Accountable Care Collaborative Phase II Concept Paper

October 20, 2015

Please send questions and comments to
RCCORFP@state.co.us

COLORADO
Department of Health Care
Policy & Financing

Contents

1.0. Introduction 3
2.0. Colorado Medicaid 4
2.1. Accountable Care Collaborative 5
2.2. Community Behavioral Health Services Program 7
2.3. Long-Term Services and Supports 8
3.0. ACC Phase II Principles 9
3.1. Person- and Family-Centeredness 9
3.2. Outcomes-Focused and Value-Based 10
3.3. Accountability at Every Level 12
4.0. ACC Phase II Overview 13
5.0. Detailed ACC Phase II Program Description 16
5.1. Client 16
5.1.1. Onboarding 17
5.1.2. Client Engagement 18
5.1.3. Client Incentives 18
5.2. Health Neighborhood 19
5.2.1. Health Team 19
5.2.2. Health Neighborhood 22
5.3. Regional Accountable Entity (RAE) 24
5.3.1. Contract and Oversee the Health Team Network 24
5.3.2. Community Engagement 27
5.3.3. Manage Systems of Care for Special Populations 28
5.4. State Agency 30
5.4.1. Flexible Benefit Package 30
5.4.2. Client Enrollment in the Regional Accountable Entities 31
5.4.3. Cross-Program and Cross-Agency Alignment 32
6.0. Tools for Transformation: Program Infrastructure 33
6.1. Payment 33
6.1.1. Shifting from Fee-for-Service to Value-Based Payments 34
6.1.2. Per-member Per-month Payments 36
6.1.3. Outpatient Professional Capitation 37
6.2. Health Information Technology 38

6.2.1. State Agency Infrastructure 38
6.2.2. State and Regional Health Information Exchange (HIE) Network Infrastructure 39
6.2.3. RAE Infrastructure 39
6.3. Sound Administration 40
6.3.1. Program Oversight 40
6.3.2. Program Maximization 41
7.0 Conclusion 42

Accountable Care Collaborative Phase II

1.0. Introduction

The Accountable Care Collaborative (ACC) is the core 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. To date, the ACC has demonstrated cost and system efficiency results, including more than $29 million in net savings in state fiscal year 2013-14. The first five years of the program have created a platform for future reform efforts. The ACC is intended to be an iterative program, driving a steady sustainable shift in the delivery system from one that incents volume to one that incents value. Contracts for the Regional Care Collaborative Organizations (RCCOs), a core component 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 of the health system and at every life stage.

Successfully capitalizing on this re-procurement opportunity will require the partnership of all of our stakeholders. This Concept Paper serves as a request for our federal, state, and local partners to collaborate with us as we work towards building a more integrated health system, to improve the health of low-income and underserved Coloradans in an innovative and cost-efficient manner.

This Concept Paper is organized into the following sections:

- **2.0 Colorado Medicaid**
- **3.0 ACC Phase II Principles**
- **4.0 ACC Phase II Program Overview**
- **5.0 Detailed ACC Phase II Program Description**
- **6.0 Tools for Transformation: Program Infrastructure**

The paper will refer to the program model between 2011 and June 30, 2017 as Phase I and the model after July 1, 2017 as Phase II.

While there are clear changes when the current contracts expire and the new contracts are implemented, the program is in a constant state of evolution. The State Agency will continue to develop and improve the program leading up to and following the implementation of Phase II.

2.0. Colorado Medicaid

Colorado Medicaid serves 1.26 million people. In the last five years, eligibility for Medicaid has expanded to include more children, pregnant women, parents, and low-income adults. Today, Medicaid serves as part of the continuum of health insurance coverage which is made up of employer-sponsored insurance, individual and exchange purchased plans, and public coverage like Medicare and Medicaid.

Figure 1. Demographic breakdown for Colorado Medicaid.

Colorado Medicaid made great strides in the last two decades to move from caring for the people we serve in institutional settings to providing community-based services and supports. The number of psychiatric beds has decreased, as have inpatient and institutional stays for individuals with disabilities or behavioral health needs. Colorado now has one of the highest rates of home and community-based services in the nation. This deliberate change has reduced institutional costs and improved the experience for clients and their families.

Colorado Medicaid enrollees are primarily served through three major systems: the **ACC**, the **Community Behavioral Health Services Program**, and the **Long-Term Services and Supports** (LTSS) System. Each of these systems has individualized payment structures, provider requirements, and target outcomes that often result in conflicting or competing financial incentives and operational requirements. For clients, the current system may result in confusion related to different entry points, multiple care coordinators, numerous customer service phone numbers, and disparate benefit designs.

Although integration of behavioral and physical health information and services results in more efficient care, it is difficult to finance, coordinate, and administer integrated care in such a divided system. In addition to the three "silos" for Medicaid services, Medicaid clients receive services and supports from a number of other governmental and non-government programs, which may also have conflicting or competing requirements and offerings. When all of the systems serving Medicaid clients do not work together, care can be fragmented, confusing, and expensive.

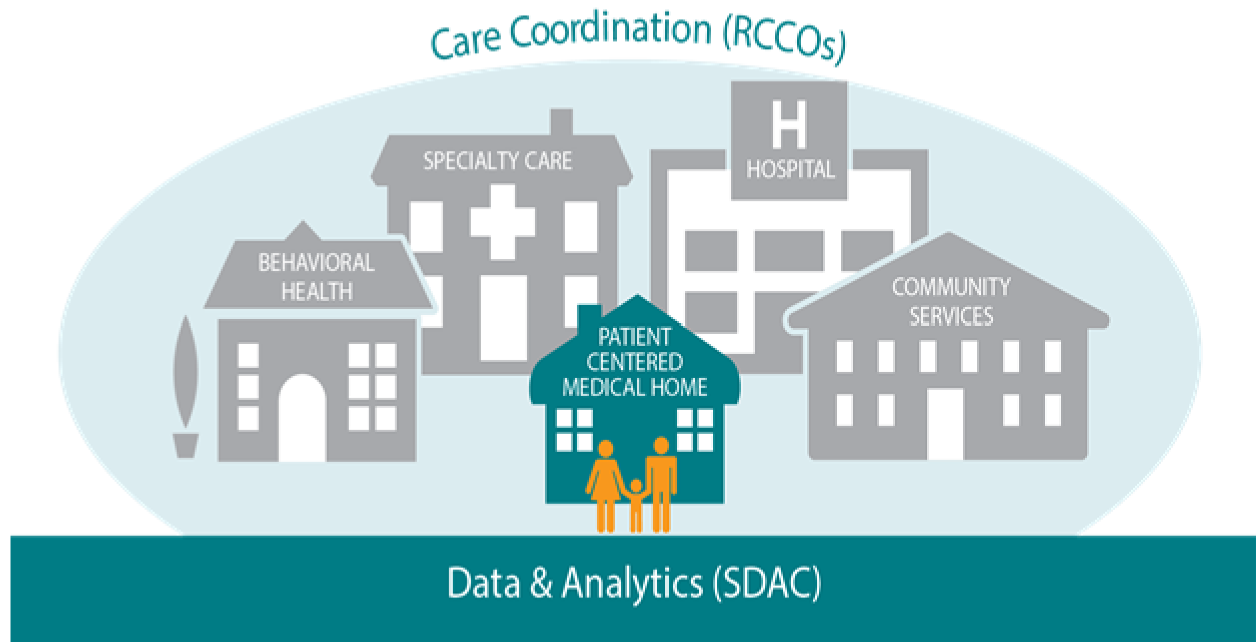


Figure 2. Key elements of Phase I of Colorado's ACC Program.

2.1. Accountable Care Collaborative

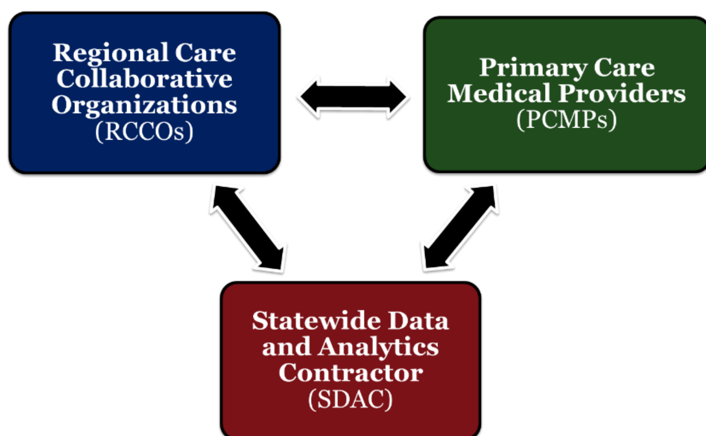


Figure 3. The three contractual components of ACC Phase I.

The ACC was designed to manage costs and improve health at a time when 85 percent of Colorado Medicaid enrollees were in unmanaged fee-for-service care. The ACC currently operates under federal authority for Enhanced Primary Care Case Management, with physical health services reimbursed fee-for-service. The program has three core components: the Regional Care Collaborative Organizations (RCCOs); the Primary Care Medical Providers (PCMPs); and the Statewide Data and Analytics Contractor (SDAC).

Colorado is divided into seven Regions; each region has one RCCO.

RCCOs are responsible for:

- Ensuring every member has a medical home level of care;
- Developing a formal contracted network of primary care medical homes and an informal network of specialists and ancillary providers;
- Supporting PCMPs to ensure they are providing high quality care;
- Ensuring every member receives the necessary medical management and care coordination; and,
- Being accountable to the State Agency for cost and outcomes.

In Phase I, there are five vendors serving the seven regions, as three regions were awarded to one vendor. All of the current vendors are based in Colorado. Two are health plans and three are partnerships that include hospital systems, federally qualified health centers, community mental health centers, and other providers. As the RCCOs have significant latitude in terms of how they achieve outcomes, the organizational background and competencies of the current vendors have manifested in significant diversity in local program design. The State Agency hopes to capture the best practices of all current vendors and advance them in Phase II of the program. The State Agency recognizes the immense value of organizations with the ability to develop deep relationships in Colorado communities and will prioritize that competency in the bidding process for ACC Phase II.

A significant portion of the RCCO responsibility is managing the PCMP network. PCMPs are responsible for:

- Serving as medical homes for ACC clients;
- Providing whole person, coordinated, culturally competent care for ACC clients; and
- Providing care coordination when the RCCOs have delegated those activities to them.

During Phase I of the ACC, the State Agency was committed to having broad networks and, therefore, established only minimal standards for PCMP participation. The RCCOs are responsible for supporting PCMPs as they continue to improve their ability to serve as patient-centered medical homes.

The Statewide Data and Analytics Contractor (SDAC) provides operational support and data (via a web-based Provider Portal) to the State Agency, RCCO staff, and PCMPs to support program functions. In addition to generating utilization and cost reporting on paid Medicaid claims (plus paid Medicare claims for full Medicare-Medicaid beneficiaries), the SDAC assigns clinical risk groupings and other markers to assist in provider analytics. Data are used to select clients for enrollment, identify clients with high care coordination needs, develop population health strategies, track regional program and provider performance, and calculate incentive payments. The SDAC maintains technical support resources and a provider help desk to answer questions related to the Provider Portal.

The functions of the SDAC will be performed by a new contractor in Phase II as part of the State Agency's newly-implemented Colorado interChange infrastructure. The new system will enable more comprehensive and flexible reporting through the Provider Portal and new opportunities for data sharing across settings, programs, and agencies. Operational support resources for Phase II will also be increased.

Developed to eventually become the overarching delivery system for Medicaid clients, ACC Phase I focused primarily on physical health because behavioral health services are already met through the Community Behavioral Health Services Program, a comprehensive behavioral health carve-out.

2.2. Community Behavioral Health Services Program

Colorado Medicaid's Community Behavioral Health Services Program is currently administered through carved-out, capitated managed care entities known as Behavioral Health Organizations (BHOs), a model that was authorized by the Colorado General Assembly in the mid-1990s. BHOs provide a comprehensive array of services for individuals who have a mental health or substance use disorder diagnosis covered by the BHO contracts. BHOs are responsible for developing and managing provider networks, service authorizations, claims payment, client appeals, audits, provider support, performance improvement, and quality assessments to ensure that behavioral health service delivery is trauma-informed and consistent with recovery and resiliency models of care.

