Welcome, thank you for joining us!

- *La interpretación* ***en español*** *comenzará en breve, gracias por su paciencia.*
- **This meeting is being recorded.** Please keep your sound muted, unless you are speaking.
- Slides and a recording of the presentation and discussion will be available on the Department's website.
- *ASL interpretation and live captioning is available.*
- **Health First Colorado members:** We will share a link in the chat to receive compensation for your time today.

Questions or comments?

- Chat Use the chat for comments.
- Q&A Use the Q&A feature for questions.
- Please hold verbal questions until the discussion portion of our meeting today.
  - ➢ Use the "raise hand" feature under Reactions to indicate a question.

ACC Phase III: Reading and Responding to the Draft Contract

February 1, 2024

Presented by:
Colorado Health Institute
Colorado Department of Health Care Policy and Financing

Today's Agenda

1:00 – 1:05pm	Introduction
1:05 – 1:15pm	Background
1:15 – 1:20pm	How to Read the Draft Contract
1:20 – 2:20pm	Draft Contract: Key Changes for Phase III
2:20 – 2:30pm	Q & A & Next Steps

ACC Background

Accountable Care Collaborative (ACC)

- Delivers cost-effective, quality health care services to Colorado Medicaid members to improve the health of Coloradans.

- Coordinates regional physical and behavioral health care services to ensure member access to appropriate care.

Role of the Regional Accountable Entity (RAE)

- Build a network of care providers
  - Contract with Primary Care Medical Providers (PCMPs)
  - Contract with behavioral health providers and administer the capitated behavioral health benefit
- Provide care coordination, care programs, and case management
  - Some RAEs do this themselves, while others contract this out
- Assist with practice transformation (e.g. support PCMP offices integrating behavioral health services into their clinics)
- Respond to local community needs to best support Medicaid members

Colorado ACC Evolution

1995 2011 2018

Accountable Care Collaborative Phase I
- Administered by RCCOs
- Managed FFS for Physical Health
- Medical Home
- Cost savings
- Iterative

