ACC Phase III: Proposed Concepts

Behavioral Health and Integration Strategies Subcommittee

September 6, 2023

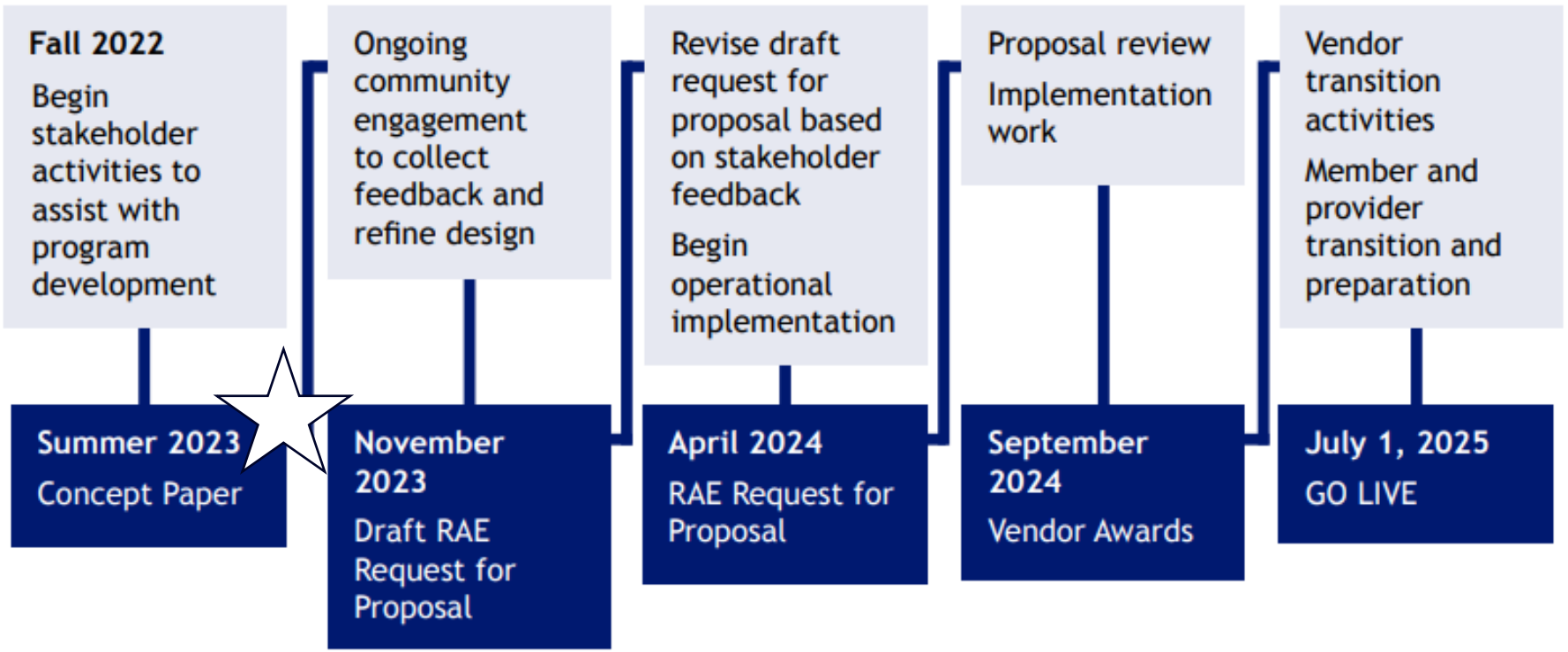
Presented by:

Colorado Department of Health Care Policy & Financing

Today's Agenda

- Background
- Overview of Phase III Proposals
  - Comments/questions may be shared via chat
- Discussion/Questions
- Next Steps

Ongoing Stakeholder Activities



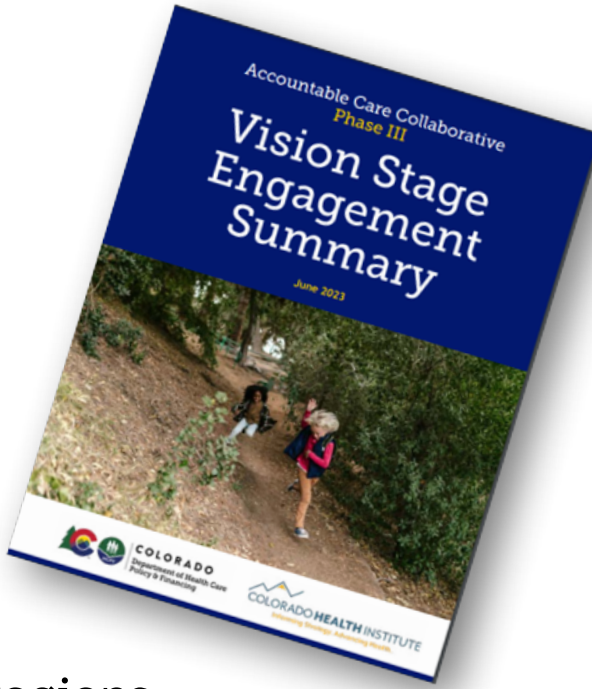
What we've heard:

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



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

Implement ACC Phase III Strategic Clinical 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

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

- Follow-up after hospitalization for mental illness (7 days).
- Follow-up after emergency department visit for alcohol and other drug abuse or dependency (7 days).
- Initiation and engagement of substance use disorder treatment.