Benefits offered (and services rendered) must be directly related to a contractually covered diagnosis and must be medically necessary. The covered diagnosis and covered service model limits the behavioral conditions that can be treated under the contract by requiring that each client have a covered diagnosis. This results in the following gaps in services:

- Prevention and early intervention
- Behavioral intervention for behaviors resulting from conditions such as intellectual and developmental disabilities (IDD), traumatic brain injuries (TBI), dementia, etc.
- Counseling services for temporary conditions that, if prolonged, can worsen/have lasting effects
- Wellness/behavioral counseling and services that address individual behaviors to support improvement in chronic health conditions, such as diabetes or heart failure, or support children who have maladaptive behaviors but do not yet have a diagnosis.

BHO services are provided under a federal 1915(b) waiver. Under this waiver, BHOs provide State Plan services (available to all Medicaid members) as well as certain community-based services, known as 1915(b)(3) or "alternative" services. These services include respite, clubhouse/drop-in services, assertive community treatment, and other non-medical services, all of which are provided in the least restrictive and most cost-effective manner in order to best use available funding. Proactively providing a broad array of supportive services in the community also reduces the need for other high cost services.

The vast majority of Medicaid clients are enrolled in both the ACC and a BHO; some clients also receive Long-Term Services and Supports.

2.3. Long-Term Services and Supports

Colorado's system of Long-Term Services and Supports (LTSS) seeks to provide comprehensive services to people with many types of long-term care needs, including those with developmental and/or intellectual disabilities. The LTSS system works to support clients in the least-restrictive settings possible. LTSS are generally delivered in home and community based settings, skilled nursing facilities or hospitals. The HCBS system is operated through 11 individual waivers under 1915(c) authority from the Centers for Medicare and Medicaid Services (CMS). Services and supports associated with HCBS waivers include, but are not limited to, personal assistance services, access to alternative care facilities, home modification, home health care, adult day programs, non-medical transportation, and medication monitoring. To be considered for waiver services, a client must meet financial, level of care, and program targeting criteria. HCBS waiver services are provided to individuals who, but for the provision of waiver services, would require the level of care provided in a nursing facility, hospital, or an intermediate care facility for individuals with intellectual disabilities (ICF/ID). Each waiver can serve a limited number of people each year.

In Colorado, most people access the LTSS system through two types of entities: Single Entry Points (SEPs) and Community Centered Boards (CCBs). SEPs and CCBs, in addition to three private agencies, act as the case management agencies for LTSS clients receiving home and community-based services (HCBS). Case management duties include:

- Assessment
- Service plan development
- Referral
- Monitoring
- Remediation of problems

SEPs predominately serve as the entry point for older individuals, adults with mental health needs, individuals with traumatic brain or spinal cord injuries, and children with life limiting illnesses. When clients over age 55 are eligible and could benefit, a SEP or CCB can refer the client to the Program of All-Inclusive Care for the Elderly (PACE). The PACE program is a capitated system using integrated Medicare and Medicaid funds. The goal of the program is to pair health care and support services to help frail individuals to continue living in their communities.

CCBs predominately serve as the entry point for individuals with intellectual and/or developmental disabilities and children with autism. Private Case Management Entities, SEPs, and CCBs can provide case management services for children with special health care needs through different waivers. There are 24 SEPs and 20 CCBs throughout the state.

In September 2014, the State Agency took the first steps to align the ACC and the LTSS system by enrolling approximately 30,000 full benefit Medicare-Medicaid enrollees into the ACC program. The experience has served to highlight the need to formally expand the ACC network to coordinate with agencies such as SEPs and CCBs. It has also brought the ACC closer to the State Agency's goal of person- and family-centered care, placing clients at the center of their care planning and delivery.

3.0. ACC Phase II Principles

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 of the health system and at every life stage. In order to achieve this goal, the ACC Phase II is based on three key principles:

- Person- and family-centeredness
- Outcomes-focused and value-based
- Accountability at every level

ACC Phase II will focus on integrating and aligning efforts and systems. That means integration within the health care system, integration between medical and non-medical programs, and alignment between efforts to achieve that integration.

Accessing needed health services can be challenging in the current fragmented health system. This is especially true for individuals and families with limited resources or who have complex health needs. While the long-term vision is seamless integration with all entities (governmental and non-governmental) that serve the Medicaid population, ACC Phase II will be focused on integration within the Medicaid system, primarily between physical and behavioral health, as well as coordination with the Long-Term Services and Supports System.

There are many federal, state, and local efforts to improve health. In order to maximize the impact of the ACC and the other health system efforts, the State Agency will seek to align with outside projects, programs, and initiatives to the greatest extent possible. Specifically, the ACC will be aligned with the Governor's *State of Health*, the Colorado State Innovation Model (SIM), the Colorado Department of Human Services' initiatives, the Colorado Opportunity Project, the Colorado Department of Public Health and Environment's strategic goals, implementation of Colorado's Olmstead Plan, and the Comprehensive Primary Care Initiative. The State Agency will align measures, provider requirements, and special project focus areas with these other efforts to the greatest extent possible. ACC Phase II represents an opportunity to ensure continuation and sustainability for some of these time-limited initiatives. The State Agency will also actively promote information sharing between state, local, and non-governmental organizations to increase opportunities for potential alignment on future health initiatives.

3.1. Person- and Family-Centeredness

A person-centered system respects and responds to individual needs, goals, and values. Aligning with person- and family-centered values means considering cultural traditions, personal preferences and values, family situations, social circumstances, goals, and lifestyles. A person- and family-centered definition of health is all-encompassing. As defined by the World Health Organization, health is a "*complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.*"

Ultimately, person- and family-centered care leads to a better consumer experience and higher level of engagement by having clients as drivers of health care decision making, empowering clients with knowledge of the health care system, and providing an opportunity for clients to form relationships with their Health Team. A client is the expert in his or her own life. ACC Phase II will maximize client choice and control to drive the development of an individualized services and support plan, especially in the LTSS system. Person- and family-centered care leads to more appropriate care decisions, and better medical and client satisfaction outcomes.

Clients and families in the LTSS system have historically been engaged in their service delivery and often must become highly engaged advocates around their own medical service delivery or policy. New Home and Community Based Services (HCBS) rules require that the State Agency go through a person-centered planning process in which the client leads the development of their own service plan. A commitment to person- and family-centeredness means increasing the ease for both this highly engaged population and other populations who are less engaged advocates to drive their own care.

In Phase II of the ACC, all policy and programmatic decisions will be person- and family-centered. This will manifest in two major ways: 1) health will be defined broadly to consider the whole person; and 2) ACC interventions will respect and value individual strengths, goals, preferences, and contributions.

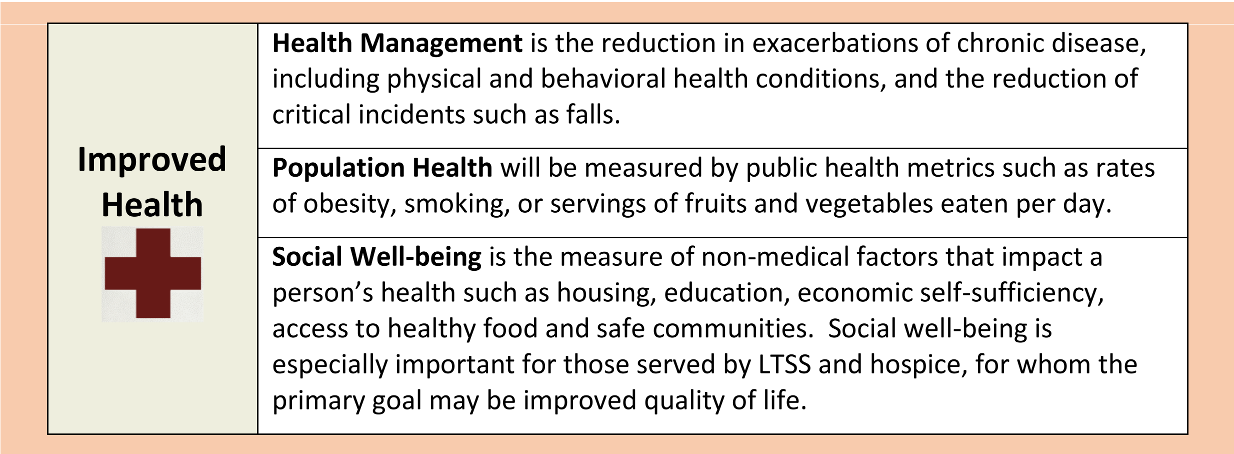
Whole person-care will have a different meaning for different populations. For clients receiving long-term services and supports, whole-person care will have a significant emphasis on supporting achievement of personal goals and improving the quality of life. Whole-person care also seeks to consider all domains of outcomes: functional; quality of life and satisfaction; utilization; and clinical outcomes. Typically, health systems focus on improvements in clinical and utilization outcomes. It is most important to consider all four domains especially for clients whose care is focused on maintaining or improving the quality of life rather than eradicating a disease. For other populations, whole-person care will require connecting clients with non-traditional or non-medical resources.

The State Agency will ensure that clients receive community- and individual-specific interventions by allowing for local autonomy and control of the program. Colorado is a geographically and culturally diverse state and allowing for local variability ensures that the ACC is able to meet the specific, local needs of clients. This requires interventions tailored to the resources, characteristics, and needs of the specific communities in which individuals live in order to reach region-specific and general outcomes.

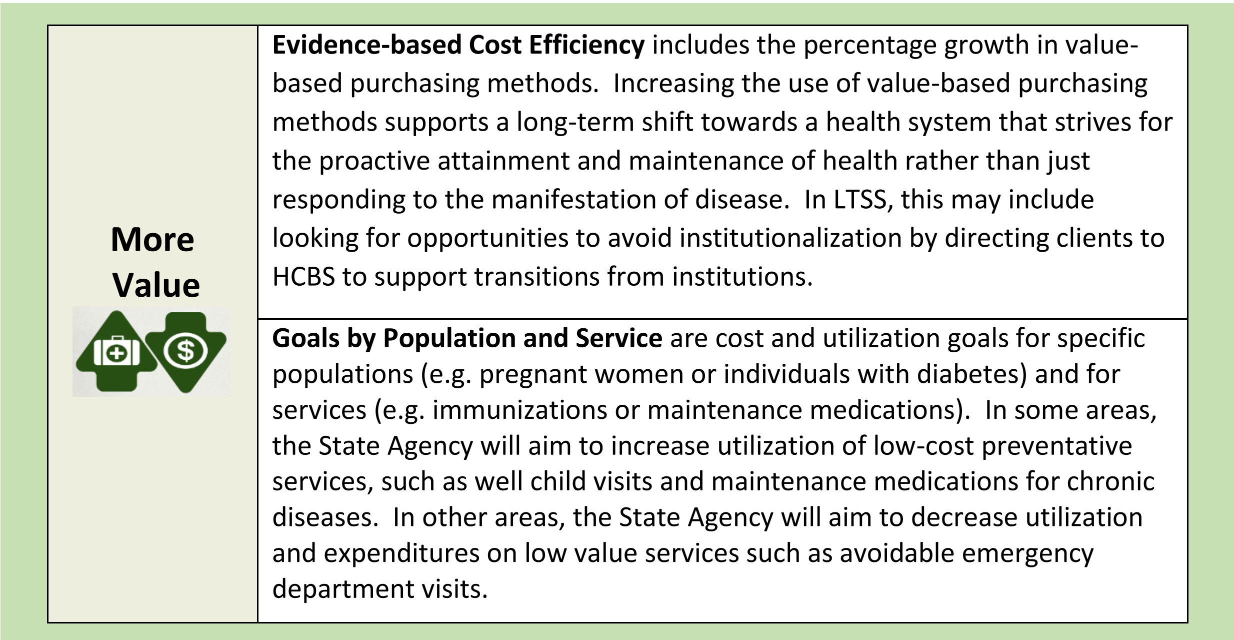
3.2. Outcomes-Focused and Value-Based

The ACC is an outcomes-driven program that aligns with the core commitments of the Hickenlooper Administration to operate programs with efficiency, elegance and effectiveness. Outcomes for ACC Phase II, like those in the current phase of the program, are built on the Triple Aim (improving experience, improving health, reducing per capita health care costs), with Colorado-specific modifications. To ensure that these outcomes are person-centered and meaningful, the State Agency has defined the high-level categories of outcomes, but will work with stakeholders to define specific measures. To track progress towards these outcomes, the State Agency intends to make use of specific metrics, including the Medicaid adult and child core measure set and the Institute of Medicine Core Measure Set.

