Colorado's Accountable Care Collaborative

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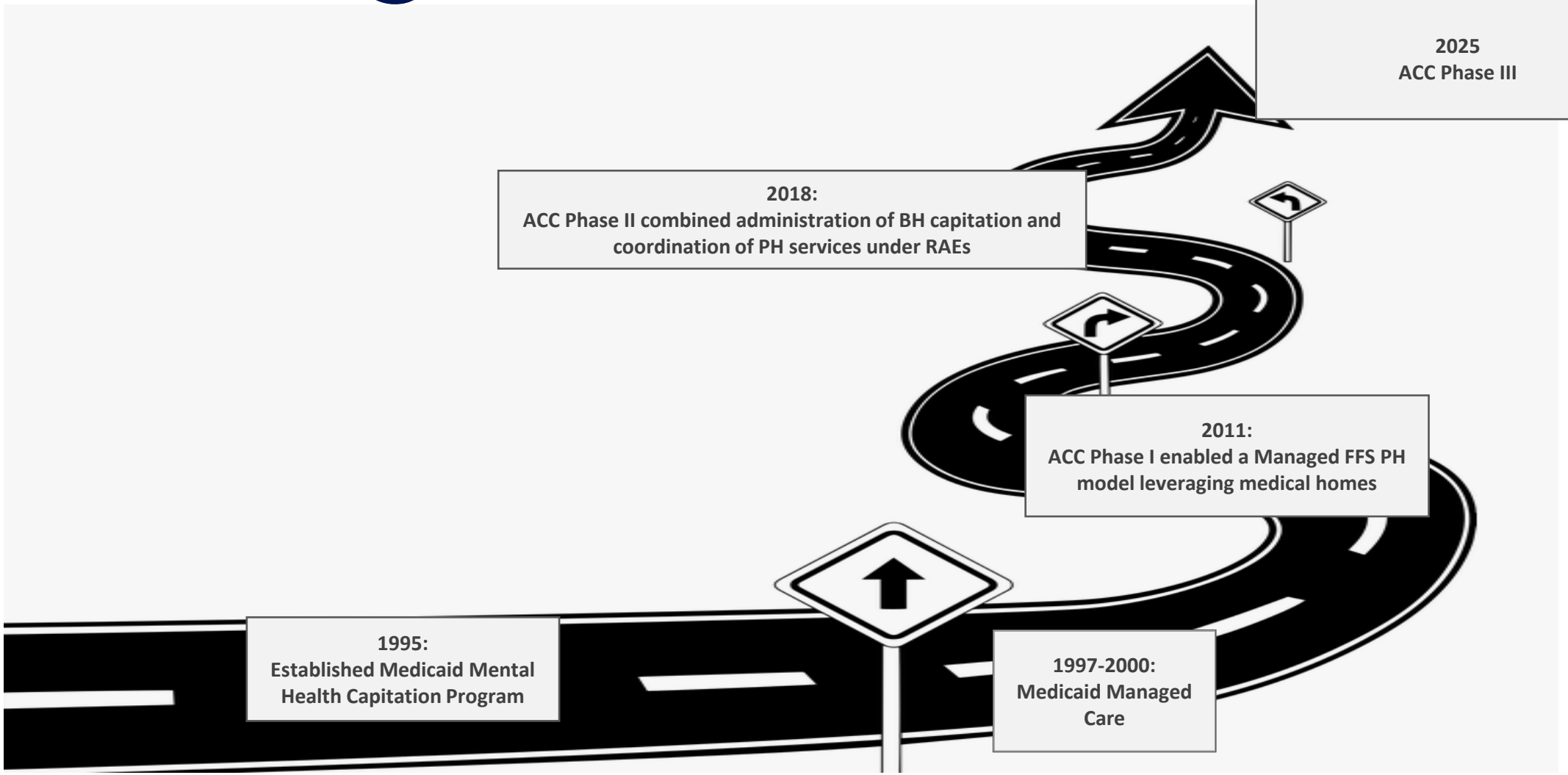
Agenda

1. History of the Accountable Care Collaborative
2. Responsibilities of Regional Accountable Entities
3. Moving towards Phase III

History & Background of the ACC

Managed Care in Colorado



Accountable Care Collaborative

Improve Health and Reduce Costs

Medical Home

Ensure Medicaid members have a focal point of care.