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

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**

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 • Private Duty Nursing • Client Overutilization Program	Clinical Care Coordinator	• 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

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 behavioral health transformation efforts**
- **Reduce total number of regions**

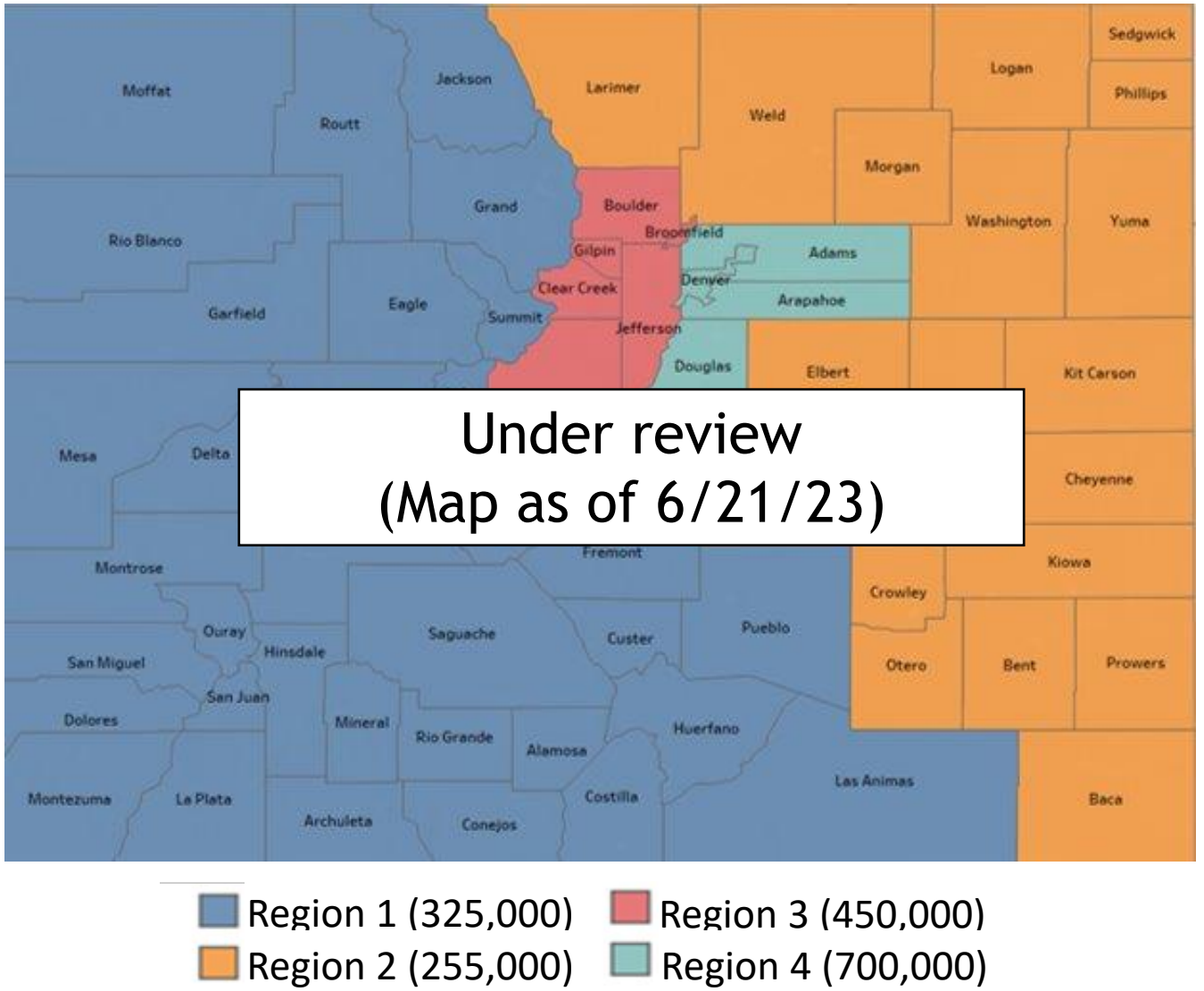
Enhance Member Attribution process to increase accuracy and timeliness

- 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)

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

Discussion

Next Steps

Provide additional feedback:

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

Upcoming Public Meetings

- **Advocates and CBO representatives:** 9/6 from 12 to 1:30 p.m.
- **Behavioral Health Providers:** 9/14 from 5 to 6:30 p.m.
- **All providers welcome:** 9/26 from 8 to 9:30 a.m.
- **Health First Colorado Members:** 9/28 from 5 to 6:30 p.m.

Thank you!