ACC Phase III Draft Contract Member Guide

How will ACC Phase III Affect Members?

COLORADO
Department of Health Care Policy & Financing

What is the Accountable Care Collaborative?

The Accountable Care Collaborative, or ACC, is how Colorado delivers both physical and mental health care to members who receive services through Colorado's Medicaid program, which you may also have heard called Health First Colorado. These services are provided through organizations called Regional Accountable Entities (RAEs). You may also know your RAE directly by name. The current RAEs are:

- Colorado Access
- Colorado Community Health Alliance
- Health Colorado, Inc.
- Northeast Health Partners
- Rocky Mountain Health Plans

The RAEs support members and providers (like doctors, nurses and therapists) in several ways, including paying for mental health services and helping providers use new technologies to improve member care. RAEs may work directly with members to help you use this program, including finding providers and other services. They can also help with care coordination, including helping you figure out transportation or helping find different providers (like a doctor, a specialist and a pharmacy).

What is the Draft Contract that was recently published?

Because the state pays the RAEs for these services, they have to have a contract with each RAE.

Under state rules, the state Medicaid agency (known as the Department of Health Care Policy and Financing, or HCPF) must allow new organizations to apply to become RAEs every few years. During this time, HCPF may change the contracts between Medicaid and the RAEs to improve programs. When the new contract goes into effect, Colorado will be in what is called Phase III of the ACC. HCPF has published a Draft Contract which includes the proposed changes for ACC Phase III.

The Draft Contract lists all of the RAEs' responsibilities for Phase III of the ACC, which will begin on July 1, 2025. The Draft Contract includes some requirements under state and federal laws, and it also includes expectations from HCPF. HCPF created these expectations after listening to members, providers, RAEs and others. Providers' responsibilities and state agencies' responsibilities will not show up in this document.

The Draft Contract tells the RAEs what they need to do — it does not tell them how they need to complete these responsibilities. A company that wants to become a RAE (even if they already are the RAE) will bid to become the new RAE in each region. In their bid, they will explain how they plan to complete their responsibilities. HCPF will then review their responses and decide who the new RAEs will be.

Why is this important to you as members?

The Draft Contract lists the types of services RAEs will be responsible for and how they will be held accountable over the next seven years.

At this point, the general policies in this Draft Contract are not likely to change, but some of the important details are still being decided, and that's where your input is most helpful. For instance, there are details about regional member advisory councils that could be changed or added to, based on your feedback. HCPF also regularly updates the contracts with the RAEs. Your feedback can help us with future changes as well.

This is the time to share what you, as members and families, want to change in the Draft Contract. Your feedback helps HCPF work to better meet the needs of people who use the Medicaid system.

What is in the Draft Contract?

The Draft Contract is very large, so below are summaries of the parts that have the most direct effect on members. These summaries also focus on places where RAEs' tasks are changing.

Member Engagement (Section 3)

Many members say they do not know their RAE or do not even know that RAEs exist. Members are then confused if RAEs reach out to them. Members also have trouble knowing who to ask when they have questions. HCPF has come up with these requirements for how RAEs must communicate with you:

- In order to improve cultural responsiveness, which essentially requires providers to value and respond to members' diverse identities and needs:
    - RAEs must translate documents that describe how members can receive services and assistance into Spanish, and into any other languages that are common in their regions.
        - They must also provide free interpretation, including sign language, for members, when members are working directly with RAEs.
    - RAEs must make trainings available for providers and for their staff around how to provide culturally competent care, including disability competent care.
- In order to improve communication:
    - RAEs must make any information they provide to members accessible for people with disabilities and easy to understand. RAEs must ask a few members to read certain RAE letters or emails before sending them out to make sure they are easy to understand and make sense to them as members.

    - RAEs must include the Health First Colorado (Colorado's Medicaid program) logo and their own logo on any communications to members. This requirement was suggested by members who said they know Health First Colorado, or Medicaid, but don't know their RAE.
    - RAEs will have to have a call line to provide customer service and care coordination. You can call this line if you have any questions about the Medicaid system or if you need help getting care or services.
        - This call line will be open during business hours, and you should not — on average — wait more than two minutes before talking to someone.
- RAEs must have information on their websites about members' rights, members' ability to submit grievances and appeal decisions, how to reach out to the RAE, and a list of available providers.
- The RAEs' lists of available providers need to include the following information for each provider:
    - The languages the provider can provide services in. Either the provider must speak the listed languages, or they must have a medical interpreter working in their office who can speak the listed languages. American Sign Language is included as a potential language.
    - Whether the provider has completed a training on cultural responsiveness.
    - Whether the provider's office has accommodations for people with physical disabilities, including accessible exam rooms and equipment.
- RAEs will also be required to create and run a member incentive program, or a program where certain members will receive gift cards, vouchers, gym memberships or similar incentives. Each RAE will play a role in helping develop their own programs, and not all members will be eligible to participate in these incentive program. The programs may focus on:
    - Getting timely prenatal care.
    - Addressing obesity.
    - Preventing diabetes.
    - Quitting smoking.