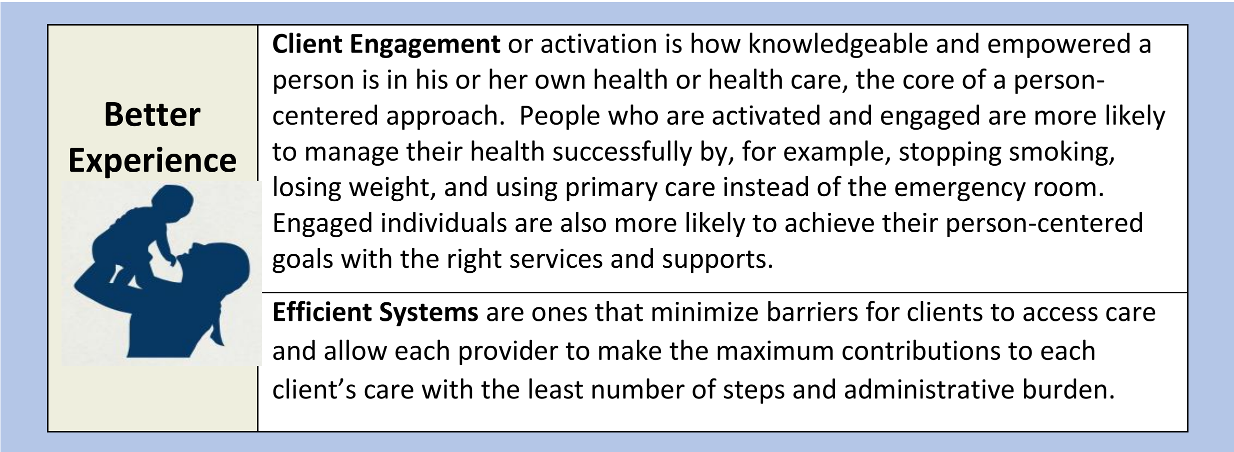
Desired outcomes of ACC Phase II



Improved Health	
	Health Management is the reduction in exacerbations of chronic disease, including physical and behavioral health conditions, and the reduction of critical incidents such as falls.
	Population Health will be measured by public health metrics such as rates of obesity, smoking, or servings of fruits and vegetables eaten per day.
	Social Well-being is the measure of non-medical factors that impact a person's health such as housing, education, economic self-sufficiency, access to healthy food and safe communities. Social well-being is especially important for those served by LTSS and hospice, for whom the primary goal may be improved quality of life.



More Value	
	Evidence-based Cost Efficiency includes the percentage growth in value-based purchasing methods. Increasing the use of value-based purchasing methods supports a long-term shift towards a health system that strives for the proactive attainment and maintenance of health rather than just responding to the manifestation of disease. In LTSS, this may include looking for opportunities to avoid institutionalization by directing clients to HCBS to support transitions from institutions.
	Goals by Population and Service are cost and utilization goals for specific populations (e.g. pregnant women or individuals with diabetes) and for services (e.g. immunizations or maintenance medications). In some areas, the State Agency will aim to increase utilization of low-cost preventative services, such as well child visits and maintenance medications for chronic diseases. In other areas, the State Agency will aim to decrease utilization and expenditures on low value services such as avoidable emergency department visits.



Better Experience	
	Client Engagement or activation is how knowledgeable and empowered a person is in his or her own health or health care, the core of a person-centered approach. People who are activated and engaged are more likely to manage their health successfully by, for example, stopping smoking, losing weight, and using primary care instead of the emergency room. Engaged individuals are also more likely to achieve their person-centered goals with the right services and supports.
	Efficient Systems are ones that minimize barriers for clients to access care and allow each provider to make the maximum contributions to each client's care with the least number of steps and administrative burden.

3.3. Accountability at Every Level

Accountability ensures that all participants in the health care system have a clear understanding of the activities for which they are responsible and the outcomes they are expected to achieve. Accountability is enabled and supported through incentives, payment, contracts, sound oversight, and tools such as health information technology. Systems of accountability empower and create a sense of shared ownership among the various members of the health care system, resulting in a commitment to continuous improvement. Accountability tied to overall health outcomes and a limited set of health indicators allows flexibility for iterative innovation as the State Agency.

Central to creating an accountable system in Colorado is having **one administrative entity responsible for health and cost outcomes for clients**. Having multiple responsible entities, as it is now with separate BHOs and RCCOs, results in no one administrative entity being responsible for the whole person, as not all services and outcomes fit neatly into the domains of "physical" or "behavioral" health.

Accountability will occur in each of the following four levels of the system:

- *Clients* – will be empowered and accountable for managing their own health and accessing the health care system effectively.
- *Health Neighborhoods* – will be accountable for providing holistic, integrated, and person- and family-centered medical care. The majority of the sick and well care will be provided by the Health Team (the PCMP and a long-term services and supports case management agency, the behavioral health provider, or certain specialists, if needed). Some clients may also require additional services from specialists, hospitals, LTSS, and community resources such as social services and public health.
- *Regional Accountable Entities* – will be accountable for the outcomes of the clients enrolled in their region and will achieve those outcomes in four major ways: supporting clients in managing their own health; developing and overseeing a coordinated delivery system; and managing to value-based payments from the State Agency and developing strategies for implementing their own value-based payments for delivery system participants; and, identifying and addressing health inequities and population health issues.
- *The State Agency* – will be accountable for administering a flexible benefits package, managing enrollment into the RAEs, providing foundational health information technology, monitoring deliverables and compliance with state and federal regulations, and ensuring cross-agency alignment.

To ensure that these various levels are able to be accountable, the State Agency will be committed to aligning with other efforts so that individuals and agencies are not pulled in a multitude of directions.

4.0. ACC Phase II Overview

The next phase of the ACC will focus on the provision of high quality and integrated services, the core of the State Agency's responsibility, while acknowledging that health care services are only a good investment if paired with activities to promote health. The ACC will continue to move towards a person-centered, outcomes and value-based, accountable, and aligned program that promotes complete health by building on current systems and investments.

In Phase II, the State Agency will no longer have separate systems responsible for physical health and behavioral health. One entity, the Regional Accountability Entity (RAE), will be responsible for duties currently performed by the Regional Care Collaborative Organizations and Behavioral Health Organizations in their region. This change will improve the client experience by creating one point of contact and clear accountability for whole-person care. In addition to whole-person care, having one entity will allow for more of a whole-family approach for children. The RAE will be responsible for client onboarding, as well as for managing health care delivery and financial systems. The state will continue to be divided into seven regions to continue to promote innovation, flexibility, and local ownership of the health care delivery system.

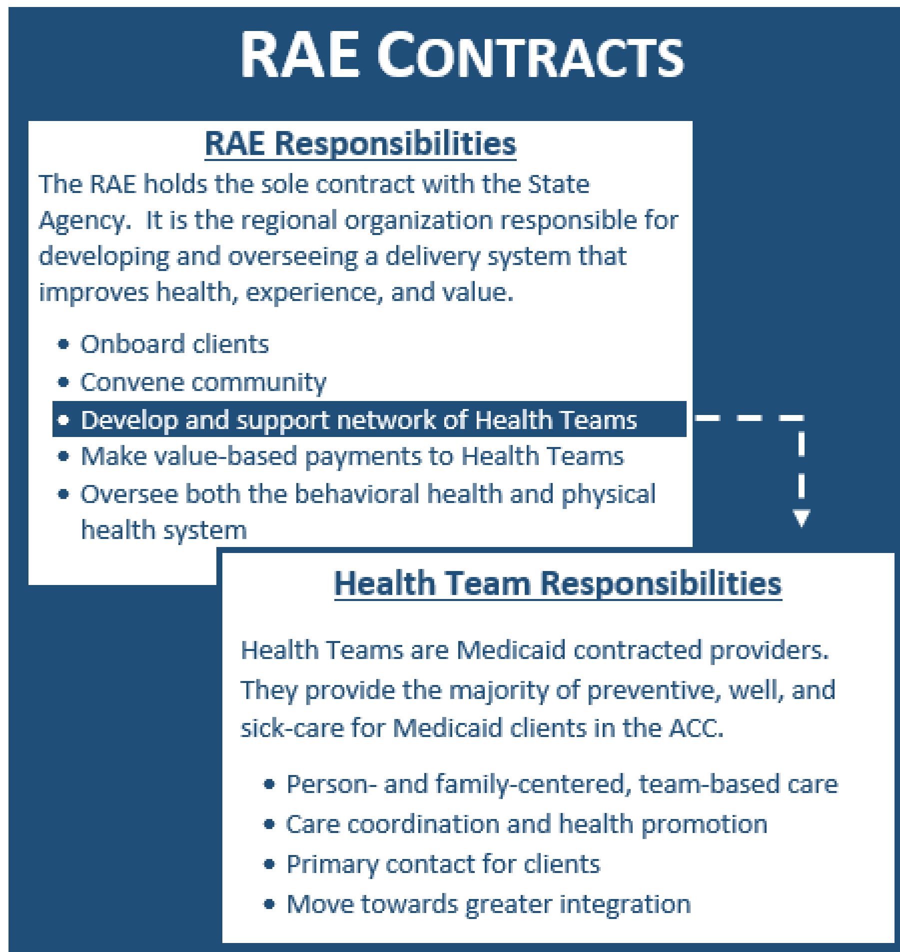
Clients will be automatically enrolled in the ACC through mandatory enrollment and immediately connected with a Primary Care Medical Provider (PCMP). A PCMP must be a medical practitioner (MD, DO, NP) with a focus on primary care (family medicine, internal medicine, pediatrics, obstetrics and gynecology). ACC Phase II will support currently integrated practices and encourage the development of more. PCMPs will be expected to provide team-based care, leveraging all staff to the greatest extent possible.

The next phase of the ACC will strengthen the PCMP network and the relationship between the RAE and PCMPs. RAEs will be given greater latitude to contract only with those practices that meet a set of basic minimum requirements. Minimum requirements will be defined for both small practices and large practices in a way that encourages the participation of small practices, but maintains the State Agency's commitment to enhancing the level of medical home standards. Exceptions will be made in cases where the requirements negatively impact client access. The Phase II enrollment and attribution methodology will ensure that most PCMPs will have a contractual relationship with ideally one, or at most two, RAEs.

Once a client is enrolled, the RAE will conduct a screen to identify a client and family's potential behavioral health, physical health, and social needs. While this screen allows the RAE and Health Team to identify high- priority clients for care coordination, all clients, especially healthy clients, will be offered services to ensure maintenance and promotion of health. The screen will inform what providers should be offered to the client to include in the Health Team.

All ACC clients will be a part of their Health Team which includes, at a minimum, themselves, their family (particularly in the case of children), and their PCMP. The Health Team may also include specialty behavioral health practitioners (providers of comprehensive, intensive, ongoing behavioral health interventions), long-term services and supports case management agencies, and certain specialists if needed. The Health Team will provide the majority of a client's care coordination, preventive and sick care, and will be the client's primary contact in the ACC.

The RAE will be responsible for contracting with the PCMPs, the Health Team providers, behavioral health practitioners, and LTSS case management agencies. For clients in the LTSS system, the RAE will act as a neutral party to support clients in selecting the case management agency that best meets their needs. The RAE will be responsible for creating a case management network that maximizes choice.



Agencies currently providing LTSS case management can continue to provide services and the RAE will honor local control. In accordance with House Bill 15-1318, the State Agency will work with current Case Management Agencies to further develop and refine a plan for the delivery of HCBS case management.

State Agency health information technology systems will have the ability to formally identify and designate additional providers as members of the client's Health Team. The system's ability to identify all members of a Health Team (not just the PCMP) will help to ensure clear lines of responsibility: facilitate more coordinated, whole-person care; promote data sharing; and ensure that the RAE is supporting the entire team. In addition, the RAE will offer a care coordination tool to Health Teams to help maximize integration and alignment of services.