Behavioral Health

Comprehensive community-based system of mental health and substance use disorder services.

Regional Coordination

Medicaid members have complex needs and are served by multiple systems. Regional umbrella organizations help to coordinate across systems.

Data

Members, providers and the system receive the data needed to make real-time decisions that improve care, increase coordination of services and improve overall efficiencies.

Regional Accountable Entities

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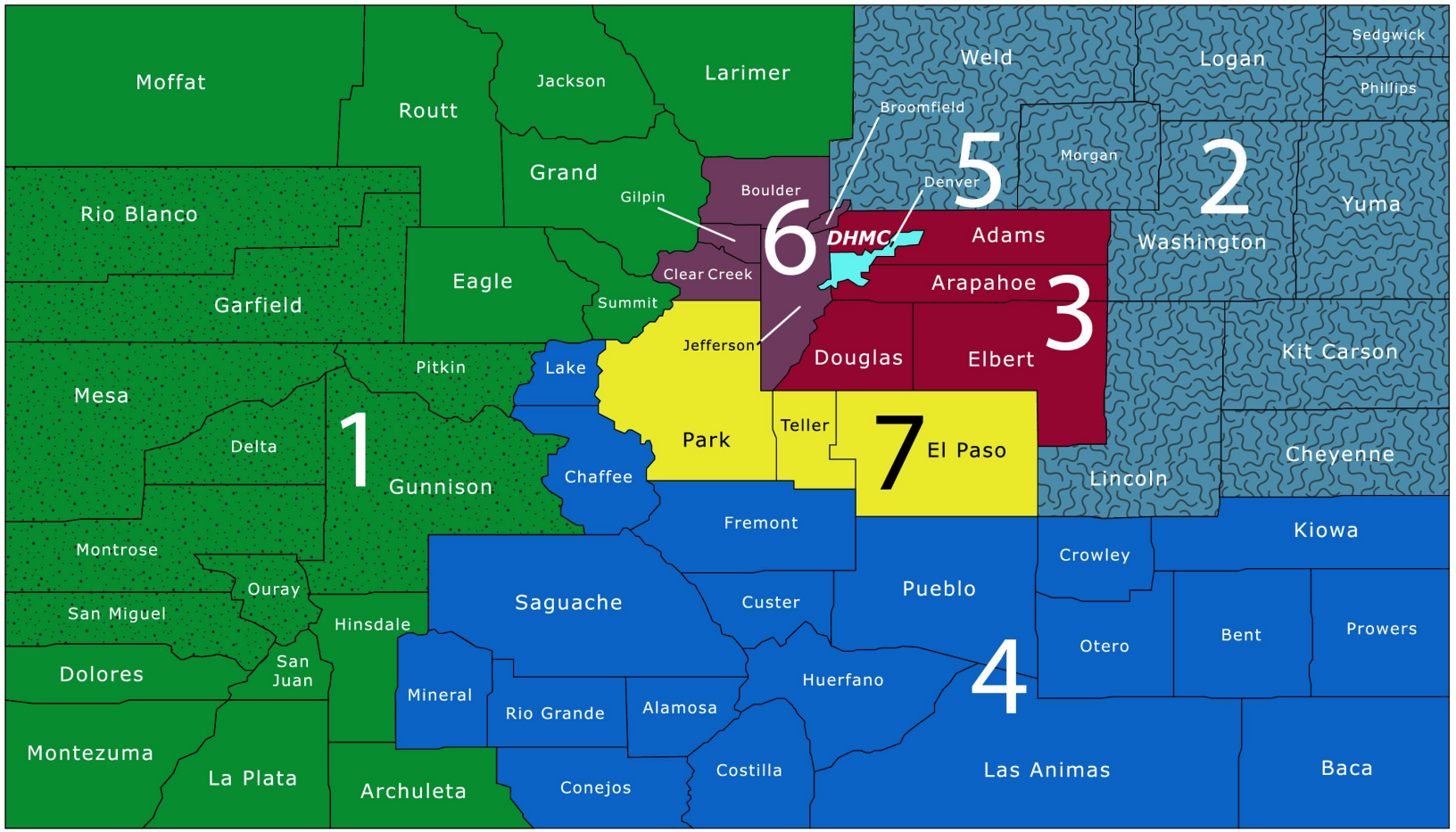
Accountable Care Collaborative