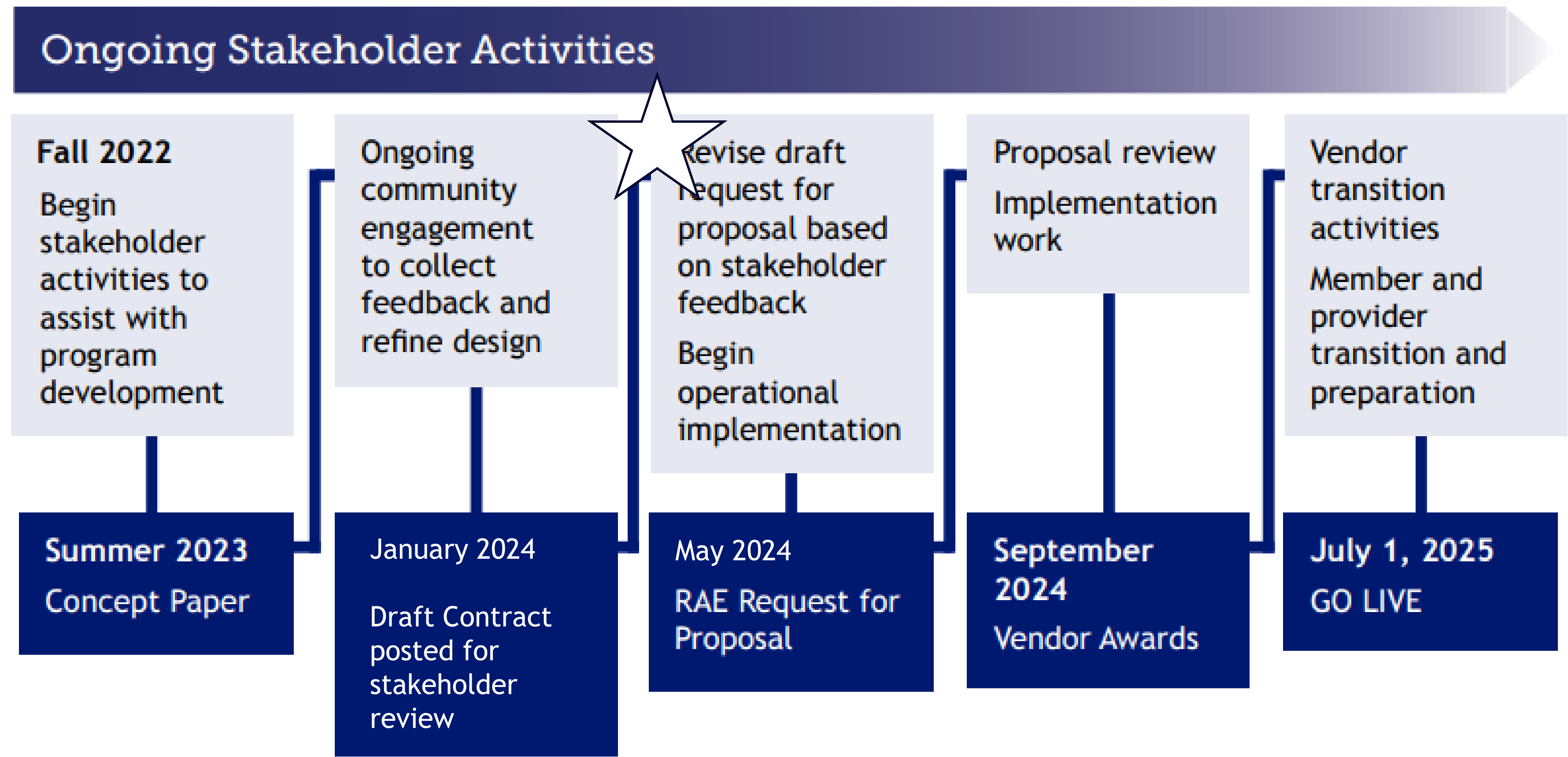
Community Behavioral Health Services
- Administered by BHOs
- Capitated Mental Health and SUD Services
- Cost Savings

Accountable Care Collaborative Phase II
- Administered by RAEs
- Join administration of physical and behavioral health
- Refine focus on cost and outcomes
- Physical PMPM, BH Capitation

2025 Phase III

Stakeholder Engagement To Date

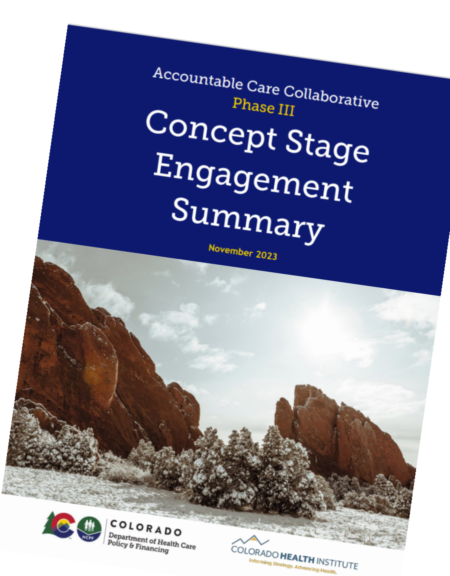
Ongoing Stakeholder Engagement Timeline



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

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?

- **Draft Contract:** Contractual requirements organizations will be required to follow to serve as Regional Accountable Entities (RAEs) for ACC Phase III.
- **Request for Proposal (RFP):** includes the Contract and questions for bidders to respond to
- **Procurement Process:** Bidders must outline their capabilities for meeting the requirements within the Draft Contract.
- Requirements in the draft contract are subject to state and federal approval

Tips for Reading the Draft Contract

- Many administrative pieces are functionally the same as in Phase II.
- 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 <u>not</u> in the Draft Contract?

