Colorado's Accountable Care Collaborative Phase II

An Overview

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ACC Program History

Created in response to:

- Unsuccessful experience with capitated Managed Care
- 85% in an unmanaged Fee-For-Service (FFS) system
- Unprecedented economic situation, highest Medicaid caseload and expenditures in state history
- Desire not to continue to pay for higher volume/utilization

Colorado's delivery system reform

- Governor's agenda, stakeholder input, and budget action
- Developed prior to federal ACO concept

ACC Successes

- FY 2012-2013: $6 million net reduction in total cost of care
- FY 2013-14: $30 million net reduction in cost (after all program expenses)
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%) relative to clients not enrolled in the ACC Program
- Over 75% of enrollees are linked to a PCMP after six months of enrollment

Community Behavioral Health Services Program History

- The Community Behavioral Health Services (CBHS) Program is a carved-out managed care model for mental health and substance use disorder treatment in Colorado
- Authorized by the General Assembly in the mid-1990s when most services were offered either fee-for-service or through comprehensive managed care plans
- Today, the CBHS Program is operated by 5 Behavioral Health Organizations (BHOs)
- System operates under 1915(b) waiver authority from the Centers for Medicare & Medicaid Services.

BHO Successes

- BHOs have been successful in using **evidence-based programs**
- Many CMHCs are **partnering**, **co-locating**, and exploring other **moves towards integration**
- BHOs have **strong relationships** with many community partners and have established **comprehensive networks** to address the needs of many clients
- The Community Behavioral Health Services Program has **protected funding** for behavioral health services
- The BHOs have successfully managed **program costs**.
- Developed a continuum of **alternative community based services**

Why Make a Change?

- Fragmented Medicaid System
- Required to re-procure Regional Care Collaborative Organizations
- Desire for greater physical and behavioral health integration
- Opportunity to continue to reduce costs and improve quality
- New federal opportunities

Designing ACC Phase II

GOAL:

To optimize health for those served by Medicaid through accountability for value and client experience at every level of the system and at every life stage

This is the impact we want to see in Colorado.

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Phase II: Guiding Principles

1. Person- and family-centeredness
2. Accountability at every level
3. Outcomes-focused and value-based

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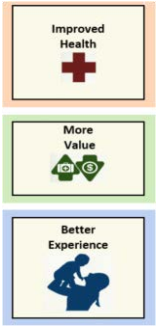
Phase II: Outcomes



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Phase II: Outcomes

Improved Health	Health Management
	Population Health
	Social Well-being

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Phase II: Outcomes

More Value	Evidence-based Cost Efficiency
	Goals by Population and Service

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Phase II: Outcomes

Better Experience	Client Engagement
	Efficient Systems

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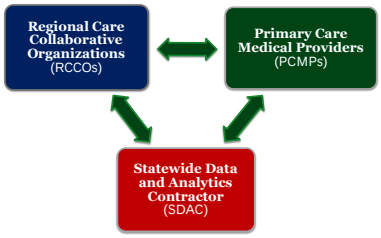
Current ACC: Program Structure



Phase II: Levels of Accountability

- Client
- Health Neighborhood
- Regional Accountable Entity (RAE)
- The Department (HCPF)

Phase II: Clients

FY14-15 YTD Average	Prenatal	Adults 65 and Over	Individuals Under 65 with Disabilities	Adults	Children & Foster Care
Number of Clients	16,646	69,862	80,641	475,463	515,872
Percentage	1.43%	6.02%	6.94%	40.95%	44.43%

Phase II: Clients

- Onboarding
- Client engagement
- Client incentives

Current: Primary Care Medical Provider (PCMP) Role

- Approximately 550 PCMPs
- PCMPs serve as Medical Homes
- Member/family centered
- Whole-person oriented
- Promotes client self-management
- Care provided in a culturally and linguistically sensitive manner

Phase II: Health Neighborhood

Health Team

- Behavioral Health Providers
- Primary Care Medical Providers
- LTSS Case Management Agencies
- Certain specialists

Phase II: Health Neighborhood

Health Team

- Team-based client care
- Provide care coordination
- Utilize non-traditional health workers
- Promote integrated care within practices

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Phase II: Health Neighborhood

Broader Health Neighborhood

- Specialists
- Hospitals
- Other medical providers
- Non-medical providers

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Phase II: Health Neighborhood

Broader Health Neighborhood

- Provider compact
- Electronic consultation and other telehealth
- Hospital engagement and other incentives