- Region 1 - Rocky Mountain Health Plans
- Rocky Mountain Health Prime
- Region 2 - Northeast Health Partners
- Region 3 - Colorado Access
- Region 4 - Health Colorado, Inc.
- Region 5 - Colorado Access
  Denver Health Medicaid Choice (DHMC)
- Region 6 - Colorado Community Health Alliance
- Region 7 - Colorado Community Health Alliance

Join Physical and Behavioral Health

Regional Accountable Entity	
Physical health care coordination & admin	**Behavioral health care services, care coordination & admin**
Per member per month	Risk-based capitation

Health Plan Program Design Options 101

(low risk for RAE) **Spectrum of Risk and Payment Models** (high risk for RAE)

	Fee-for-Service (FFS)	Managed Fee-for-service	Managed Care
HCPF	• HCPF pays medical/BH services • HCPF performs **ALL** administrative oversight which is limited to UM, compliance with federal and state statue and regulation	• HCPF pays medical/BH services • HCPF pays administrative $ to RAE/MCO • HCPF performs **SOME** administrative oversight (UM, policy design, program design)	• HCPF pays full-risk capitation to RAE • HCPF sets policy but not program design

RAEs	• N/A
	• No care coordination
	• No condition management programs
	• No population health management
		• RAE accountable for population health outcomes
		• RAE performs **SOME** administrative oversight
		  • Provider network mgmt
		  • Care coordination
		  • Condition management programs
			• RAE performs **MOST** administrative oversight including most program design
			• RAE pays medical/BH services
			• RAE has flexibility to pay for (BH) care not exclusively driven by the medical code billing model
			• RAE responsible for administrative functions (UM, …)

Mandatory Member Enrollment

All full-benefit Health First Colorado Members enrolled, except PACE

Enrollment effective on the same day eligibility is received

Member RAE assignment based on the member's PCMP practice site location

Role of the RAEs

- Promote members' physical and behavioral health
- Contract with a regional network of Primary Care Medical Providers (PCMPs) to serve as medical home
- Administer capitated behavioral health benefit
  - Credential and contract with behavioral health providers
  - Negotiate rates and pay claims
  - Conduct utilization management
- Support providers in coordinating care across disparate providers
- Provide administrative, financial, data and technology, and practice transformation assistance

Role of the RAEs

- Establish, support and strengthen local and regional relationships with the full range of Medicaid providers, as well as community-based organizations.
- Implement and utilize variety of interventions targeting Department identified conditions (e.g. maternity, diabetes, heart conditions, serious mental illness)
- Ensure members have access to appropriate care coordination, either at the point of care of as delivered by the RAE

Primary Care Medical Providers

- RAEs negotiate funding arrangements with PCMPs to:
  - Expand primary care capacity
  - Advance the medical home model in the region
  - Expand delivery of evidence-based models of care
  - Promote innovation at the provider level to
  - Achieve the goals and performance metrics of the ACC

Capitated Behavioral Health Benefit

State Plan/Medical Services

Behavioral Health Assessment

School-Based Mental Health Services

Psychotherapy

Physician Services

Pharmacological Management

Outpatient Day Treatment

Outpatient Hospital

Psychosocial Rehabilitation

Crisis Services

Emergency Services

Inpatient Psychiatric Hospital

State Plan/Medical Services—SUD Specific

Substance Use Disorder Assessment

Alcohol/Drug Screen Counseling

Medication Assisted Treatment

Social Ambulatory Detoxification

Inpatient Withdrawal Management (1115 Waiver)

Residential Withdrawal Management and Treatment (1115 Waiver)

Community-based/Alternative Services

Prevention/Early Intervention

Clubhouses/Drop-in Centers

Vocational Services

Intensive Case Management

Assertive Community Treatment

Residential (Mental Health)