The Health Team is supported by a Health Neighborhood of specialists and hospitals who can provide higher acuity services. The RAE will be responsible for ensuring access to specialty and hospital care and developing infrastructure that supports coordination between the Health Team and Health Neighborhood. To that end, the RAE will be responsible for promoting and supporting State Agency initiatives including those around electronic consultation and other telehealth programs.

Since an individual's health is impacted by many other services beyond just clinical services, the RAE will be responsible for developing mechanisms to engage community partners across the RAE's region on population health and non-medical community services.

ACC Phase II value-based payment strategies will further support the provision of team-based, integrated, and coordinated care and provide the RAEs and the State Agency with more leverage to manage the delivery system. To fully meet the needs of clients and to accommodate existing systems of care, the RAEs will be responsible for a Primary Care Case Management (PCCM) system of care. Payments to the RAE will include value-based components such as payments tied to— Key Performance Indicators, shared savings, and a competitive pool. The RAEs will be responsible for making value-based administrative (PMPM) payments to Health Team providers with more than 1,000 attributed ACC clients.

The State Agency will pay directly for clinical services, including behavioral health. This means all providers of services, including behavioral health providers will have to be able to accept claims payments from Medicaid. The State Agency will develop a benefit package, a value-based payment system that supports comprehensive and integrated care, and utilization management strategies that ensure that the clients receive appropriate access to high value services.

5.0. Detailed ACC Phase II Program Description

The remainder of the document will provide a detailed description of the program organized by the following levels of accountability:

- Clients
- Health Neighborhood
- Regional Accountable Entity
- State Agency

Those areas are all supported by program infrastructure. The final section of the Concept Paper, 6.0 Tools for Transformation: Program Infrastructure, will include the following sections:

- Payment
- Health Information Technology
- Sound Administration

5.1. Client

In ACC Phase II, the client and client's family will be empowered and accountable for managing their own health and appropriately using the health care system. In order for clients to be accountable, the State Agency must provide the necessary tools and resources.

Colorado's Medicaid program currently serves 1.26 million people, about 940,000 through the ACC Program. This chart provides an overview of the ACC eligible Medicaid population:

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

From: https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports

This represents a diverse and large percentage of all Coloradans.

Promoting client responsibility and empowerment can only be successful if the client perspective is built into the program design. The State Agency is currently piloting a Person- and Family-Centeredness Advisory Council and is having success obtaining client input on issues critical to client experience and engagement. Each RAE will be responsible for creating mechanisms to ensure that program and policy decisions (particularly those that impact clients including strategies for client accountability, client satisfaction, cultural competency, outreach, quality improvement, access to care, and similar issues) are vetted by clients and family members.

Clients are best able to engage in their health with appropriate **orientation to their benefits and the program**, few administrative barriers, **tools for engagement** and **the right incentives**.

5.1.1. Onboarding

All clients will be mandatorily enrolled in the ACC when they are enrolled in Medicaid. Immediate enrollment with the RAE will allow the State Agency to fully leverage the RAE's knowledge and expertise about the health system and allow the RAE to develop client-specific solutions more quickly.

All clients, including new Medicaid enrollees and current ACC and BHO enrollees, will be enrolled with the new vendors and will be onboarded to the new system. Current ACC and BHO enrollees will need to be enrolled in the new system. The State Agency, in partnership with the new RAEs and the current RCCOs and BHOs, will develop a staged transition plan that ensures smooth handoffs. The RAE will onboard clients orient them to the health care system, explaining their Medicaid benefits, and providing tools to manage their own health. For children, the responsibility of onboarding to Medicaid will be divided between the RAE and the Healthy Communities programs. The State Agency will leverage Healthy Communities expertise, which will be responsible for connecting children with a provider and ensuring that clients are receiving full access to Early and Periodic Screening, Diagnostic and Treatment benefits.

Understanding client needs and goals is crucial to offering clients the most appropriate options of Health Team providers and services and supports. In many cases, the Health Team itself can be as simple as the partnership between a PCMP and a client, but for some clients, additional providers are needed. To determine the members of each client's Health Team, the RAE (or a delegated community provider) will begin the onboarding process by helping clients complete an eligibility-type-specific physical, behavioral, and social needs screening. The RAE will have significant latitude in how and where this screening is completed but will be required to collect and submit the discrete data to the State Agency. In the case of children, the screening will include a family component to acknowledge that a child's welfare is often dependent on their parent's social, emotional, and physical well-being. The client assessment data will provide the State Agency with greater insight into the ACC population, enabling better evaluation of program efficacy, improved payment methodologies, and improved partnerships with other state agencies.

RAEs will have **clear minimum standards** for the care coordination **interventions** they will offer to each unique client population. As part of these standards, clients, advocates, and providers will know what services (types of assistance, in-person meetings, home visits, and phone calls) they can expect from the ACC. Clients who require care coordination will know how frequently they can expect to interact with their care coordinator. In addition, the RAE will work to structure care coordination so that clients with multiple care coordinators, such as clients in the LTSS system, will know which care coordinator provides which services. In order to develop those minimum standards, the RAE will be required to develop a menu of interventions and consider different combinations of those services for different client populations.

For healthy clients, the intervention may be as simple as identifying a PCMP and connecting clients with community resources related to health and wellness. For higher-acuity clients, it might be a commitment to a minimum of a monthly care coordination call.

5.1.2. Client Engagement

Client engagement is a priority for Phase II and each RAE will be expected to test various methods of engagement and activation. RAEs will be expected to take a continuous improvement and iterative approach to client engagement, an important area where there is significant room for new strategies. The State Agency will encourage engagement methodologies that leverage new technology and will require that the RAE have 24-hour availability to both clients and providers.

Phase II will trial a number of client engagement strategies, from high touch, personal interactions to technology-based solutions. With a mobile population, more than 30% of paper letters mailed to clients by Colorado Medicaid never reach the intended client.[1] Reducing paper mailing can save money and improve client experience and activation. Research indicates that 90% of all text messages are opened within 3 minutes of delivery and that cell phones are checked for messages on average 150 times per day.[2] In ACC Phase II, the RAEs will trial and evaluate various client engagement strategies using a standardized tool to measure client activation/ engagement so that it is possible to assess and compare the efficacy of these efforts and replicate or scale efforts that are successful. Technology may be a particularly effective strategy for engaging youth so they develop better lifelong health behaviors and habits.

RAEs will be required to develop a system to support clients who are seeking information or assistance and who are not engaged with their Health Team or are not receiving the information or services they need. Navigating the health care system appropriately is particularly difficult outside of normal business hours. The RAEs will be required to be a 24-hour resource. Clients who call either the nurse advice line or the crisis hotline can be transferred to their RAE to connect to medical or non-medical services. This is an important tool for clients who may require assistance in identifying the right services and attaining them.

In addition, RAEs will be required to support Health Teams in using client engagement techniques such as motivational interviewing, chronic disease self-management, and health coaching.

5.1.3. Client Incentives

In ACC Phase II, the State Agency will trial client incentives as a method to encourage clients to engage in healthy behaviors and appropriate use of the health system. With stakeholder input, the State Agency will determine a specific statewide focus for the first year of the program. A defined, statewide scope is necessary for budgeting and assessing efficacy. Incentives will be between $50 and $250 per client per year. They can be either in-kind (e.g., gym memberships, nutrition or cooking classes, bicycle rentals, Fitbits, etc.) or financial incentives. Stakeholders will assist the State Agency to identify appropriate populations and strategies for incentivizing clients. The RAE will be required to offer evidence-based interventions and have methodologies for measuring the efficacy of their approach.

---

[1] Footnote: 2014. Research conducted by Colorado Department of Health Care Policy and Financing's Policy, Communications, and Administration Office. Based on a postal bounce-back and "return as undeliverable" rate of approximately 31 percent. It is expected that some additional percentage of conventionally-mailed communications do not reach the intended client.

[2] Footnote: June 2010. Mobile Squared. Conversational Advertising, Page 8. Mosio and SinglePoint research whitepaper.

To support RAE client incentive programs, the State Agency will make its first foray into utilizing clinical measures for program administration. The client incentive program success will be measured on both claims and clinical measures.

After the first year of the program, the State Agency will work with the RAE to assess what the focus of client incentives should be for future years.

5.2. Health Neighborhood

The Health Neighborhood, the second level of accountability, is responsible for providing ongoing integrated, coordinated, and person- and family-centered care. There are two levels in the Health Neighborhood: the Health Team and the broader Health Neighborhood.

5.2.1. Health Team

A Health Team's core members are the client and PCMP. Clients may also have a specialty behavioral health provider, LTSS case management agency or providers, or certain intensive specialists (who provide the majority of the client's care) as members of their Health Team. These additional providers will be identified by the RAE and linked in the State Agency's provider portal, so that they can see client data relevant to their role and receive support from the RAE. The RAE or the RAE's delegate will perform the initial health and social screen, and the Health Team is responsible for collaborating with clients to create a care plan, if needed, to address identified needs and goals defined by the client.

ACC Phase II will be designed to promote continuous and comprehensive relationships between the Health Team and the client. The State Agency is seeking to retain and build on current successes in ACC Phase II.

Health Teams have responsibilities, and receive supports, in two domains:

- Provision of Team-Based Care within the PCMP Practice
- Coordination between Health Team Providers

5.2.1.1. Team-Based Care within the PCMP Practice

In Phase II, like in the current system, PCMPs must be medical practitioners (MD, DO, NP) with a focus on primary care (family medicine, obstetrics and gynecology, internal medicine, pediatrics, etc.). Behavioral health practices that offer integrated medical services, as defined, can also be PCMPs. The State Agency will support the development of additional integrated sites so that more behavioral health practices meet the criteria.

In Phase II, the State Agency will have a firm set of minimum requirements for practices seeking to be the PCMP for Medicaid clients, enabling the RAE to limit the network to high-performing practices. Emphasis will be placed on ensuring an adequate number of practices who can provide culturally competent and disability competent care. The minimum requirements will be aligned with other medical home standards such as the National Committee for Quality Assurance (NCQA) and the Comprehensive Primary Care Initiative (CPC) and will be vetted by providers. Small practices or practices with fewer than 1,000 attributed Medicaid clients will have a modified set of requirements. If the higher standards result in inadequate access to care, the RAE and the interested practice can request a waiver from the State Agency. Examples of the types of minimum requirements that the State Agency might set for all practices include the following NCQA standards:

- The practice can identify clients who would benefit from care management and the practice monitors the percentage of the total population identified.
- The practice can demonstrate that it tracks ordered tests until results are available, flagging and following up on overdue results.

Changes in the attribution and enrollment methodology will mean that PCMPs only have clients in one or, in limited cases, two RAEs (described in greater detail in section 5.4). This change is taking place based on feedback that it will simplify and strengthen relationships between PCMPs and RAEs and will maximize the support that RAEs provide to practices.

All clients will be linked with a PCMP at the time of enrollment to improve access and reduce barriers to utilizing primary care.

Consistent with current methodology, most clients will be linked to a PCMP based on their most recent Medicaid visits. As of March 2015, 76 percent of enrollees were attributed at the time of enrollment based on claims.

If a client has no claims history with Medicaid, the State Agency will suggest PCMPs for clients based on their needs, location, and provider performance. Provider performance for purposes of attribution will be defined by the State Agency in collaboration with the RAE and will be standardized statewide. Assignment of a PCMP may reduce barriers to utilizing primary care by giving clients the name, location, and contact information of a nearby practice accepting Medicaid clients. Clients will be able to switch providers for 30 days after enrollment, after which time they will be encouraged to keep their PCMP. Auto-assignment will mean that a Health Team will know they are responsible for a client, will have the client's contact information, and will be able to conduct outreach more efficiently. Clients may be more responsive to outreach from a local practice than from the RAE, which can further help to reduce system barriers.