Questions for You:

- Do you know who your RAE is, and have you received communication from them?
- If you've received communication from your RAE, did you know that it was about Medicaid?
- Have you contacted your RAE member call center before? Were you able to speak to someone who provided the assistance you needed?
- Did you know that RAEs have resources on their websites to help you find a provider? If you have ever used these resources, were they helpful? What challenges did you have?

Provider Network and Access Standards (Section 5)

HCPF has updated requirements about how close providers must be to members. RAEs must make sure that all members have primary care medical providers nearby. The exact distance may differ, depending on whether you are in an urban or rural area. At least 90% of members must be able to choose between at least two providers in this range.

Members also need to be able to get timely care when they need it. RAEs must ensure they partner with enough providers so that patients can access:

- Urgent care within 24 hours.
- Outpatient follow up within 7 days of hospital discharge.
- Well-care or routine visits within 1 month of a request.
- Emergency behavioral or mental health care within 15 minutes by phone, within 1 hour in person in urban counties, and within 2 hours in person in other counties.
- Non-urgent behavioral health services within 7 days of a request.
- Evaluation for medication-assisted treatment within 72 hours of a request.

HCPF is currently developing a way to make sure that RAEs meet these standards most of the time.

Finally, RAEs must try to recruit diverse providers to work with. As a member, this should give you more choice in finding the right kind of provider.

Questions for You:

- If you've had trouble getting in to see a provider, what would have made it easier to find a provider?
- Did you know you could reach out to your RAE for assistance? What type of assistance would you like?

Health Neighborhoods (Section 6)

With these new contracts, HCPF has expanded RAEs' responsibilities when it comes to helping members access social services that can improve health, such as housing and food. RAEs will need to form partnerships with community organizations that provide resources like food and housing.

HCPF has listed some additional RAE requirements to help address food and housing insecurity. These requirements might have to be approved by the state legislature or the federal government.

- To address food insecurity, RAEs must:
  - Refer members to organizations like food banks.
  - Partner with groups who can help members enroll in SNAP and WIC benefits. SNAP is the Supplemental Nutrition Assistance Program, and WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children.
  - Train RAE staff on food insecurity and the process of applying for SNAP and WIC.
  - Train providers on their role in the process of applying for WIC.
- To address housing insecurity, RAEs must:
  - Identify members who are homeless or are at risk of becoming homeless, and they must conduct additional outreach to these members.
  - Partner with groups that help people experiencing homelessness.

        - RAEs are required to work closely with partner organizations to help identify housing options for these members, assist members in applying for housing and coordinate housing-related services, including permanent supportive housing.
    - Support a network of permanent supportive housing providers in their area. Permanent supportive housing is when organizations offer people experiencing homelessness both housing and other supports, such as mental health care, legal aid, and job training.
    - Coordinate care for members who have applied for or are receiving permanent supportive housing.

RAEs must also support health equity. Supporting health equity means creating policies to stop the discrimination that happens in the health care system that causes some people to have worse health outcomes.

- RAEs will create regional health equity plans, and they are expected to get input from members, providers and others on these plans. The plans will have measurable goals, and RAEs will be responsible for meeting these goals.
- RAEs will also need to work toward ensuring their staff and the providers they work with are culturally responsive.

Questions for You:

- Have you ever received care coordination support or referrals from your RAE for needs like food, housing, or transportation?
    - If "yes," was your RAE able to help you get the support you needed? If not, what was lacking and could be improved?
    - If "no," what type of support would you want to see from your RAE?
- Does your RAE seem knowledgeable about community resources? What are the most critical connections to health-related social needs, like food, housing, or transportation, that should be available to members?
- Have you received referrals to health-related social needs from your medical providers? If so, what do they do that works well?

Care Coordination (Section 7)

In the new contract, HCPF has increased RAEs' responsibilities for care coordination. HCPF hopes these requirements will ensure that members, especially members with complex health or social needs, can access care coordination when they need it. HCPF wants there to be some services and supports that people get no matter where in the state they live, regardless of their RAE.

RAEs are allowed to pay others, including doctors and community organizations, to provide care coordination on the RAE's behalf. Doctors' offices will also be asked to coordinate care when appropriate. However, the RAE will still be responsible for making sure that members are being offered the appropriate level of care coordination, including helping members whenever providers cannot.