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Current: RCCO Role

- Achieve financial and health outcomes
- Ensure a Medical Home level of care for every Member
- Network Development/Management
- Provider Support
- Medical Management and Care Coordination
- Accountability/Reporting

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Current: BHO Role

- Provide comprehensive behavioral health benefit
- Manage provider networks
- Operate authorization processes
- Pay providers
- Perform audits and quality functions
- Care coordination
- Accountability and reporting to the State

COLORADO Department of Health Care Policy & Financing **Original CBHS Program**

Phase II: Regional Accountable Entity

- Unified administration of physical health and behavioral health
- Onboard clients
- Contract, support, and oversee network
- Develop a broad health neighborhood
- Convene Community
- Manage systems of care for special populations
- Make value-based payment to Health Team

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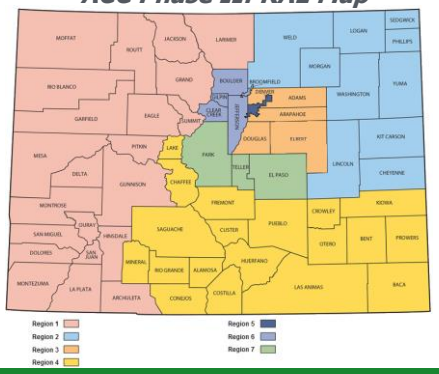
ACC Phase II: RAE Map



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Phase II: The Department (HCPF)

- Administer benefit package
- Enrollment into the RAEs
- Cross-program and cross-agency alignment

Phase II: Program Infrastructure

There will need to be infrastructure investments at every level of accountability. These fall into three domains:

1. Payment
2. Health Information Technology
3. Sound Administration

Current: ACC PMPM Payments

- RCCO PMPM: Payment is reduced for clients unattributed longer than 6 months
- PCMP PMPM: Enhanced Primary Care Standards
- FFS reimbursement for Medical Services

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Current: BHO Payment

Capitated managed-care payment. BHO is responsible for the claim when:

- The client is enrolled in the BHO
- The client has a BHO-covered diagnosis
- The service in question is covered by the BHO contract
- The service is medically necessary for the covered condition

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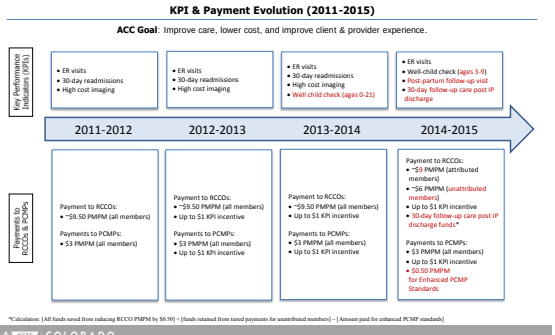
Phase II: Payment

- PMPM to RAE: RAE makes value-based payments to Health Team providers
- Leverage new functionality for hospital payments
- Exploring aligned alternative payment methodologies for FQHCs and CMHCs
- Value based payment formula
- Payments to support integration
- Outpatient professional capitation

Current: Pay for Performance



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Original ACC

Phase II: Pay-for-Performance

- Key Performance Indicators
- Competitive Pool
- Shared Savings

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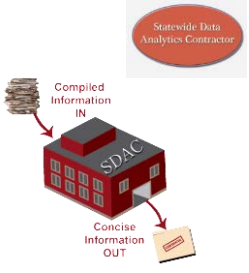
Current: Statewide Data Analytics Contractor Role

- Data Repository
- Data Analytics & Reporting
- Web Portal & Access
- Accountability & Continuous Improvement



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Original ACC

Phase II: Health Information Technology

- Data, analytics, HIT
  - Enhanced Provider Portal
  - Additional analytics
  - New data sources
- Focus on Health Information Exchange
- Care coordination tool

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Phase II: Sound Administration

- Program oversight
- Program maximization

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Phase II: Request for Proposals (RFP) Timeline

- Spring-Summer 2014: Stakeholder meetings across Colorado
- Fall 2014: Request for Information (RFI) published
- Winter-Spring 2016: Drafting RFP and developing federal waiver authority
- Winter-Spring 2016: Draft RFP released
- Summer 2016: RFP published
- 2017: New ACC (RAE) contracts begin

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Opportunities to Get Involved