Within the PCMP practice, the client will receive team-based care, where available, leveraging all staff resources in a practice in a coordinated manner. Team-based care may include primary and non-primary care providers, front desk staff, pharmacists, behavioral health specialists, nurse practitioners, nurses, integrated care managers, medical assistants, lay health workers, transition coordinators, social workers, nutritionists, and other service providers. Team-based care can lead to improved access to preventive care, improved consistency of care, and improved treatment of chronic conditions. In addition, team-based care may mean that pediatric or family practices have the capacity to assess the whole family and identify issues within the family that could negatively impact the child before they manifest in an acute manner. In a team-based approach, each team member has clear roles and responsibilities that are appropriate to their training and function in the group. For example, a front desk staff member will anticipate the needs of clients and help them identify what visit they need and how to sequence the visits in efficient manner. Individual care plans for clients guide the work of the whole team (although not every member of the team will have access to the care coordination tool or care plan).

Phase II will focus on three strategies for team-based care (in sequence):

1) Maximizing the use of current practice staff, including mid-level licensed professionals;
2) Maximizing the use of and/or incorporating lay health workers within the team; and
3) Providing integrated physical and behavioral health services within the practice.

First , all staff within a practice, including front desk and administrative personnel, nurses, medical assistants, physician assistants, and licensed behavioral health staff, will work to the full extent of their training, experience, and qualifications. Health Teams will be supported by RAEs in developing processes and procedures to improve workflow, establish goals for team-based care, establish roles for team members, and improve communication across care teams.

Second, lay health workers are a cost-efficient way for clients to receive the high touch, non-clinical services needed to help them achieve their health goals. Using lay and paraprofessional health workers to perform non-clinical tasks, education, and client support can also support medical, behavioral, and other specialists who provide clinical interventions to practice at the top of their license. Non-traditional or lay health workers can also help expand the capacity of the finite, and often overburdened, specialty care workforce. Chronic Disease Self-Management Programs use trained peers to facilitate classes for people with chronic disease. Self-management support is a function of a medical home. Many specialists have reported that they spend considerable time addressing needs that can reasonably be addressed by lay health workers or paraprofessionals without their specialized expertise. The RAE will be expected to support the PCMPs financially and operationally in utilizing lay health workers such as patient navigators, community health workers, *promotoras* (Latino/a community health workers), and peer specialists (including family, youth, and adult peer specialists).

Third, ACC Phase II will promote providing integrated physical and behavioral health services within the practice. The State Agency will work to increase the number of ACC clients who receive integrated physical and behavioral health care within the Health Team. This will be the State Agency's mechanism for aligning with the other payers participating in the State Innovation Model. Co-location is not synonymous with integration. True integration requires that physical and behavioral health providers function as a team and collaboratively develop care plans or interventions for clients. In these cases, there is a single care plan that includes physical and behavioral health services. Transitioning a practice that provides only one type of service to a practice providing both behavioral and physical health services will be a multi-year and multi-step process.

5.2.1.2. Coordination among Health Team Providers

Services within the PCMP practice and between different Health Team providers will be coordinated. A care coordinator located in the Health Team will be the lead for each client that needs and wants care coordination. The State Agency has received strong feedback that care coordination is most effective when it is provided face-to-face by individuals with strong ties to the community who can develop ongoing relationships with clients. Care coordination may occur in a number of different ways, for example:

- A care coordinator located in the PCMP office;
- A care coordinator located in the office of one of the other Health Team providers;
- A care coordination team funded by the RAE and shared across small practices, physically located in the community, but not necessarily in any individual provider's office.

Care coordination must meet the minimum requirements defined in the RAE contracts. However, those requirements will allow for a great deal of latitude as to how and by whom care coordination is provided. Special emphasis will be placed on care transitions and populations who cross systems. Care coordination strategies must be evidence-based and built on learnings from Phase I, such as the Super-Utilizer Program. In addition, care coordination for some populations, such as clients in the Client Over-Utilization Program (COUP) who inappropriately or excessively use the health care system, will include additional requirements.

The RAEs will procure and offer an interoperable mobile-ready care coordination tool to support communication and coordination between members of the Health Team. An acceptable care coordination tool will include role-based access that supports HIPAA compliant data sharing and will enable the Health Team to identify the full team serving the client, especially the lead care coordinator.

It is expected that care coordination strategies will differ based on the needs and life stages of clients. The RAE will evaluate care coordination models and support the Health Teams in evolving care coordination strategies based on evaluation findings.

5.2.2. Health Neighborhood

Medicaid clients often have needs that go beyond comprehensive primary care provided by their initial Health Team and so require services from a broader Health Neighborhood. The **Health Neighborhood** includes specialists, hospitals, oral health providers and other ancillary providers. Health Teams alone are not sufficient for a coordinated and complete delivery system. For clients with needs that go beyond the Health Team, the RAE will be responsible for ensuring access to a network of specialists, hospitals, and all of the other medical and non-medical providers who serve Medicaid clients.

As discussed previously, the RAE will have concrete requirements around ensuring access to this network and promoting engagement and coordination with this broader neighborhood or community of providers. The RAE requirements in this area will be primarily process requirements and will involve supporting adequate access to coordinated health care services by:

- **Identifying available Medical Providers.** The RAE will maintain a list of the available medical providers (specialists) and non-medical services available to clients within the community. Each RAE will share its list with all the other RAEs. The burden of mapping specialty care will be heavily borne by the Denver-Metro RAE.
- **Maximizing limited specialist resources.** Promoting the Colorado Medical Society Provider Compact and use of electronic consultation and telehealth.
- **Coordination among all members of the health neighborhood.** The RAE will work to develop protocols, MOUs, and business processes to help the various members of the health neighborhood work together. The RAE will also be encouraged to work with other vendors; for example, creating an MOU with the Medicaid Dental Administrative Services Organization to promote coordination and collaboration on shared clients.
- **Engaging members of the health care community.** At the most basic level, the RAE will be responsible for creating or supporting existing community forums that enable different providers to form personal relationships and facilitating the development of necessary relationships on an *ad hoc* basis.

Clients in ACC Phase II will benefit from PCMPs' increased access to specialty care resources through the effective employment of the Provider Compact, use of electronic consultation and other telehealth tools to maximize specialist time, and other enhancements of PCMPs' capacity to manage complex clients.

The Colorado Medical Society Provider Compact offers a framework of responsibilities for specialists and Health Teams to improve communication and ensure the safe, effective, and timely transition of care among providers. *Ad hoc* referrals, differing processes, and levels of coordination have meant that lines of accountability have been difficult to untangle in the past. Communication and data sharing have also been non-standardized, making specialty care-primary care relationships time-consuming and often burdensome. The Provider Compact identifies what data should be provided by the PCMP in advance of the specialist visit so that the visit can be effective. It also identifies what information should be provided back to the PCMP who will resume managing the client's care.

The Provider Compact will help identify situations where clients may not actually require intensive care and, instead, a brief specialist consult would suffice. Electronic consultation modernizes traditional patient consultation and referral processes by using telemedicine technology to exchange client information. PCMPs can quickly and easily consult with specialty physicians using an online, HIPAA-compliant electronic consultation system. These tools can also facilitate PCMPs and specialists in co-managing care for ACC clients. The program is scheduled to be implemented in 2015 and will begin with rheumatology specialists. The State Agency looks to gradually build the program to include other medical subspecialties, such as neurology and behavioral health.

In ACC Phase II, the State Agency will work with the University of Colorado to expand the Chronic Pain Disease Management Program to include more areas of specialty care shortage including neurology and orthopedics. Using this model allows for greater number of clients with complex conditions to receive care at a primary care setting, while simultaneously maximizing the capacity of individual providers.

Hospitals are another key part of the Medicaid delivery system as they have intensive interaction with many of the most complex clients and account for more than 20 percent of total Medicaid expenditures. The State Agency seeks to incentivize hospitals to promote a shared, proactive system that improves health and drives innovation. The State Agency, in partnership with the hospitals, intends to explore the feasibility of developing and implementing a Delivery System Reform Incentive Payment (DSRIP) program as a means for coordinating hospitals with the ACC and engaging hospitals around the vision of accessing whole-person care and creating shared accountability and goals.

5.3. Regional Accountable Entity (RAE)

As the third level of accountability, the RAE is ultimately responsible for the health outcomes, value, and client and provider experience in its region. The RAE is responsible for creating and supporting the whole delivery system including the Health Team, Health Neighborhood, and larger community.

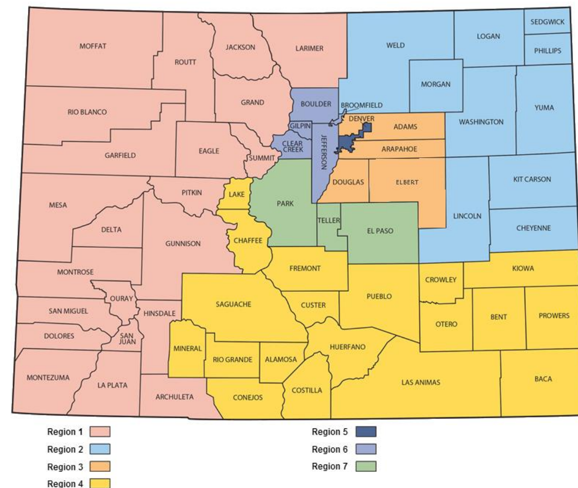


Figure 4: Map of Colorado with future RAE regions.

As the accountable entity procured by the state, the RAE will be responsible for the activities currently performed by the RCCOs and the BHOs and for ensuring a greater level of integrated and coordinated care.

In ACC Phase II, the state will continue to be divided into seven regions with one RAE per region. RCCO and BHO regions will be aligned to better support combining administrative functions within one RAE. The current ACC map will apply in Phase II with one exception: Elbert County will be moved from Region Seven to Region Three. Input from stakeholder meetings in July 2015 in and around Elbert and Larimer counties, the two counties for which RCCO and BHO boundaries were not aligned, informed the State Agency’s decision regarding this change.

This section will focus on the following RAE responsibilities (not detailed elsewhere):

- Contract, support and oversee the Health Team Network
  - PCMPs
  - Behavioral Health Network
  - Case Management Agencies
- Developing a broader community network
- Manage systems of care for the enrolled population
  - Administer the Community Behavioral Health System
  - Develop and operate systems of care for special populations

5.3.1. Contract and Oversee the Health Team Network

The RAE must develop and maintain a formal, contracted network of PCMPs, specialty behavioral health providers, and home and community-based services case management agencies. The RAE will be responsible for ensuring the quality of services provided within the network and tracking how the network is meeting requirements such as access, person-centeredness, and others. RAEs will be expected to develop strategies to serve rural and frontier areas to ensure that all clients receive the same high-quality care and have adequate access to care.

5.3.1.1. Primary Care Medical Providers

The RAE will be responsible for providing intensive support to contracted PCMPs. Currently, many PCMPs have clients from more than one RCCO. In Phase II, the State Agency will use a new enrollment methodology so that most PCMPs will have clients in only one RAE. For large PCMPs (with 1,000 or more attributed clients[3]), the State Agency will identify which geographic region has most of the practice's Medicaid clients. This region will be the primary RAE with which the practice will contract. If less than 35% of the practice's attributed clients are in any one RAE, all attributed clients will be enrolled in the primary RAE. If a practice has more than 35% of its attributed clients in different RAEs, the practice must contract with both. Smaller practices (fewer than 1,000 attributed clients) will have all of their enrollees assigned to the RAE with whom they have the most clients. For example: a PCMP has 80 percent of their clients in Region "A" and 20 percent in Region "B." All of the clients who are attributed to that PCMP will be enrolled in Region "A" so that the practice just has to work with Region "A," even those clients who reside in counties assigned to Region "B."

