at local level; Supported local programs i.e. Dietician in 3 county area; DSMES programs at clinic level. |
| **COVID-19 Support** | $827,415 (FEMA & NHP) Provided support to providers for vaccination, equipment (refrigeration unit, battery backup) and testing supplies (masks, syringes, and testing kits) |
| **Provider Incentive Program** | $7,711,706 (KPI + PP) Based upon provider performance and contribution in serving members. |
| **Community Incentive Program** | $188,000 Provided funding to enhance pediatric services in frontier clinic, offer telehealth services through immigrant/refugee center, integrated services via a pediatrician, food bank support and distribution. |
| **Behavioral Health Incentive Program** | $4,860,989 Overarching goal was to support practices for engaging in behavioral health measures, support workforce and enhance access for members. |

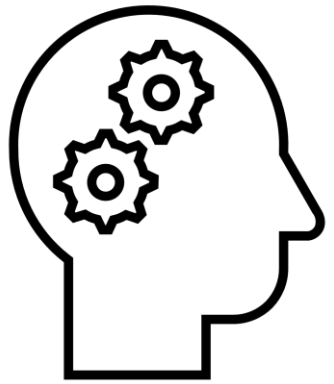
*Since 2019

# Community Investment Grant

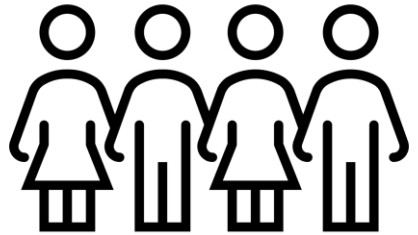


$188,000

Three
Physical Health
Programs

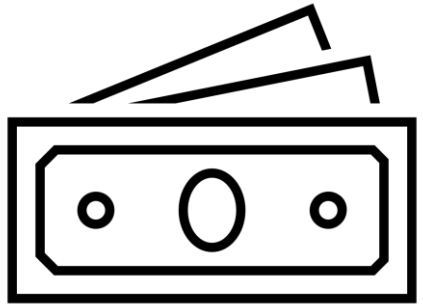


Two
Behavioral
Health Programs

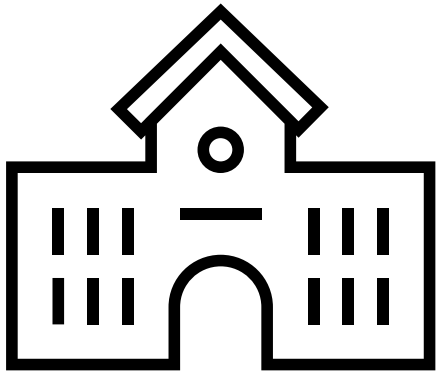


Three
Community
Partnership Programs

# Diabetes Investment Awardees



$330,000



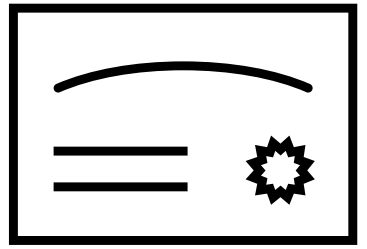
<u>Five Awardees</u>

2 Hospitals

1 FQHC

1 PCMP

1 Community Partner



Three Evidence-Based Programs

# Community Investment Opportunity

The Community Investment Grant opportunity was developed to create effective strategies to improve health, wellness, and life outcomes for Medicaid members within the region.

**Deadline for applications is April 1st, 2022**

Contact: Natasha Lawless, NHP Contract Manager
Phone: (970)-324-4170
Email: communityinvestmentgrant@nhpllc.org