- Draft Contract is focused on **RAE obligations:**
  - Contract requirements detail what the RAEs will be responsible for, not *how* they complete those requirements.

- Processes primarily managed by HCPF are <u>not</u> 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.

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

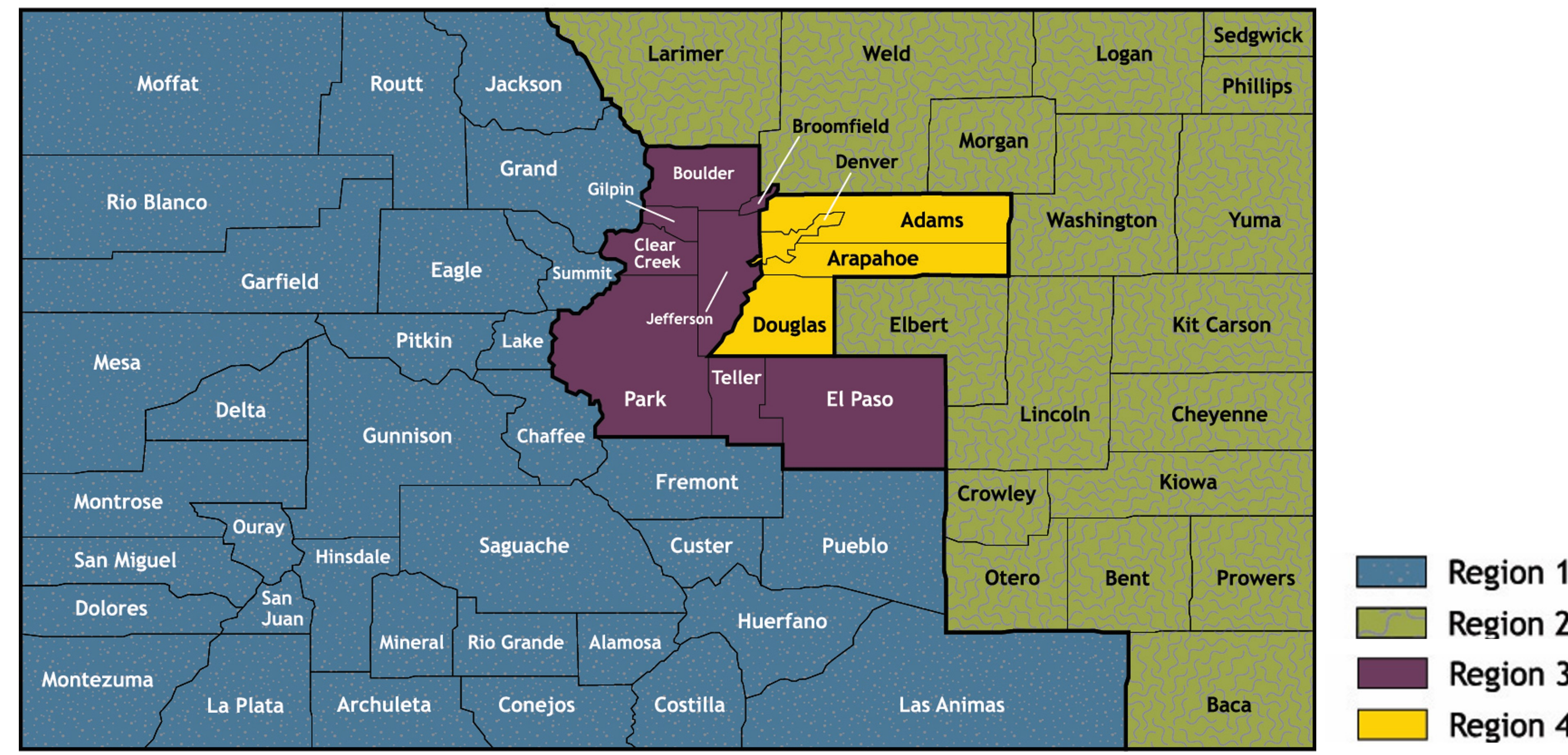
The Procurement Process

- Bidders will submit **proposals** in response to the RFP in the summer
- Proposals are judged holistically: There are not a specific number of points assigned to different answers
- Offeror Questions from Phase II are posted on the HCPF website for review
- Letters of support may be submitted as part of bidder's application

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 re-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 connect members accessing health care services with a PCMP.
- Comprehensive Safety Net Providers can serve as PCMPs.