- October 21, 2015: ACC Phase II: Overview and Client Engagement
- November 10, 2015: Open Forum
- November 18, 2015: Program Improvement Advisory Committee Retreat
- December 16, 2015: Health Team Support & Payment
- January 12, 2016: Open Forum
- January 20, 2016: Advisory Structure and Stakeholder Engagement
- February 17, 2016: Care Coordination Strategy

Thank You

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Accountable Care Collaborative Phase II Overview of Key Concepts

October 1, 2015

The Accountable Care Collaborative (ACC) is the delivery system for Colorado Medicaid. The ACC Program is operated by Colorado's Single State Agency, the Colorado Department of Health Care Policy and Financing (the State Agency). The first ACC clients were enrolled in May 2011 and as of August 2015, more than 940,000 of the 1.26 million total Medicaid enrollees were in the ACC. Contracts for the Regional Care Collaborative Organizations (RCCOs), the foundation of the ACC, expire in July 2017, creating a key opportunity for the State Agency to evolve the program.

The goal of the next iteration of the ACC is to optimize health for those served by Medicaid through accountability for value and client experience at every level and at every life stage.

This document outlines a number of key concepts for the program in Phase II. This document, as well as a longer concept paper to be released in mid-October, serve as a request for our federal, state, and local partners to collaborate with us to build a more integrated health system, with the shared goal of improving the health of Coloradans served by Medicaid.

Outcomes

The Accountable Care Collaborative is an outcomes-driven program. Outcomes for the next phase of the program, like those in the current phase, are built on the Triple Aim – improved experience, improved care and lower costs. Outcomes the State Agency aims to achieve in the next phase of the ACC are aligned with the Governor's State of Health, the Colorado State Innovation Model (SIM), and the Institute of Medicine Core Measure Set. Three key domains will be used to measure outcomes: **Improved Health, More Value, and Better Experience.**

Phase II Structure

Regional Accountable Entity

To reach a complete state of health, individuals and families served by Medicaid need access to services and support for their physical health, behavioral health, and social needs. To ensure innovation, flexibility, and local control, the ACC will continue to be delivered through seven regions in the state. The regional map will be similar to the current ACC map, with one exception – Elbert County will be part of Region Three (rather than Region Seven). In Phase II, one entity, the Regional Accountable Entity, will be responsible for duties currently performed by the Regional Care Collaborative Organization and Behavioral Health Organization. This will improve client, family, and provider experience by integrating administrative functions and responsibility for all services.

Health Teams

To ensure access to care coordination services and health providers in Phase II, clients will be automatically and mandatorily enrolled in the ACC and immediately connected with a Primary Care

Medical Provider. Like today, Primary Care Medical Providers must be medical practitioners with a focus on primary care. However, behavioral health providers, including Community Mental Health Centers, who meet the criteria are encouraged to become Primary Care Medical Providers. The Regional Accountable Entity will be responsible for supporting ongoing efforts to advance integrated health services that align and build upon integration efforts of SIM.

Many clients identify a variety of providers as core members of their Health Team including long-term services and supports case management agencies, behavioral health providers and particular specialists. To acknowledge the role of these additional providers in a client's care, the Primary Care Medical Provider will be part of a larger Health Team that will be responsible for providing care coordination services. Each Regional Accountable Entity will assist Primary Care Medical Providers, as needed, to develop relationships across a client's Health Team and will establish contracts with Primary Care Medical Providers, specialty behavioral health providers, and long term services and supports case management agencies.

Client Engagement

Client engagement is a priority for Phase II. Each Regional Accountable Entity and provider will be expected to test various methods of client and family engagement and activation. Upon enrollment in the program, a screening will be conducted to identify the client's and family's behavioral health, physical health, social needs, and life stage. This screening will help clients and families identify goals and will help the Regional Accountable Entity and Primary Care Medical Provider identify appropriate Health Team members. Additionally, this screening will help to identify services for clients and families, including health maintenance services for healthy individuals, and allows the Regional Accountable Entity and Health Team to prioritize clients and families for care coordination.

In addition to the initial screening and engagement work, Regional Accountable Entities will be encouraged to use new technology to connect with clients and will be required to have 24-hour availability for both clients and providers. In addition, Phase II will include a statewide client incentive program that promotes healthy behaviors and appropriate use of the health care system.

Certain clients, such as clients engaged in the correctional system and children at risk of out of home placement, require additional support and coordination between state agencies. The State Agency and the Regional Accountable Entity will work to provide coordinated systems of care for these populations.