HCPF will require RAEs and providers to use a three-tier system. A tier system means that people with greater needs get offered more care coordination than those with fewer needs.

The three tiers are:

1. Tier One: For **all members,** RAEs and providers will need to make sure **preventive care coordination is offered to members**. This includes contacting members who have not visited a provider for a well-visit or have not gone to the dentist recently. RAEs and providers will provide brief screenings to determine if members require more support. Members do not have to accept the screenings, and no one will be required to use any specific service.
2. Tier Two: For those with ongoing conditions (such as members with diabetes, asthma, depression, anxiety, and substance use disorders), as well as pregnant members, RAEs and providers will need to offer members support in managing their conditions and needs. This includes conducting a needs assessment and helping develop or supporting a treatment plan. Care coordinators are expected to engage with members in this tier on a quarterly basis. Members will be offered this support but not be required to accept it.
3. Tier Three: For members with the most **complex needs**, such as members with more than one health condition, members who are involved in other systems (like the child welfare or criminal justice system), and those who regularly use the emergency departments or crisis systems, RAEs will need to offer the most **intense care coordination**. For instance, RAEs and providers will need to offer a comprehensive needs assessment and develop a comprehensive care plan. Care coordinators at this tier are expected to work with members on at least a monthly basis. This will be a performance standard that RAEs are measured on.

HCPF knows that transitions of care can be a challenging time for members. Examples of transitions of care can include discharging from the emergency department, a residential mental health unit, or the hospital. It can also involve follow-up after a crisis visit for mental health issues. To ensure that members going through these and other transitions are supported, RAEs will have to develop specific plans to ensure members continue to receive care after their discharge. Care coordinators must contact members after an inpatient stay to ensure they have a follow-up appointment within 30 days of a physical health discharge or within seven days for a behavioral health discharge. This is a performance standard that RAEs will be measured on.

HCPF has heard concerns that there isn't enough accountability for care coordination. Because care coordination may vary from person to person, it is impossible to totally standardize care coordination. However, RAEs will be required to create and follow a policy guide to describe their strategy to provide care coordination. RAEs also will be required to describe in this policy guide how they will provide specific support for different populations, including members who may receive care coordination from other entities. RAEs also will need to report on the care coordination they have provided to members in different tiers and to those undergoing transitions of care, so HCPF can make sure RAEs are providing effective care coordination. RAEs are expected to involve members in creating these guides.

Questions for You:

- Have you received care coordination from your provider? Has it been the level of support you needed?
    - If you needed more support, did you know you could reach out to your RAE?
- How can the RAEs inform members that care coordination is available?
- How can RAEs make it easier for you to access care coordination services?

Provider Support Practice Transformation (Section 8)

RAEs are required to provide a range of trainings and supports to the providers in their networks. Among these trainings, RAEs have to ensure that providers have access to trainings on the following topics every six months:

- Cultural competency
- Equity, diversity, inclusion, and accessibility
- Member rights, grievances, and appeals
- Trauma-informed care

Questions for You:

- What do you feel are the top two skills your provider should have that would make you feel more comfortable when you see your provider? This can help HCPF inform the trainings that RAEs should make available to providers.

Behavioral Health Benefit (Section 9)

One major RAE responsibility is to pay providers for behavioral health services. This means that RAEs must make sure that members can access medically necessary behavioral health services. Most of the changes to this section are technical and specific to how RAEs must cover behavioral health services. However, some of the changes may improve your experience and should help you access behavioral health services more quickly, including:

- Improving how HCPF pays certain providers, with the goal of increasing access to care across the state for key behavioral health services.
- Standardizing the RAEs' guidelines for using care to make sure members can access similar services across RAEs. RAEs use these guidelines to review services your doctor provides to determine whether they are appropriate.
- Increasing accountability for the RAEs. RAEs must make sure providers are following up with members after leaving mental health hospitals or having a crisis visit for mental health issues. HCPF wants to ensure members are getting the follow-up care they need.

Standardized Child and Youth Benefit (Section 10)

For the new contract, HCPF is increasing requirements for RAEs to comply with federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which ensures that children and youth receive regular care according to evidence-based, national guidelines. This will occur through:

- Improving how families are given information about when and how to access their benefits.
- Creating new ways to make sure the RAEs and HCPF are meeting EPSDT requirements.

HCPF is also standardizing how the RAEs will make behavioral health benefits available to children and youth, regardless of which RAE a family works with. RAEs will use standard screening tools for all children and youth. Depending on the outcome of those tools, children and youth will be matched with a set of services that the RAE must help coordinate.