Where to look for more info?
Section 2

Member Support

Member Experience and Incentives

- Improve member communication.
  - Co-brand materials
  - Operate a member call center within performance standards.
- Member experience of care strategy as part of continuous process improvement.
  - Focus on hearing from recent utilizers and new members.
- 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

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 data for WIC enrollment.
- 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.
  - 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.

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

Provider Support

Provider Support

- Offer 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

Three-Tier Payment Framework

- Payment programs must 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, expanded network time and distance standards from 3 county types to 5 county types.
- RAEs must collaborate with HCPF on a process to monitor timeliness standards within provider network.
  - New standard related to medication assisted treatment.
- 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

- Implement strategies to improve data sharing throughout the Health Neighborhood.
- Provide support to the following programs:
  - eConsult: promote among specialty providers and support primary care medical providers on using it.
  - Social Health Information Exchange: 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-Specific Changes

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

Where to look for more info?
Section 9, 7

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

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!

Support for Children and Youth

Services for Children and Youth

- New RAE requirements to improve screening of EPSDT eligible populations and support with referrals
- 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

Entry to Care	Determine access points for different tiers [e.g., PHQ-9 in PCP; CANS with IA through CW]			
Level of Care	1	2	3	4
Service Category	Low	Medium	High	Inpatient
Services Available	Targeted services for each acuity/complexity TBD through engagement with you			
Care Coordination Level	Tiered care coordination associated with evidence-based practice for different levels			

Pathway to Care

Standardized screening process as part of a pathway to care

IA needed

Standardized IA which includes CANS tool

CANS Decision Support Model to help determine level of care and guide treatment/service planning

For those with complex behavioral health needs, ITP and HFW provided by third-party

IA not needed

Referrals to the needed services based on the screen

Acronyms:

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

Care Coordination

Continuum of Care Coordination Program Activities

Least 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

Most intensive

Care Coordination

- RAEs must create a program that supports the full continuum of care coordination for physical and behavioral health care, 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
  - Partnering 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

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. 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.

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

ACC Clinical Quality Metrics

- Clinical quality strategic objectives will be developed and monitored for the entire Phase III contracts
- Key Performance Indicators (KPIs) under consideration:
  - Child and Adolescent Well-care Visits
  - Childhood Immunization Status
  - Screening for Depression and Follow-up
  - Comprehensive Diabetes Care: HbA1c Poor Control
  - Controlling High Blood Pressure
  - Emergency Department Visits
  - Timeliness of Prenatal Care
  - Postpartum care
- HCPF intends to align KPIs with DOI Primary Care Measure Set, CMS core measures, other statewide initiatives and through consultation with the RAEs and stakeholders

Commitment to Quality Program

- Performance standards are defined throughout contract for key areas of the program
- RAEs will be required to reinvest a portion of their profit margin into key program areas depending on how many performance standards they met in a specific time period

Percent of Performance Standards	Required Profit Margin Reinvestment
90% or more	0%
85-89%	5%
80-84%	15%
80% or less	25%

Next Steps

Sections Under Development

- HCPF is continuing to refine the requirements for each of the following:
  - Quality
  - Payment strategy
  - Services for children and youth
  - Deliverables
  - Performance standards
  - Commitment to Quality Program
- Stakeholder feedback in these areas will help us develop the final RFP

Q&A

Opportunities for Feedback

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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