Respite Care

Providers Networks

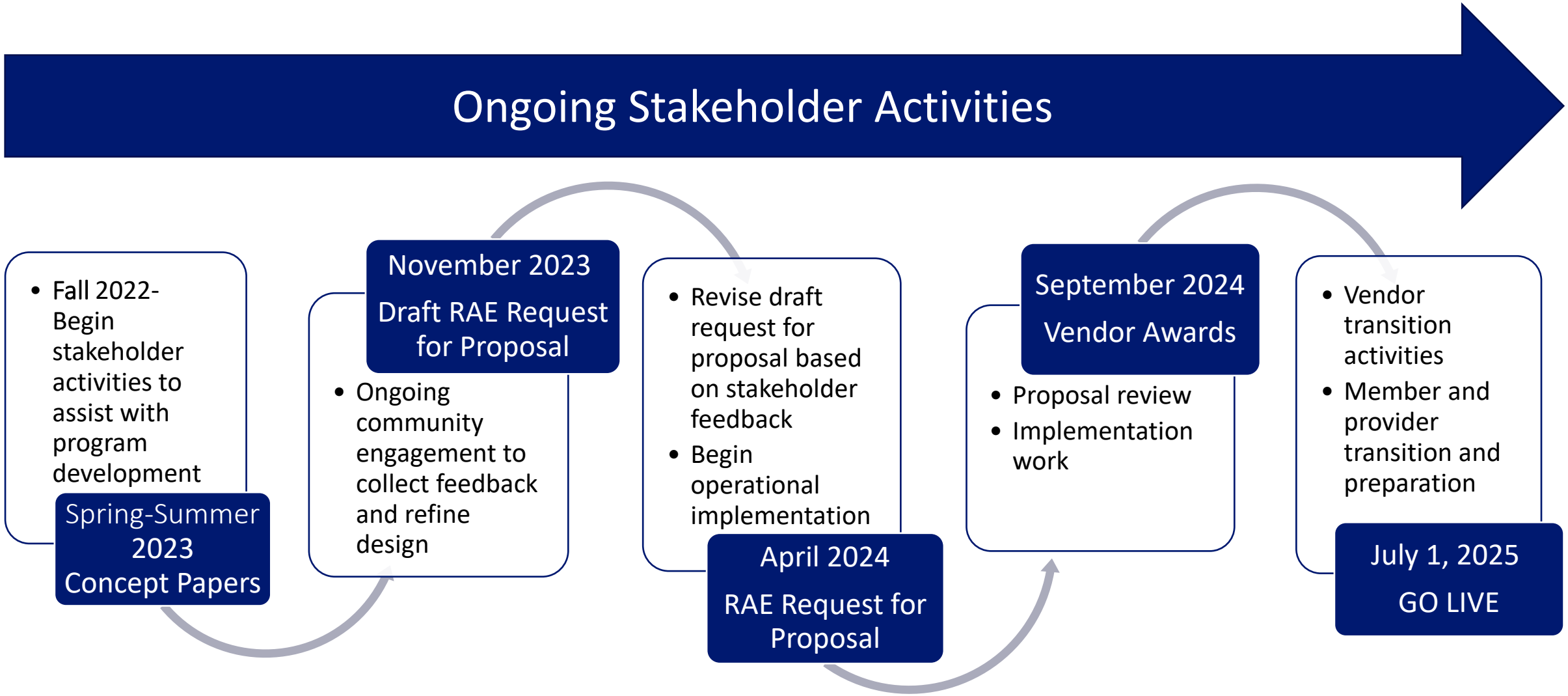
- Creating a unified network of public BH providers with BHA
- Benefits of being a Medicaid provider
  - No Co-pays or Deductible means Medicaid pays from first visit
  - Providers don't have to send clients to collections
  - Pays 90% within 14 days, 99.5% in 30 days
  - More comprehensive benefit, we cover services many commercial payers don't cover
- BH Rates & Reimbursement
  - Federal partnership requires actuarily sound rates
  - HCPF makes rate estimates, but RAEs hold the contract and pay the providers
  - Safety Net Provider, expanding definition allows for access to better rates

Pay for Performance, Accountability

- **Key Performance Indicators**
  - Incentive for the RAEs, focus on whole person care, try to keep these consistent year to year, i.e. well child checks, engagement in SUD services
- **The Behavioral Health Incentive Program** (BHIP)
  - Moving to national measures instead of “home grown”
  - Compare RAEs to national benchmarks and past performance
- **Contract Management**
  - Required reporting focuses on data, finance, and local programs
  - System migrations, contract language to protect members and providers from disruption in payment
- **Medical Loss Ratio (MLR):** 85% spent on services,15% on operations, administration and profit