Children and youth whose screening identifies them as being at risk of an out-of-home placement may be eligible for intensive treatment planning and/or high-fidelity wraparound. Intensive treatment planning and high-fidelity wraparound means that care coordinators who specialize in working with children and youth with acute behavioral health needs work collectively with the family, providers and support staff to decide on treatments. High-fidelity wraparound services also include connecting families with other community services. The exact details of this benefit are still being developed in collaboration with the Behavioral Health Administration and with stakeholders, and HCPF plans to align with other state systems.

Questions for You:

- What challenges have you experienced in seeking children's behavioral health services?
- If your child has been referred for follow-up services after a screening (this could be for hearing, vision, behavioral health, physical health, developmental needs, or more), were you able to get that in a timely manner? Did you need support to access that follow-up service?

Outcomes, Quality Assessment, and Performance Improvement Program (Section 12)

In order to improve the performance and results for members, HCPF has proposed the following requirements:

- RAEs will need to propose a way to measure and report on members' experiences when they are seeking or receiving health care. As part of this work, RAEs will need to regularly survey members who have recently received care and members who were recently enrolled in Medicaid.
    - They will need to propose projects to improve member experience based on the results of these surveys and report on their progress annually.
- Each RAE will need to set up at least five stakeholder groups:
    - Two member advisory councils, made up entirely of Medicaid members and their families, friends, and supporters.
    - Two program improvement advisory councils, made up of a mix of members, providers, and other stakeholders.
    - One regional health equity committee, which will provide feedback on RAEs' health equity plans, made up of a mix of members, providers, and other stakeholders.

- Stakeholder groups are required to meet several times per year to review different parts of the RAE's performance, and the RAEs will be required to dedicate money to these committees.
- The member advisory councils and regional health equity committee will be led by people who have a background in equity, diversity, inclusiveness, and accessibility.

Questions for You:

- HCPF wants members to advise and inform the RAE's decisions, particularly on decisions that directly impact members. Do you think the requirements for regional member advisory councils (as described in section 12.8.4 of the Draft Contract) will help members be more involved?
- Are there other requirements you would like to see to ensure that members' experiences are being listened to?
- HCPF is thinking about how to ensure that RAEs have a presence in local communities and are responding to local needs. Section 12.8 of the Draft Contract outlines several requirements for RAEs to form committees with community stakeholders. Are there other requirements that could help make sure RAEs are working at a local level? How should HCPF monitor that RAEs are responding to local community needs?

How does HCPF plan to make sure that RAEs are meeting these requirements?

HCPF has heard from many members that, in practice, these requirements are not always met. In the contract, HCPF has included "performance standards." A few of the performance standards have been noted in this guide. For instance, there is currently a performance standard that care coordinators meet monthly with members in the highest care coordination tier. If RAEs meet fewer than 90% of these performance standards, they will need to reinvest a portion of their profits into improving their program. As performance decreases, RAEs must reinvest a greater percentage of their profit into improving the program.

Additionally, RAEs must submit deliverables to HCPF that ensure each RAE has internal procedures and that they are transparently reporting on their performance in different areas.

What happens next?

HCPF is collecting feedback about the Draft Contract until March 10 about anything you think is missing, needs to be removed from this contract, or needs to be changed. You can find the full Draft Contract and all related materials on the ACC Phase II Draft Contract webpage.

Once that feedback has been collected, HCPF will finalize a contract and publish a comprehensive request for proposal that includes the finalized contract language and questions that organizations bidding to win these contracts must answer.

HCPF hopes to have each RAE represent, at most, one region. However, if HCPF finds that, in one region, there are no other organizations capable of fulfilling the Draft Contract responsibilities, a single RAE may be awarded two regions.

HCPF will judge each proposal as a whole — there are not "points" for specific answers.

In addition to seeking your thoughts on the Draft Contract, HCPF would like to know the types of questions organizations who respond to the request for proposal, should be asked. You can review the questions from Phase II and make suggestions on what should be added or amended for Phase III. Also, if there are certain factors that you think are particularly important to consider as part of the evaluation process, HCPF would like your feedback on what those factors are.

If you have feedback, HCPF has three ways for you to reach out. HCPF encourages you to use the two feedback forms listed but understands that email may be easier for some people:

- Draft Contract Feedback Form. This form is for any thoughts you have about RAEs' requirements.
- Offeror Questions Feedback Form. You can use this form to share your thoughts about questions that HCPF should ask organizations who respond to the request for proposal.
- HCPF_ACC@state.co.us. If you have problems filling out a feedback form, you may send feedback over email.

All feedback must be received by **March 10** for HCPF to have time to review and consider making changes to the final request for proposal. Thank you so much for taking the time to share your thoughts about your experience!