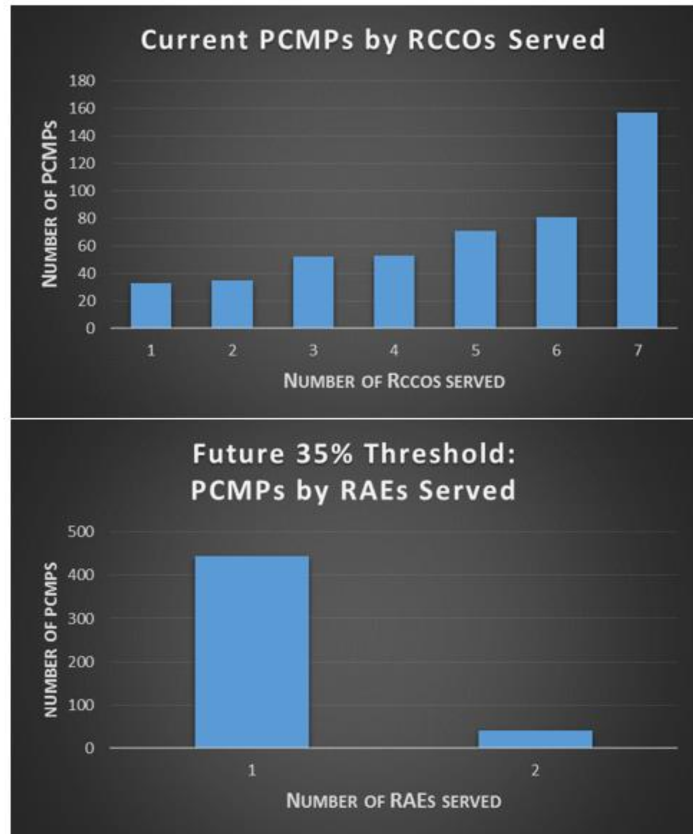


Figure 5: Current number of RCCOs each PCMP serves (top) and the future state of enrollments allowing most PCMPs to work with just a single RAE (bottom).

In other words, the State Agency will assist PCMPs and RAEs in identifying which RAE has most of the practice's clients. If the PCMP meets the minimum criteria, the RAE will complete a contract with the PCMP. Then, once the PCMP is contracted, the State Agency will set up the PCMP to receive attributed clients.

5.3.1.2. Behavioral Health Network

The behavioral health network will serve clients with both early intervention and brief treatment needs and clients with more acute, intensive, and chronic needs. The network will span the continuum of care, from hospital services to outpatient services to non-traditional services such as clubhouses or drop-in centers, respite, and recovery services. The network will include specialty behavioral health providers with experience rendering services to children and adults, including those providers with experience interacting with Child Welfare.

---

[3] The 1,000-person cutoff was selected based on stakeholder feedback that this is the point at which a practice can potentially hire a new FTE to assist with care coordination and supporting the team.

5.3.1.3. Case Management Agencies

In addition to the physical and specialty behavioral health networks that serve everyone, the RAE will be responsible for managing the network of Case Management Agencies (CMAs) that serve the LTSS population. Under federal HCBS regulations, CMAs cannot provide both case management and home and community-based services. Because some CMAs currently perform eligibility, case management functions, and direct HCBS services, potential conflicts of interest may exist. Guidance from CMS, as well as new federal regulations and state law, require that the State Agency present a plan to address potential conflicts of interest for these case management agencies.

Consistent with the principles of person- and family-centeredness, client choice, and client self-direction, the RAE will provide clients with open, informed, and conflict-free choice among CMAs by contracting with a diverse network of qualified CMAs and functioning as a neutral party to connect clients with a CMA that meets their needs

Currently, Community Centered Boards (CCBs) serve individuals with intellectual and developmental disabilities (I/DD) and Single Entry Points (SEPs) serve others in the LTSS system. Both entities conduct eligibility determinations and provide case management. In addition, CCBs also provide direct services for individuals enrolled in HCBS waivers for individuals with I/DD.

The State Agency will work with stakeholders, including the CCBs and SEPs, to develop clearly defined roles for the multiple vendors in the system. To generate conversation, the State Agency is proposing the following division of roles.

When a client self-identifies that they require assistance or a provider identifies they need assistance from the LTSS system, the "No Wrong Door" entity (or entities) will assess level of care eligibility. If the client meets LTSS criteria, the RAE will then be responsible for helping the client select a CMA. The CMA will conduct a needs assessment and develop the service plan in conjunction with the client and/or family. The CMA will be responsible for referrals, ongoing monitoring, and remediation of problems related to the service plan. The Utilization Management (UM) vendor and the RAE will act as checks and balances for the CMA. The UM vendor will review and approve the resource allocation. The RAE is responsible for monitoring the CMAs, addressing issues that have been elevated, and for assisting the client in selecting a new CMA if the client elects to do so.

5.3.1.4. Supporting the Health Team

Just as client interactions will be person-centered, practice support for Health Team providers should be practice-centered and align with other efforts in which the practice is engaged. The strategies used will be different for practices with greater than 1,000 clients and those with fewer than 1,000 clients. Building capacity in some smaller practices will not be feasible and the RAE will have to play a more active role and/or devise other ways to ensure that clients receive a comprehensive medical home level of care and care coordination, as needed.

The RAE will be required to offer practice support to the Health Team, using strategies approved by a RAE Board of Directors (described in Oversight) and the community. Practice supports may include:

- Financing
- Technical support (e.g., clinical care guidelines and best practices, training on culturally-competent care)
- Non-financial resources (e.g., chronic care templates, client reminder templates, screening tools), and,
- Operational support (facilitating LEAN processes, training support staff to maximize their knowledge and skills, supporting the practice in incorporating data into the workflow).

RAEs will aid in developing processes and procedures to improve workflow, establish goals for team-based care, establish roles for team members, and improve communication across teams. The RAEs approach to practice support will be aligned with other provider support efforts in the community and will be focused on those efforts that directly tie to improving client outcomes.

The RAE will be able to offer grants to PCMPs and community partners to invest in rapid-cycle quality-improvement activities related to State Agency-directed priority areas. The grant process will be similar to that of the Adult Medicaid Quality Measures (AMQM) process and will build upon lessons learned. Grant projects must be focused on care for Medicaid clients and be related to a defined priority area, including behavioral health integration, care coordination and care transitions, care for special populations, and key performance indicators. Projects cannot duplicate existing contractual responsibilities.

Grant funding will come from an annual pool with an option for an additional bonus payment for exceptional outcomes related to the priority area. All grant applications from community partners and PCMPs will be submitted through the RAE to the State Agency.

5.3.2. Community Engagement

The RAE will be responsible for engaging and supporting the communities within its geographic region. Each of the seven regions has many distinct communities with unique needs and resources. Phase II of the ACC program will provide infrastructure to support communities in ensuring clients have access to the resources they need. In ACC Phase II, the RAEs will focus their community activities on those areas that are most directly related to the health and well-being of clients. ACC Phase II will focus on creating a cohesive community of care with providers clearly within the Medicaid system while taking small, concrete steps to engage and support community members that have a direct impact on health but are not "health care." Although it is not the central focus of this phase of the ACC, the State Agency does recognize that an effective system of health simultaneously supports public health activities and addresses social determinants of health. A truly integrated and robust community strategy would have seamless integration between these medical and non-medical services.

RAE's engagement with the community should include:

- Supporting and meeting the medical and non-medical needs of individual clients
- Supporting current community engagements
- Forming connections and facilitating meetings between the Health Team, Health Neighborhood, and broader community
- Engaging all partners in developing population health strategies
- Maintaining a list of available medical and non-medical services that can be shared with providers and the other RAEs
- Making RAE investments that support or build independently-sustainable infrastructure within the community

The RAE should also be familiar with and, to the extent possible, align its efforts with the community health improvement plan and nonprofit hospitals' community health needs assessments and implementation strategies.

The RAE will be required to focus on those community health-related activities prioritized by the Colorado Opportunity Project, a multi-agency initiative aimed to support low-income Coloradans in achieving middle class by middle age. The Project is a collaboration of the Colorado Departments of Health Care Policy and Financing, Public Health and Environment (CDPHE), Human Services (CDHS), and others. In addition, special emphasis will be placed on partnering with or supporting current local public health activities. Local Public Health Agencies (LPHAs) in Colorado have existing capacity and community connections, and are often leaders in health in their area. RAEs will engage with LPHAs on community health efforts as detailed in each LPHA's survey of community needs. The RAE will work collaboratively with interested LPHAs to explore appropriate funding approaches to support enrollment, population health, and public health information sharing activities taking place at each LPHA. RAEs would also have the latitude to pilot other population health activities outside the traditional scope of local public health.

The RAE will be encouraged to adhere to the following principles of community engagement. Engagement will be:

- Based on an assessment of community needs – including input from assessments done by local public health agencies and area hospitals;
- Encourage public-private partnerships and be community driven; and
- Adhere to principles of sustainability and collective impact philosophies.

5.3.3. Manage Systems of Care for Special Populations

There are many populations and individuals with special needs within Medicaid. As part of the broader network and system processes, the RAE will create unique systems to serve specific sub-populations. The RAE will be required to retain BHO functionality by **administering the Community Behavioral Health System** to ensure individuals with serious and ongoing behavioral health needs receive the services and supports they need.

In addition, the State Agency will look for opportunities to improve care for **special populations** that are particularly impacted by a lack of coordination between state systems, such as children with high behavioral health needs who are at-risk for out-of-home placement, and individuals leaving the Corrections system. These populations represent a clear opportunity to improve quality of care and reduce cost in multiple state agency budgets.

5.3.3.1. Administer Community Behavioral Health System

The RAE will be responsible for administering Colorado's Community Behavioral Health System to ensure the client care and service functions of the BHO are retained as appropriate. The RAE will be expected to develop systems of care for clients with behavioral health needs. Activities may include network development, quality-improvement, contracting and licensure activities, and helping clients to navigate the behavioral health system.

The RAE will be required to have staff expertise pertaining to behavioral health and will develop systems of care for enrolled members that are evidence-based and serve the whole person. These systems will acknowledge the role of purpose and community in a client's life.

5.3.3.2. Serving Special Populations

The RAE will have specific requirements to develop systems of care to serve children with high behavioral health needs who are at-risk of an out-of-home placement and clients who are transitioning back into the community from Corrections. These two populations were selected as opportunities to better coordinate services for Medicaid clients who receive services from multiple state agencies. Once the state agency gains confidence and competency in cross-agency coordination, the state agency will develop strategies for other populations impacted by multiple state agencies.

Children with high behavioral health needs at-risk of out-of-home placement will be offered the support of a special System of Care including a higher level of care coordination, known as *Wraparound*, and will be eligible for a Systems of Care benefit package. This is an important effort to improve clinical and functional outcomes for children/youth, improve their experience in the system (and that of their families), and avoid expensive out-of-home placements. The focus of the System will be on avoiding out-of-home placements and decreasing the rate of inpatient or residential stays. Children will be assessed for eligibility for the System of Care using standardized assessment criteria. The System of Care will be focused on intensive in-home therapies, family-to-family peer support services, and the provision of flexible funds to meet needs identified in a care plan. The System of Care for at-risk children and youth would be developed under the ACA Section 2703 authority. The System would initially serve 500 children statewide and then expand to all eligible children.

Although the criminal justice-involved population represents a small subset of the Medicaid population in Colorado, these clients frequently have considerable needs and incur outsized costs. Former inmates in Colorado are, on average, high users of health care upon release to the community. In particular, those with chronic physical health, mental health, and substance use disorder conditions often seek care in the emergency room. The RAE will be required to initiate contact and begin intensive care coordination for those transitioning to the community immediately prior to their Medicaid eligibility start date.

To support both of these efforts, the State Agency will work with relevant agencies in the state of Colorado to foster information sharing and align efforts. The RAE's responsibilities are all designed to ensure accountability at every level of the system while holding true to the State Agency's principles. These responsibilities will be detailed in contracts between the State Agency and each RAE.

The success of the RAE is predicated upon the support provided by the State Agency, the role of which will be described in detail in the next section.

5.4. State Agency

The fourth and final level of accountability in the program is the State Agency itself. The State Agency is accountable to its clients, to the taxpayers, and to federal partners at CMS.

The State Agency serves as the foundation for the program, playing a crucial role in providing the infrastructure needed for success. The State Agency will ensure the program has a strong commitment to person- and family-centeredness, focuses on outcomes and value, is accountable at every level, and aligns with other health reform efforts in the state. The State Agency will administer a **flexible benefits package**, manage **enrollment into the RAEs**, and ensure **cross-agency alignment**.

5.4.1. Flexible Benefit Package

The State Agency will retain all of the responsibilities related to administering benefits for clients and moving payment for those services toward a more value-based payment system. The two key functions of the State Agency in this area are **benefits management**, with a particular focus on promoting the integration of physical health and specialty behavioral health services, and ensuring effective **utilization management**. The State Agency will also be responsible for better **aligning hospital incentives with the rest of the delivery system**.