Moving towards Phase III

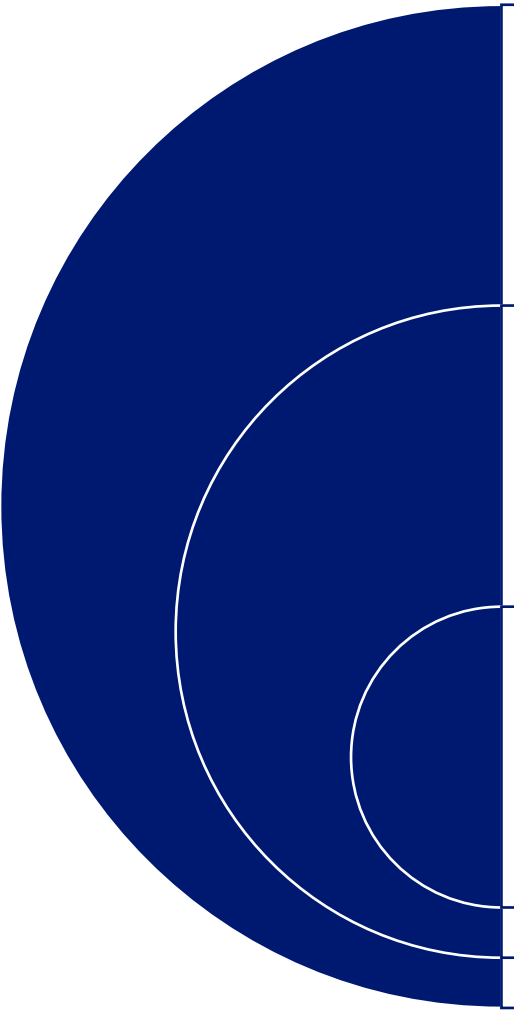
Timeline


Ongoing Stakeholder Activities
• Fall 2022- Begin stakeholder activities to assist with program development
Spring-Summer 2023 Concept Papers
November 2023
Draft RAE Request for Proposal
• Ongoing community engagement to collect feedback and refine design
• Revise draft request for proposal based on stakeholder feedback
• Begin operational implementation
April 2024
RAE Request for Proposal
September 2024
Vendor Awards
• Proposal review
• Implementation work
• Vendor transition activities
• Member and provider transition and preparation
July 1, 2025
GO LIVE

Building On What Works

- Compliance with federal guidance supporting paying for value
- Coordinated behavioral, physical and community-based services through a regional delivery system
- Continued evolution towards a comprehensive, integrated, and accountable behavioral health benefit
- Innovating and evolving the managed fee-for-service and behavioral health infrastructures while holding all critical partners accountable
- Collaboration with state agencies to provide high quality, whole-person care that improves health equity and overall health of Medicaid members

ACC Phase III Goals



IMPROVE	• Quality care for members • Care access • Member and provider service experience
PROMOTE	• Health equity and close health disparities
MANAGE	• Manage costs to protect member coverage and benefits, and provider reimbursements

- Member Communication and Support
- Accountability for Equity and Quality
- Improving Referrals to Community Partners
- Alternative Payment Methodologies
- Care Coordination
- Children and Youth
- Behavioral Health Transformation
- Technology and Data Sharing

Statewide Partnerships

- **With the community**
  - We have ongoing member committees, multi-stakeholder committees, partnerships with counties, hospital forums, etc.
  - Feedback on system issues have been essential in developing our goals for ACC 3.0, but also for ongoing accountability and improvement
  - Thank you for your engagement and bringing us the stories!

- **With other state agencies**
  - BHA at the helm, leading the strategic vision, improving standards and accountability, and building collaborative and networked government
  - Focus on priority population through DOLA, DOC, and CDHS
  - Equity, prevention and public health with CDPHE
  - Affordability with DOI, Office of Saving Money

ACC Role in Transforming Behavioral Health

Increasing access to integrated care

Expanding access and wraparound support for children & families

Improving care transitions and the continuum of care

Continuing to focus on value-based payment structures, flexible payments and payment reform

Promoting recovery supports, whole person health, and addressing health related social needs

Aligning with the Behavioral Health Administration in data sharing and quality strategy

Questions

ACC Phase III Website and Newsletter:

Colorado.gov/HCPF/accphase3

Thank You for Your Engagement!