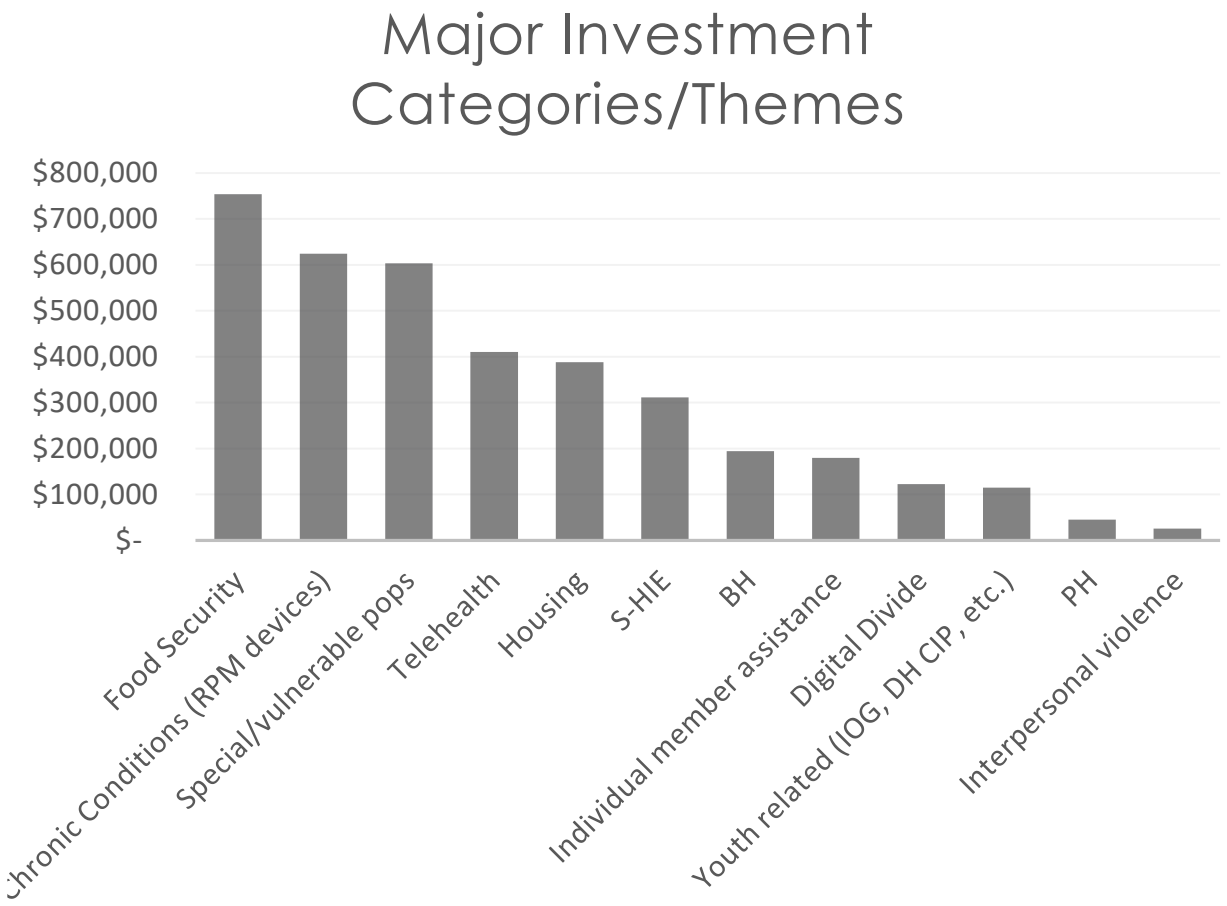
# COA Provider Incentive Funding: SFY19 – SFY21

