ACC Phase III: Reading and Responding to the Draft Contract

Behavioral Health and Integration Strategies Subcommittee

February 7, 2024

Presented by:

Colorado Health Institute

Colorado Department of Health Care Policy and Financing

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Department of Health Care Policy & Financing

Today's Agenda

9:10 – 9:25am	Behavioral Health Improvements
9:25-9:40am	Health Equity and Health-Related Social Needs
9:40-9:55am	Care Coordination
9:55-10am	Next Steps

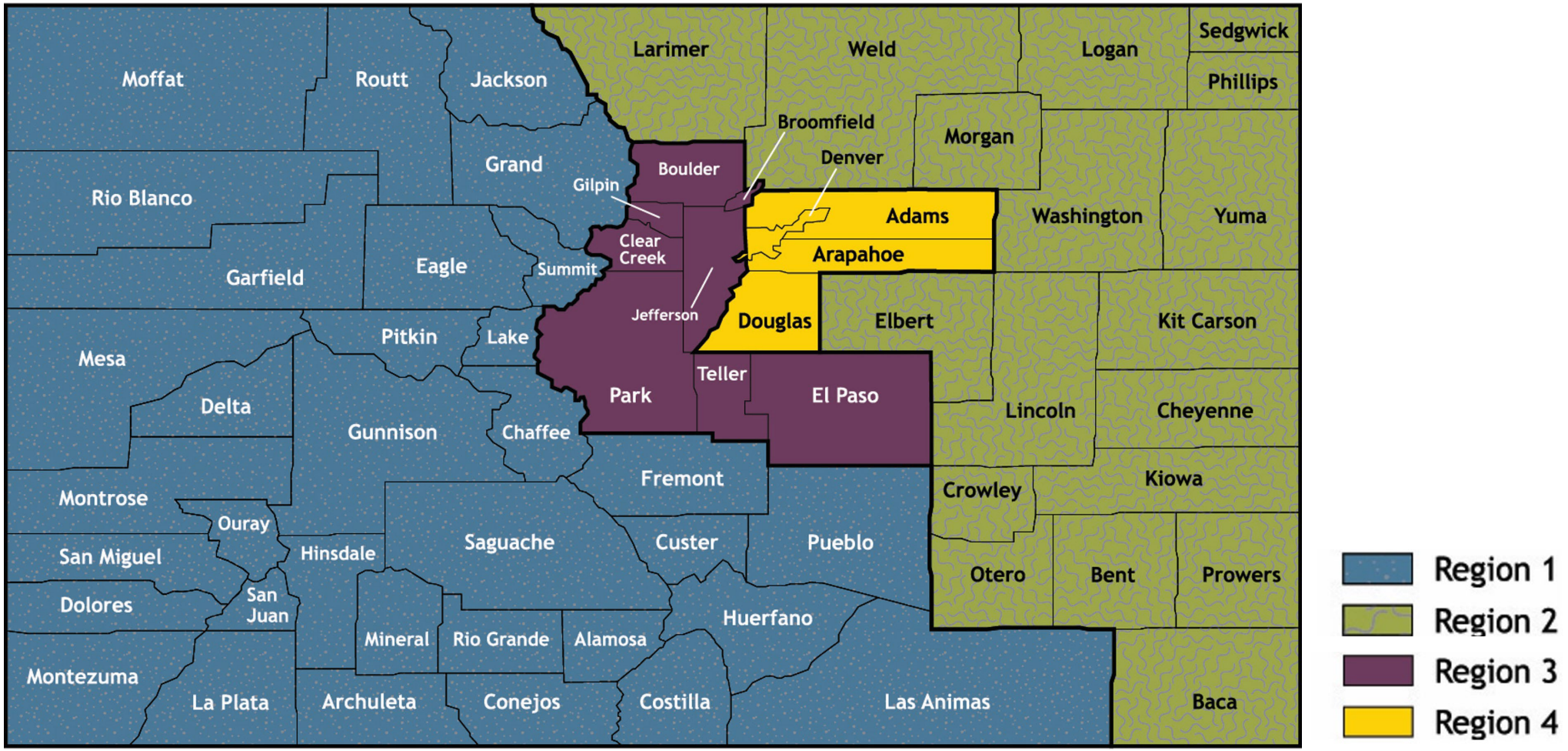
What is the Draft Contract?