5.4.1.1. Benefits Management

Clients in the ACC Program will receive physical and behavioral health services through a more integrated value-based payment structure. Value-based payments will be layered on a fee-for-service platform.

The State Agency is committed to promoting physical and behavioral health integration. The State Agency will work with stakeholders and conduct rigorous cost/benefit analysis to determine the best method for achieving physical and behavioral health integration. The State Agency is specifically considering the following four policy changes. First, the State Agency will remove the covered diagnosis criteria for all behavioral health services and allow a low threshold for time-limited therapy to increase access across the board. Second, the State Agency will work to define integrated care and find ways to reimburse for instances that involve both physical health and behavioral health in the same visit. The State Agency heard stakeholders' request for opening health and behavior codes and believes that developing solutions for reimbursing integrated care will allow for the provision of this type of care. Third, the State Agency will seek to resolve any other barriers to integrated care, such as time-based procedure codes, and ensure that reimbursement is sufficient for the service provided. Fourth, the State Agency will explore options for reimbursing multiple and new provider types for low acuity behavioral health services.

Paying for services through a value-based payment structure ensures that clients enrolled in Medicaid have the opportunity to receive integrated health services from providers that are accountable for whole person health outcomes, supports the provision of prevention and early intervention services, and provides the State Agency and the public with greater insight into the population's needs and utilization patterns. This heightened transparency will allow for better budgeting and design of future payment reforms. Moving most clients out of a capitated behavioral health system will allow the State Agency greater flexibility to integrate with other state systems such as Corrections or Education because the State Agency will not have to work within the constraints of a capitated program.

5.4.1.2. Utilization Management (UM)

Phase II will include stronger coordination between the State Agency's UM vendor and RAEs as part of a new UM strategy. The State Agency will attempt to reduce the number of high-value services requiring a prior authorization request (PAR). In addition, the State Agency will need to expand UM activities to include specialty behavioral health services. Part of the UM strategy will include developing a Client Over-Utilization Program.

5.4.1.3. Align Hospital Incentives

Hospitals are a key part of the Medicaid delivery system as they have intensive interaction with many of the most complex clients and account for more than 20% of total Medicaid expenditures. The State Agency seeks to better align hospitals with the ACC and incentivize them to promote whole-person health. The State Agency is evaluating the feasibility of a Delivery System Reform Incentive Payment (DSRIP) program as a means for aligning hospital incentives with the ACC by creating shared accountability for shared goals. An intentional inclusion of hospitals in the community through the DSRIP program will improve coordinated whole-person care, access to care, and help manage costs.

5.4.2. Client Enrollment in the Regional Accountable Entities

To improve onboarding, reduce client confusion, and ensure that clients can quickly benefit from the enhanced delivery system, the State Agency will mandatorily enroll clients into the ACC at the time of Medicaid enrollment. Mandatory enrollment is crucial to the success of this program and to improving the health of Medicaid clients because it will give clients access to the support of their RAE and the provider network immediately upon enrollment. Mandatory enrollment will also improve the continuity and comprehensiveness of client data, which is necessary for effective value-based payment strategies and improving provider performance.

The State Agency feels confident in moving to mandatory enrollment for many reasons. Mandatory enrollment is a logical next step given stakeholder support and the low opt-out rate for the program, which is below five percent. Over the five years of the current contract, growth in program enrollment and scope has been paced deliberately to develop capacity and competencies to serve all Medicaid enrollees. The ACC is the primary delivery system for Medicaid enrollees; if enrollees are not in the ACC, they are often in unmanaged and unsupported fee-for-service, which is sub-optimal for both clients and taxpayers.

5.4.3. Cross-Program and Cross-Agency Alignment

The State Agency is committed to ensuring that the ACC is aligned with internal benefits and with federal, state, and local health improvement efforts in order to maximize impact and minimize redundancies. Requirements for RAEs will also be aligned with the work of the Community Living Advisory Group, which recommends changes to improve and streamline the LTSS delivery system.

With regard to alignment with internal benefits, the State Agency will ensure that Non-Emergent Medical Transportation (NEMT) contracts with vendors will be cross-referenced with requirements in RAE contracts. Similarly, dental administrative service organization contracts will also be cross-referenced with RAE contract requirements. With regard to statewide initiatives and partnerships, areas in which the State Agency will work to create ACC Phase II alignment include:

- Comprehensive Primary Care Initiative (CPC)
- The State Innovation Model (SIM).
- Better Care, Better Costs, Better Colorado ("BC3") and
- The Colorado Opportunity Project

The State Agency's participation in these programs, especially SIM, has and will continue to influence the vision and model development of ACC Phase II. ACC Phase II will also focus on greater coordination with the departments of Human Services, Public Health and Environment, and Corrections. Increased coordination among these agencies will necessitate changes in payment structure and data sharing in order to ensure maximum impact and reductions in redundancies.

6.0. Tools for Transformation: Program Infrastructure

Accountability at all of the levels described above will be supported by program infrastructure including **payment**, **health information technology**, and **sound administration**. These tools are necessary for transformation that may originate either with the State Agency itself, or with the RAE. However, the benefits of this infrastructure will be shared across the system.

6.1. Payment

The first part of the infrastructure underpinning ACC Phase II is payment. Payment is a powerful lever for the State Agency to effect systems change. The next phase of the Accountable Care Collaborative will develop a payment model that is consistent with the three key principles.

- *Person- and Family-Centered*—A central principle of Phase II payment is ensuring that clients identified as needing medical and/or behavioral health services will be able to get them. The assumption is that the existing different payment systems for physical health care services and behavioral health services have become an obstacle to delivering whole-person care. For Phase II, the State Agency seeks to align payment methodologies to facilitate coordinated and comprehensive care. An aligned payment and benefit package may present new opportunities for access and ensure a robust continuum of physical health and behavioral health care from early intervention and prevention to complex care for all clients.
- *Accountable*—In order to achieve greater transparency and increase the State Agency's insight into utilization, the State Agency will transition to paying clinical services directly, to the extent appropriate. This will allow the State Agency to more effectively monitor duplication of services and other potential unwanted uses of state and federal funds. Centralizing payment and other key activities within the State Agency will also maximize State investments in infrastructure, such as the claims payments systems, and promote alignment with other programmatic efforts, such as the State Innovation Model. Additionally, having one Regional Accountable Entity will stimulate administrative efficiencies and promote responsibility for whole-person care.
- *Outcomes Focused and Value-based*—Outcomes focused payment means that payment is tied to value (quality and cost). Payment will be designed to incentivize effective activities at the point of care. In other words, value-based payment will be implemented through incentives and disincentives paid directly to rendering providers. Providers who demonstrate ability to achieve greater outcomes will have greater flexibility, such as incentives, bundles, and other payment methodologies.

Following these guiding principles, the State Agency has designed three major types of payment in ACC Phase II. First, in the Primary Care Case Management System the State Agency is transitioning to value-based payments for behavioral health and physical health services. Behavioral health services for all clients will be reimbursed by the State Agency either for encounters or for services rendered, rather than through capitation. Second, per-member per-month (PMPM) payments for the primary care case management system; these PMPMs include payments to the RAE and from the RAE to Health Teams. Third**,** the State Agency will implement a population-based payment option specifically for highly-integrated systems through an outpatient capitation. To maximize the impact of these payments, they will be aligned with other payment reform efforts, including the State Innovation Model, the Comprehensive Primary Care Initiative, and others.

6.1.1. Shifting from Fee-for-Service to Value-Based Payments

6.1.1.1. Base Payment Changes

The State Agency will continue to move from paying for volume to paying for value by integrating a value component to many fee-for-service payments. The State Agency has already started to make some steps in this direction.

For **overall rates**, the State Agency is forming a stakeholder steering committee to periodically review provider rates. One aspect of this review is identifying high-value services and determining if those services receive appropriate payment. The State Agency has made this change in response to statute passed in 2015.

For **hospital inpatient** payments, the State Agency is moving to integrate additional value-based payment models through the All Patient Refined Diagnosis Related Grouper. Implementation has already allowed for the refinement of the State Agency's Hospital Acquired Condition (HAC) logic and a more accurate neonatal grouper assignment. In the future, the State Agency will pursue payment adjustments for Potentially-Preventable Conditions (PPCs), Potentially-Preventable Readmissions (PPRs), and clinical and/or demographic risk factors.

For **hospital outpatient reimbursement**, the State Agency will use Enhanced Ambulatory Patient Groupings (EAPGs). EAPGs will introduce payments for bundled services to prepare outpatient hospital providers for bundled visits via grouping mechanisms and will move Colorado away from the cost-to-charge reimbursement methodology. New functionality will better align payment with value. After implementing EAPGs in hospital settings, the State Agency wants to explore applying it to other outpatient settings beginning with facility-based settings. In addition, the State Agency is exploring the Delivery System Reform Incentive Program (DSRIP) as a means to promote innovation and efficiency in hospital services.

The State Agency will explore payment changes that support **outpatient practitioners** in providing high-quality and efficient care. The State Agency is considering applying a value payment formula or multiplier to providers' base rates for certain services (or to certain provider types) so that providers are compensated for meeting quality standards and for serving clients who have higher acuity and greater social needs. The quality multiplier could be tied to certain discrete measures relevant for that provider's specialty and updated regularly based on the provider's performance. Then, the service rate could also be multiplied by clinical risk group (or another measure of client acuity), and a social metric culled either from the health and social need screening or another measure such as percentage of federal poverty level.

The State Agency is exploring alternative payment methodologies specifically for **Federally Qualified Health Centers and Community Mental Health Centers** that will drive integration and value while offering these safety net providers flexibility when serving Medicaid clients. Alternative payments may be tied to total cost of care, client health and well-being, and client experience outcomes.

6.1.1.2. Outcomes-Based Payment

The State Agency will continue to tie a greater proportion of administrative PMPM to value and outcomes. The State Agency will utilize a variety of methods for outcomes-based or value-based payments, such as: **Key Performance Indicators (KPIs)**; **competitive pool**; and **shared savings**. Each of these value-based payments presents an opportunity to tie payment to outcomes.

In addition to contract compliance with prescribed interventions, the State Agency will use KPIs to hold the RAE accountable for interim measures or indicators of progress towards the goals around health, value, and client and provider experience. Annually or quarterly, each RAE will be paid based on incentive payments or KPIs based on nine measures. Some of the measures may be composites that include several discrete measures. There will generally be three measures in each of the core Outcome domains: Improved Health, More Value, and Better Experience. The State Agency may shift the proportions of measures for each domain based on availability of robust data. Performance will be measured as a combination of improvement against a regional baseline and comparison to state or national benchmarks. In the RFP, the State Agency will define the incentive strategy (annual changes of measures) for six of those measures for the full course of the contract. Those measures will be designed to ensure the RAE is focusing on the diverse needs of the different Medicaid populations: Adults; Children; and Individuals with Disabilities. By setting different measures for different populations, the State Agency can be person- and family-centered and recognize that there may be different goals for different populations. For example, among the LTSS population, quality of life is an important measure. The remaining three measures (one in each domain), will be selected by the region from a menu of options provided to the RAE as part of the annual contracting process. While the State Agency will monitor and measure a large number of indicators of program performance, stakeholders have indicated that for the measures to be meaningful, a limited number should be tied to payment.

The State Agency will use a competitive pool to drive innovation in an area of particular need or an area in which the program has not been successful to date. This competitive pool will account for a small percent of the administrative PMPM and the measure will be recommended by the ACC Program Improvement Advisory Committee (PIAC). Enabling the PIAC to recommend the measure used will empower and engage stakeholders. In addition, as the recommendations must be grounded in data, it will require that the PIAC be attuned to program performance data, thus putting a public spotlight and greater pressure on the program to perform. The RAEs will be paid on the basis of their relative performance. This model promotes healthy competition among the RAEs on performance in a specific area of statewide concern.