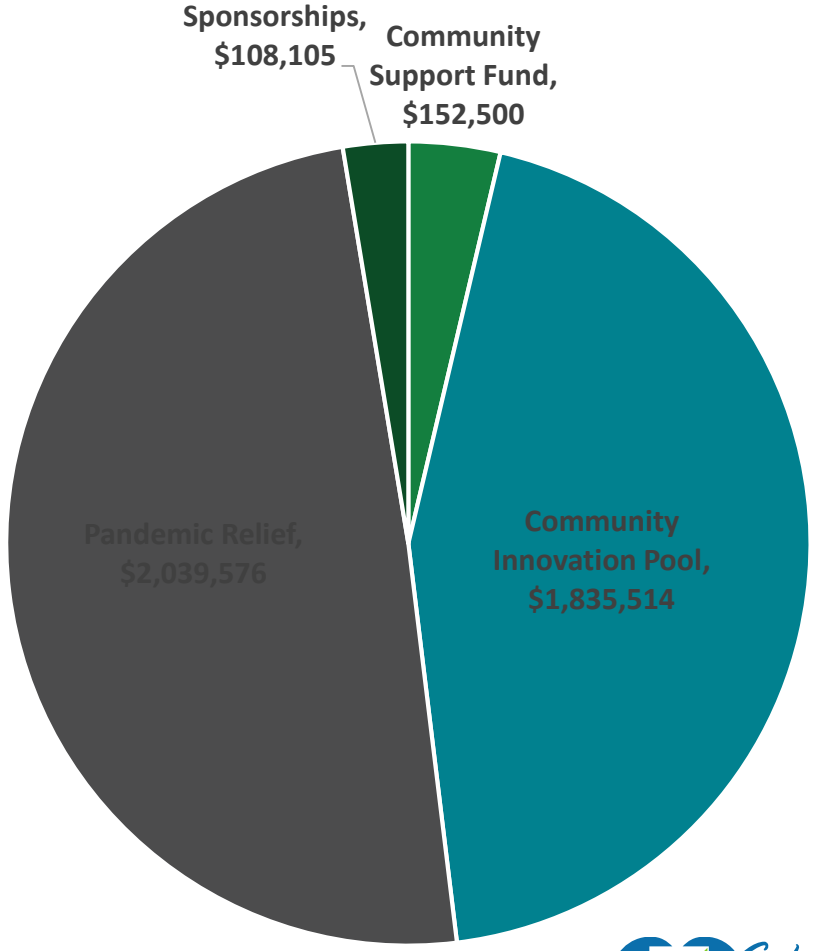
| | |
|---|---|
| KPI Incentives | $16,675,910 |
| BH Incentive Measures | $7,793,766 |
| COVID-19 | $4,254,342 |
| Community Innovation | $1,835,514 |
| Total | $30,559,532 |

# 2020 Community Donations and Investments

**Total = $4,135,695**

[Unique organizations = 72  MOUs = 49  Total # checks = 109]



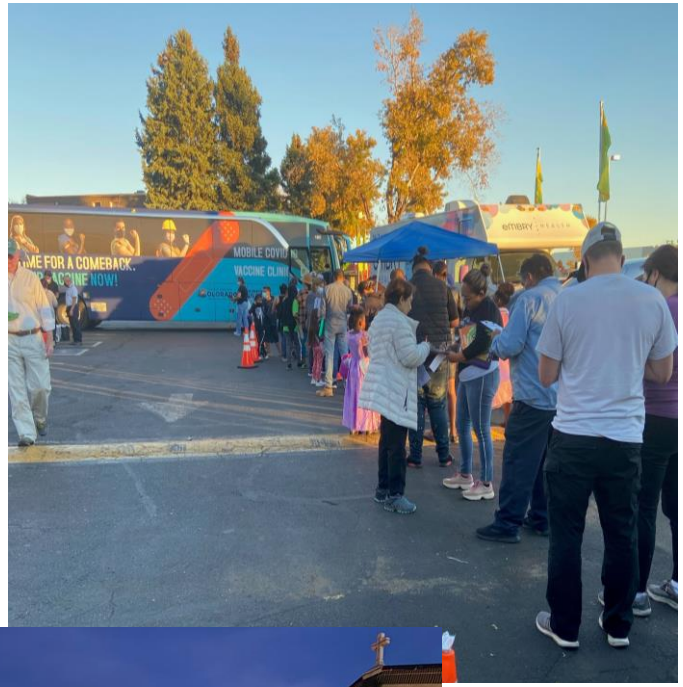
# 2021 Community Investments

## Community Innovation Pool

**BLACK BIRTHING HEALTH DESIGN CHALLENGE WORKSHOP SERIES**

## COVID Vaccinations in Community

$550,000 in support for community events with trusted local ambassador organizations
*(in addition to FEMA funding)*

