

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

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Original ACC

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



Original ACC

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.

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Original CBHS Program

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**



Original CBHS Program

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.



Phase II: Guiding Principles

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



Phase II: Outcomes



Phase II: Outcomes

Improved Health 	Health Management
	Population Health
	Social Well-being



Phase II: Outcomes

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

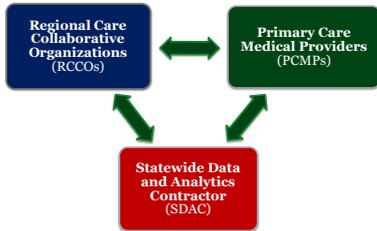


Phase II: Outcomes

Better Experience 	Client Engagement
	Efficient Systems



Current ACC: Program Structure



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Phase II: Levels of Accountability

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

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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%

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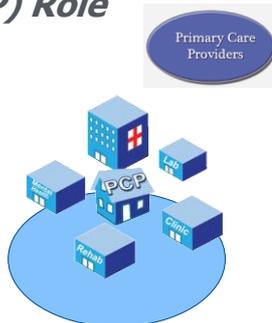
Phase II: Clients

- Onboarding
- Client engagement
- Client incentives

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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



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Phase II: Health Neighborhood

Health Team

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

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Phase II: Health Neighborhood

Health Team

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



Phase II: Health Neighborhood

Broader Health Neighborhood

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



Phase II: Health Neighborhood

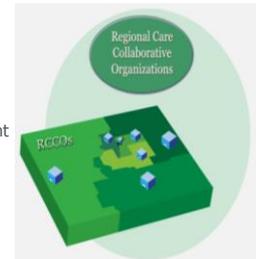
Broader Health Neighborhood

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



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



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

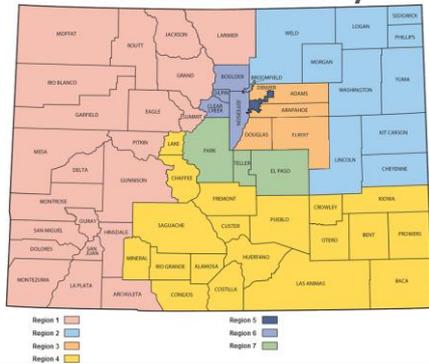


Phase II: Regional Accountable Entity

- 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



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

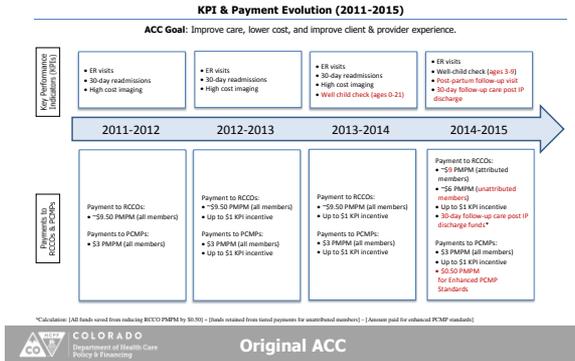


Phase II: Payment

- 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



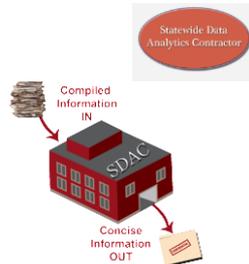
Phase II: Pay-for-Performance

- Key Performance Indicators
- Competitive Pool
- Shared Savings



Current: Statewide Data Analytics Contractor Role

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



Phase II: Health Information Technology

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



Phase II: Sound Administration

- Program oversight
- Program maximization



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



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

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Thank You

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