Practice Support

Primary Care Medical Providers who directly engage with clients to maximize their health will continue to be the foundation of the Accountable Care Collaborative. To support and strengthen these practices, Regional Accountable Entities will have greater latitude to contract only with practices that meet established minimum requirements. Minimum requirements will be defined for both small practices and large practices in a way that encourages the participation of small practices. The State Agency will work with Health Team providers to ensure that program requirements do not place an undue burden on practices and are aligned with existing policies.

To address problems related to Primary Care Medical Providers located in communities on the borders of Regional Accountable Entity regions, clients will be enrolled in a Regional Accountable Entity based on their attribution to a PCMP, rather than by county of residence. This enrollment and attribution methodology will ensure that most Primary Care Medical Providers have a contractual relationship with just one or two Regional Accountable Entities.

Health Neighborhood: Engaging Specialists and Hospitals

Some individuals served by Medicaid have episodically urgent or ongoing complex health needs that require a well-coordinated network of providers. In Phase II, specialists and hospitals that are involved in providing higher acuity services will be a more formal part of the program and join Primary Care Medical Providers and Health Teams as members of a Health Neighborhood. The Regional Accountable Entity will be responsible for ensuring access to specialty and hospital care and developing infrastructure that supports coordination between the Health Team and Health Neighborhood. In addition, the Regional Accountable Entity will be responsible for promoting and supporting the State Agency's electronic consultation and other telehealth initiatives.

Community

Since an individual's health is impacted by many things other than clinical services, the Regional Accountable Entity will be responsible for convening non-medical community partners and engaging communities to address systems issues impacting the health of Medicaid clients and to improve population health. The Regional Accountable Entity will assist in creating interconnectivity between the Community and Health Neighborhood.

Payment

In Phase II, payment methodologies will create accountability for whole person health outcomes and costs through value based payment models. The Regional Accountable Entities will be paid an administrative payment in a per member per month payment structure and have the opportunity to earn value-based or outcomes-based payments such as Key Performance Indictors or Shared Savings. However, to ensure more value is achieved in Phase II of the ACC, a much higher percentage of payments will be tied to value.

To support access to wellness services and services that are needed when a client is ill or injured, the State Agency is exploring provider payment methodologies that support the provision of high-quality, integrated, and efficient care. In Phase II, the Regional Accountable Entity will be responsible for making value-based administrative payments to Health Team providers with more than 1,000 attributed ACC clients.

Recognizing the importance of flexibility, innovation, and local variation, the ACC will continue to support payment methodologies for different regions and providers that promote value based purchasing. For example, the State Agency intends to build on current work to move towards an aligned, alternative payment methodology for federally qualified health centers and community mental health centers. In addition, the State Agency is continuing to explore various partial risk models that support integrated care delivery and build on payment methodologies currently being piloted in the first phase of the ACC program and through SIM.

Sound Administration

The model of Phase II of the Accountable Care Collaborative is driven by accountability for value and client experience at every level and every life stage. The State Agency will invest in enhanced program oversight and program maximization efforts. Program oversight will be increased by strengthening deliverables through clearer contract requirements and templates; team-based contract management to leverage expertise and capacity across the State Agency; staff training; and leveraging stakeholders as part of the oversight and monitoring process. The State Agency will invest in program maximization

efforts, including technical assistance, to identify best practices and ensure that the program is attaining the most value possible.

Health Information Technology

Health Information Technology (HIT) is foundational to every activity in Phase II. Regional Accountable Entities must maximize the use of State Agency systems and regional Health Information Exchange (HIE) network data to effectively coordinate care on a daily basis and to track changing Medicaid population demographics and utilization patterns. The Regional Accountable Entity will be required to offer practices support in the use of their own internal data and capturing care coordination information.

The State Agency will have the capability to formally link the additional Health Team members in the Medicaid Provider Portal, currently known as the Statewide Data and Analytics (SDAC) provider portal. The Medicaid Provider Portal will include, at a minimum, the names and contact information of the Health Team providers and client claims data. This will help to ensure clear lines of responsibility, facilitate more coordinated care, promote data sharing, and ensure that the Regional Accountable Entity is supporting the entire team. Phase II will include a strategy to ensure all Health Teams have access to a care coordination tool to support tracking, monitoring, and communication between Health Team members.

Conclusion

Building on the successes of the current ACC Program, Phase II will bring a new focus on the provision of high-quality, integrated, person- and-family-centered, and whole-person services. The next phase of the ACC Program begins in July 2017.