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# COMMUNITY INNOVATION POOL

## 2022 – FINAL PROJECTS FOR FUNDING ($1.15M)

| Black Doulas Pilot | Online Community Hub | Mental Health Community Fund |
|---|---|---|
| Budget = $450,000<br><br>Purpose: Serve 40 Medicaid Black families through the perinatal experience. Study the impacts on health outcomes, cost, and quality.<br><br>Partners:<br>• Mama Bird (Doulas)<br>• Stride (3 prenatal clinics)<br>• Sacred Seeds Black Doula Collective (consulting, marketing/recruitment)<br>• Adam's Purpose (Fiscal Sponsor) | Budget = $200,000<br><br>Purpose: Build a hub and social network exclusively for the Black community in Colorado to connect with Black medical professionals, find needed resources, and connect with each other. Market the hub and provide train-the-trainer on how to navigate, update resources, and moderate online groups.<br><br>Partners:<br>• Moo Social (platform development)<br>• Denver Delta Inc. (Fiscal Sponsor)<br>• Community focus groups for design and testing | Budget = $500,000<br><br>Purpose: Provide grants to community-based organizations looking to serve black birthing individuals and families with mental health supports. Reduce stigma within the Black community and increase accessibility of mental health services.<br>• RFP process for 1-to-2-year awards<br>• Funding decisions made by a steering committee of Design Challenge participants and other experts, grounded in lived experience |

# Region 1 Investments- $58.5 million Over 3 Years

**Primary Care**

- ✓ Primary care tiering structure for comprehensive care
- ✓ Health equity enhancements for non-white / non-English speaking populations and members with complex needs
- ✓ Additional primary care support for behavioral health integration

**$12.5 millions per year / $7.00 per Member per month**

**Community and Health Neighborhood**

- ✓ Broad-based, strategic funding for health neighborhood
- ✓ Focus on community-based care coordination, accessibility and independent living, county human services and public health, and health information exchange
- ✓ Targeted HCPF priorities, complex health coordination, housing & related focus

**$2.6 millions per year / $1.46 per Member per month**

**COVID**

- ✓ Testing, treatment, and vaccination
- ✓ Direct funding for capacity and staff retention
- ✓ Programs for People of Color and Homebound Members

**$2.0 millions per year / $0.90 per Member per month**

**Behavioral Health**

- ✓ Workforce incentive for new independent provider onboarding (“WIN program”)
- ✓ Retroactive payment increases SFY 21 for partnering independent provider (alignment, access and service gaps)

**$2.3 millions per year / $1.02 per Member per month**

# Region 1 Investments

**$58.5 million dollars distributed over 3-years**
**($0.00 in related party payments)**

| | | |
|---|---|---|
| **Community and Health Neighborhood** | $2.6 millions per year | $1.46 per Member per month |
| **COVID** | $2.0 millions per year | $0.90 per Member per month |
| **Primary Care** | $12.5 millions per year | $7.00 per Member per month |
| **Behavioral Health** | $2.3 millions per year | $1.02 per Member per month |
| **Total** | $19.5 millions per year | $10.39 per Member per month |

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# Region 1 Community Integration Investments

**Impactful.** **Measurable.** **Replicable.** **Scalable.**

- ✓Advocacy Organization Consultation – Member Engagement, Health Equity and Curriculum/Training
- ✓Contingency Management
- ✓Hospital BH Integration
- ✓Transportation for Independent Living
- ✓Transportation Support for Rural Hospitals
- ✓Health Information Exchange
- ✓Department of Human Services – Staff Retention and Early Intervention

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# Community Reinvestment

Practice Transformation-Using the Bodenheimer building blocks, and the tenants of evidence-based Patient Centered Medical Home

Community Reinvestment Grant- innovative projects that will improve existing Medicaid services to expand access to needed services, promote a more connected health neighborhood, avoid duplication of services, improve quality of care and outcomes, improve member experience, and address Social Determinants of Health needs.

Health COLORADO
A system of integrated healthcare providers.