- Includes 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.
  - At most, each bidder will be able to serve as the RAE for one region.
- Requirements in the draft contract are subject to state and federal approval.

Draft Contract:
Key Changes for Phase III

Behavioral Health-Specific Changes

ACC Phase III Region Map



Reducing Administrative Burden

- Centralized credentialing
- Universal contracting provisions
- Standardizing utilization management processes
  - Timelines for RAE determinations on prior authorizations
  - Requirements for RAE to consult with an ordering provider to discuss denial determination (peer-to-peer consultation)
  - RAE requirements for managing members with co-occurring disabilities and children under 21

Behavioral Health Improvements

- Continued evolution of payment for safety net providers to include value-based payments
- Specific care coordination requirements for members accessing inpatient and residential behavioral health services and transitions of care
- Expanded requirements around discharge planning and follow-up with performance standards
- RAE plan to reduce readmissions and emergency department utilization related to behavioral health
- New behavioral health key personnel position
- Support safety net provider adoption of Measurement Based Care
- Comprehensive Safety Net Providers can serve as PCMPs.

Where to look for more info?
Section 9, 7

Integrated Behavioral Health

- Incorporate learnings from the current integrated care grant program to create a sustainable model in ACC Phase III
- Identifying opportunities to ensure that members are able to access behavioral health services in primary care settings
- Want physical health providers to be involved – be on the lookout for future updates!

Member Support

Health-Related Social Needs

- Create formal, documented partnerships with critical community organizations.
  - Improve referrals to food resources and help with SNAP and WIC enrollment.
  - Provide referrals and coordination for members experiencing housing instability and working with permanent supportive housing providers.
- Provide pre-release services to eligible incarcerated individuals
  - Contingent on approval of a new program from CMS

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

Food Security Requirements

- Establish formal, documented partnerships with community organizations to refer to food resources and to help with SNAP and WIC enrollment.
  - Report the number of referrals made to SNAP outreach and application organizations.
- Train network providers on the WIC referral process and create streamlined processes for sharing member information.
- Participate in 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:
  - Partner with other organizations (including Continuums of Care).
  - Conduct additional outreach to members identified as homeless or at risk of homelessness.
  - Work closely with partners who will identify housing options, assist members in filing housing applications, and coordinate provision of supportive housing and related services.
- RAEs will support a network of permanent supportive housing (PSH) providers, support enrollment of PSH providers, and coordinate care for those eligible for and enrolled in PSH.

Health Equity

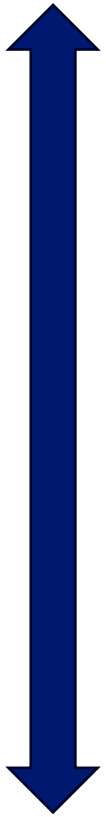
- Develop annual health equity plans with measurable goals and submit data on their performance.
- Establish a Regional Health Equity Committee to help with development of plan and oversee performance.
- Make trainings available to staff and network providers on cultural responsiveness and EDIA.
- Hire 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

Care Coordination

Continuum of Care Coordination Program Activities

Least intensive



Most intensive

- General outreach and health promotion
- Support a network of community-based organizations
- Address health-related social needs
- Utilization of the social health information exchange and related systems
- Connect members with appropriate entities for enrollment in other state benefits (SNAP, WIC, etc.)
- 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
- Complex case management and effective collaboration with multi-provider care teams

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 partner 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
- RAEs are encouraged to subcontract with Comprehensive Safety Net Providers to meet the care coordination needs of members with complex behavioral health needs

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.
  - 7 day follow up for behavioral health inpatient discharge.

Next Steps

Upcoming Public Meetings

- **Primary Care Medical Providers:** 2/12, 2:30 – 4 PM
- **Informational Meeting #2:** 2/14, 3 – 4:30 PM
- **Behavioral Health Providers:** 2/15, 12:30 – 2 PM
- **Advocates and CBO Representatives:** 2/21, 12:30 – 2 PM
- **Health First Colorado Members Only:** 2/29, 2:30 – 4 PM
- **Prospective Bidder Conference:** 3/1, 9:30-11am

Thank you!

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