# Practice Transformation

| Milestone | Milestone Description |
|---|---|
| Milestone #1 | Practice leadership develops and implements a process to recognize and reward clinic level quality improvement initiatives |
| Milestone #2 | Practice develops quality improvement (QI) team that represents the whole clinic and meets monthly. |
| Milestone #3 | Practice implements a patient experience survey and uses data to assess their delivery of primary care services as well as patient satisfaction with care received |
| Milestone #4 | Practice develops processes for providing performance feedback to providers at least quarterly, including data that represents each part of the triple aim of healthcare. |
| Milestone #5 | Practices assesses teamwork and team experience. |

EARLY RESULTS:

- Each practice can potentially earn **$13,000**.
- Potential payout to network: **$676,000**
- 29 Practices qualified for early payout of two milestones
- Several practices are planning to use the early payout to enhance their Rewards and Recognition program (Milestone #1)

Health COLORADO
A system of integrated healthcare providers.

# Community Reinvestment Grants

Health Colorado has distributed **$2,840,000** in community reinvestment grants. This does not include incentive payments for Key Performance Indicator achievement or COVID initiatives.

| | |
|---|---|
| Wellness and Prevention | Increase Well Visits access and engagement for Health First Colorado members. Priority will be given to proposals focused on Well Child Checks for members 0-21 yrs of age. |
| | Increase access and engagement for dental visits for members of all ages. |
| Condition Management | Program with interventions to address/prevent avoidable costly outcomes for members with chronic conditions. |
| | Program to support transitions of care throughout the continuum |
| Maternal Health | Pregnancy support and services to members by increasing prenatal visits and educating members about benefits. |
| Behavioral Health and Substance Use Disorder | Increase access and engagement in behavioral health services including behavioral health services in a primary care medical provider setting. |
| Social Determinants of Health | Program must have a focus in at least one of the five (5) key areas of social determinants of health:<br>• Education Access<br>• Social and Community Context<br>• Economic Stability<br>• Healthcare Access<br>• Neighborhood and Built Environment |

Health COLORADO
A system of integrated healthcare providers.

# Community Reinvestment Grants 2022

| Community Agency | Counties Served | Initiative |
|---|---|---|
| Care on Location | Custer, Fremont, Huerfano, Las Animas, Pueblo | Partner with local community-based organizations to offer on-site access to COL physical and behavioral health (BH) services. |
| Chaffee County Public Health | Chaffee, Lake, Fremont, Custer, Saguache | Mobile health clinic to provide health navigation, education, prevention, and early intervention services in partnership with First Street Family Health. |
| Friendly Harbor | Pueblo | Referrals for BH treatment court, veterans' health treatment court, and safe baby court to support. Increase access and engagement in BH services and social determinants of health |
| Project Angel Heart | All 19 counties | Medically tailored meals and enhanced nutrition services for 125 members with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and high-risk pregnancy. |
| Pueblo Triple Aim - DOTS | Pueblo | Educating 911 Super-Utilizers Project (DOTS) team members provide education to super-utilizers and the local community to proactively teach targeted communities Adding this proposed technology component to equip and educate super-uses will allow for growth of the DOTS program by increasing a patient's access to diverse healthcare options and ability to manage their own healthcare needs. |
| Senior Resource Development Agency | Crowley, Custer, Fremont, Huerfano, Las Animas, Otero, Pueblo | Supporting Aging and Disability Resources Colorado (ADRC) activities and address the social and community context, aiming to increase social and community support through psychoeducational support groups. Increase member's healthcare access referral services and application assistance. |
| Servicios de La Raza | All 19 counties, primarily Pueblo | Develop an onsite program for members in need of both Spanish/English BH. Address social determinants of health through individualized service plans to include affordable housing, transportation assistance, connections to childcare services, employment, financial literacy services, Medicaid enrollment and services for individuals that identify as LGBTQ+. |
| Southern Colorado Harm Reduction | Pueblo | Community center restoration and healing central hub in the Pueblo Bessemer neighborhood to enhance programs and services by offering equitable opportunities and care to individuals and families living with substance use disorder by promoting wellness, support, and prevention. |

Health COLORADO
A system of integrated healthcare providers.