While the KPIs will drive the RAE to invest in those activities that will result in long-term savings, a shared savings program will result in a focus on reducing costs in the short-term. The State Agency will use shared savings to incentivize the RAEs to manage total costs and to ensure reductions in Medicaid expenditures. After program expenses and budgeted savings, the RAEs and participating providers will be eligible for a share of any additional statewide program savings. Eligibility for savings will be based on achieving certain quality thresholds. The State Agency is developing measurements that can be attributed to individual providers to ensure the entities responsible for reducing costs receive the savings. Distribution of these savings among RAEs and providers will be weighted towards providing significant financial incentives to providers. The program parameters, including selected quality metrics, will be communicated prior to implementation. This will allow RAEs and providers time to develop action plans for the measurement periods to reduce costs and allow for maximum savings attributable to their organizations. The shared savings program will be designed to change the long-term trajectory of expenditures, while acknowledging that the program is designed to "phase itself out." In other words, as the system becomes more efficient and there are fewer savings to be shared, the program will be reassessed and redesigned.

6.1.1.3. Reimbursement for Behavioral Health Services

Behavioral health services for all clients will be reimbursed for encounters with CMHCs and FQHCs, or through managed fee-for-service for all other providers. The State Agency will move away from a covered diagnosis model to ensure more robust services for clients with conditions not on the current covered diagnosis list, such as traumatic brain injuries, autism, and developmental disabilities.

6.1.2. Per-member Per-month Payments

The RAE is paid a value-based PMPM payment for each Medicaid client served. The RAE will receive a PMPM payment for all administrative activities such as developing infrastructure, onboarding clients, supporting practices, and managing the network of providers. The RAE will receive tiered PMPM payments tied to RAE performance and to process measures pertaining to management of the network, the provision of care coordination, and similar requirements.

In general, the RAE reimbursement will not be tiered on the basis of client characteristics. In general, the RAE will receive a flat PMPM (the same amount per client), as many of the activities for which the RAE is responsible (such as provider support or facilitating community meetings) are fixed costs. The PMPM will be designed to reflect the cost of administering the program.

However, there will be several discrete populations for whom the RAE will have specific additional contract requirements, and will receive a correspondingly higher PMPM:

- Systems of Care and criminal justice-involved populations: The RAE will have specific care coordination requirements for these populations (intensive wraparound care coordination for Systems of Care, expedited care coordination for those transitioning into the community from Corrections).
- Client Over-Utilization Program: Clients who are excessively or inappropriately using the health care system will be placed in a Client Over-Utilization Program (COUP). The RAE will have additional requirements tied to this population.

The Health Team will receive payment for services rendered from the State Agency and PMPM payments from the RAE. The RAE will be required to use a portion of their PMPM to develop innovative, creative, and targeted PMPM reimbursement methodologies to support Health Teams with over 1,000 attributed clients. These payments will be designed to support Health Teams in providing a medical home level of care and continuing to improve their practice toward higher levels of team-based, coordinated, and integrated care.

Passing payment through the RAE will strengthen the relationship between the RAE and the Health Team members and allow the RAE to align payments with practice support efforts and goals. Within State Agency-defined parameters, the RAE will be able to consider how much funding is a sufficient investment to make an impact, how frequently funds should be provided, and what monitoring is required to ensure that the investments are moving the program to the desired outcomes. The RAE will be more able than the State Agency to tailor their payments to practice needs and adjust their payment methodology as they have new information. The RAE will pay the practice based on its performance rather than the performance of the region in order to strengthen the practice's investment in achieving program outcomes. To ensure that adequate funding is going to PCMPs, the State Agency will approve all RAE Health Team financing strategies.

The PCMP payment methodology will be required to include a value-based purchasing strategy or an incentive program and must align with and support the SIM practice payment components.

6.1.3. Outpatient Professional Capitation

The State Agency will offer a limited number of outpatient capitation programs for health systems that meet certain requirements. In the Outpatient Professional Capitation, the RAE will have another tool to support integration and coordination, especially for integrated systems that have difficulty operating in a fee-for-service environment. If an integrated system is willing and able to take on managed care risk for ambulatory services, the RAE and the system can jointly submit an application to the State Agency to request reimbursement by this methodology. Applying systems should already have a proven track record of service in their communities.

The Outpatient Professional Capitation would enable practices with a foundation of integration the flexibility to provide innovative and cost-effective services. The State Agency would also explore tying a Medical Loss Ratio (MLR) to outcomes so that as a practice is able to achieve outcomes, it would have a larger amount of flexible funding to support innovative activities. In addition, having a standard process and requirements for an Outpatient Professional Capitation would ensure that all of the systems in Colorado who are seeking this type of model would have to meet standard requirements rather than being able to negotiate independently with the State Agency. This standard process and criteria will promote transparency and alignment within the program.

6.2. Health Information Technology

Health Information Technology (HIT) is foundational to every ACC activity in Phase II, from maximizing the use of individual practice Electronic Health Records (EHRs) to leveraging statewide systems. The RAE will be required to support practices in the use of their own internal data. Communities will be provided with data to inform their collective activities. The RAE will be incentivized to capture, provide, and maintain care coordination information, as well as integrate or directly access the State Agency's HIT resources when appropriate.

Recognizing that various community and regional infrastructures exist to facilitate care coordination efforts, RAEs should commit to developing an environment of interoperability and data standards that enable data sharing between entities and with the State Agency.

The RAE will be encouraged to find ways to leverage and better-integrate existing technologies rather than making major HIT investments or overhauls. RAEs 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.

6.2.1. State Agency Infrastructure

The State Agency's Colorado interChange Provider Portal will replace today's SDAC Web Portal and provide a single point of access for program participants to check client eligibility, understand individual client needs and utilization, access enrollment rosters, and assess performance for payment incentives and quality-improvement activities.

The portal will provide access for RAEs, PCMPs, and Health Teams to care management reporting, population health metrics, and a common Provider Performance Assessment (PPA) tool. This tool is intended to:

- Apply the most current nationally adopted quality measures to evaluate effectiveness and manage sub-populations
- Report client compliance rates for specific care, identify gaps in care, and facilitate targeted client interventions
- Enable episode-based analysis of provider performance by capturing all costs associated with a course of treatment
- Create case mix risk adjustment of provider results to offer a fairer comparison of providers against their peers by accounting for both the severity of their patients' illnesses and comorbidities

The emerging State Agency HIT ecosystem will also enable greater data sharing among the Health Team, Health Neighborhood, and the broader community that is not possible in current data systems. Better insight into non-claims and non-medical data in the Provider Portal will exponentially increase the RAE's ability to develop effective strategies to support clients. These data will include:

- State agency data: Colorado Department of Public Health and Environment (Immunizations, and LPHA datasets); Human Services (Foster Care, Child Welfare, Children and Youth with Special Health Care Needs intake data, Division of Youth Corrections data); Corrections; Department of Labor and Employment; Department of Local Affairs and Department of Regulatory Agencies (Division of Housing data, etc.).
- Clinical data via statewide Health Information Exchange.
- Survey assessment data (e.g., Colorado Client Assessment Record [CCAR], Support Intensity Scale [SIS], Long Term Care Eligibility Assessment [ULTC100.2], Systems of Care)
- Health and Social Assessment: Discussed previously, this will include basic information about Medicaid enrollees and their goals; this information will be used to help connect people to the right resources.

6.2.2. State and Regional Health Information Exchange (HIE) Network Infrastructure

RAEs will support practices in efforts to connect electronic health records (EHRs) with regional HIE for exchanging clinical alerts and clinical quality measures (CQM) data. RAEs will encourage new and innovative ways to integrate State Agency data into clinical decision-making and workflow. The RAE will make use of existing telehealth infrastructure and will be encouraged to explore new opportunities for leveraging emerging technology, particularly for home and community-based services.

Additional State HIT investments will promote the emergence of new technologies at the HIE networks to support both RAEs and practices. Monetary incentives for providers that connect to regional Health Information Organizations (such as the Colorado Care Connections Program) will expand to all participating PCMPs rather than just those who meet the current Meaningful Use Medicaid volume requirements. A Medicaid-enabled Personal Health Record (PHR) application at the HIE network will enhance transparency and encourage client engagement through shared decision-making. Medicaid LTSS clients will soon begin piloting this infrastructure through the CMS Testing Experience and Functional Tools (TEFT) demonstration grant.

6.2.3. RAE Infrastructure

The RAE will offer Health Teams a care coordination tool. This tool will be interoperable with the State Agency's Business Intelligence Database Management (BIDM), enabling the two-way exchange of data and the possibility of analytics that leverage the physical, behavioral, and social data in the tool. Basic standardized fields will be required in the tool to facilitate data portability and reporting. Ultimately, this tool will enable all of the members of the Health Team to identify the other individuals serving the client to develop a shared care plan and to provide services in accordance with that plan.

6.3. Sound Administration

Sound administration is necessary to ensure that the ACC Program continues to achieve its goals of improved health, more value, and better experience. The State Agency's commitments to person- and family-centeredness, focus on outcomes and value, accountability at every level of the program, and alignment with other reform efforts are manifest in both **program oversight** and **program maximization**.

6.3.1. Program Oversight

The State Agency will invest in enhanced internal and external oversight of the program. RAEs will be expected to embody the programmatic principles of person- and family-centeredness, operate in an outcomes-focused manner, ensure accountability at every level of the system, and align with other efforts currently underway. To support the RAE in achieving these goals, the State Agency will develop infrastructure that holds the RAE accountable to both the State Agency and its respective community.

Internally, the State Agency will improve contract manager training, expand the number of contract managers, and implement matrix management teams. The matrix team will be led by a higher-level Contract Lead and will include staff from Program (including health programs and LTSS), Data, Finance (rates and/or budget experts), and Quality. In other words, each RAE will be managed by several specialized employees. The vast majority of these staff are existing state staff whose work already intersects with the ACC Program. However, by narrowing each individual's focus to a single region and a single contract and by explicitly designing these teams, each individual can become a subject matter expert able to quickly and skillfully ensure optimal program oversight. Outcomes-based contract language and clear minimum standards will provide these teams with greater ability to ensure performance. Specifically, the contract will add corrective action language and greater specificity around program deliverables including RAE financial reporting. The State Agency will support current staff in becoming experts in Accountable Care Organization management by strategically investing in continuing education.

Additionally, the State Agency will explore the possibility of creating cross-agency partnerships with other agencies. For example, the Office of Behavioral Health, Quality Assurance staff may be able to partner with the State Agency to oversee the program in a way that benefits both agencies.

Externally, the State Agency will leverage interested stakeholders by revising the ACC Program Improvement Advisory Committee to have greater access to RAE performance data and greater ability to direct improvements in the performance of the RAEs. The Committee will be composed of individuals with clinical, research, health plan operations, and customer service expertise, nominated through a robust process and appointed by the State Agency. In addition to the Program Improvement Advisory Committee, monitoring and providing feedback on the ACC will continue to be an important activity of the State Medical Assistance and Services Advisory Council (commonly called NightMAC).

At the local level, the RAE will have enhanced requirements for its own stakeholder process. Specifically, each RAE must facilitate a Consumer Advisory Board to weigh in on issues of importance to the community, focus on client and family experience, and to evaluate RAE communications to ensure they are accessible and clear. Furthermore, each RAE will have a general Advisory Committee with members approved by the State Agency. The RAE will propose the Advisory Committee membership and the State Agency will approve or disapprove the proposed members. This Advisory Committee will include representatives from the community. The Advisory Committee will ensure community buy-in on RAE activities and will support the RAE in developing a broader community network. The Advisory Committee will be provided with high levels of information about RAE activities including financing. To support the Advisory Committee's efficacy, comments from the Advisory Committee may be submitted to the State Agency. To strengthen the relationship between the State Agency and the RAE, the State Agency contract lead will participate in all RAE Advisory Committee meetings.

6.3.2. Program Maximization

Assisting the RAEs in achieving their full potential requires skills and activities that differ from program oversight. The State Agency will explore opportunities to use subject matter experts to analyze and distribute best practices and provide technical assistance to the RAEs and their networks of Health Teams, such as expanding the Utilization Management contract to include this responsibility. These experts can provide national perspective, technical assistance, and specialized research to the RAEs that would be beyond the scope of their in-house expertise. They can assist the State Agency in reviewing a set of program deliverables and identifying strengths and areas of opportunity.

Best practices among the RAEs and their networks will be distributed through learning collaborative meetings among the RAEs, interested provider groups, and other important participants in Colorado's health care system. Topics could include effective care coordination and medical management, data sharing and utilization, effective usage of the BIDM system, legal clarification of regulations, strategies for utilization management, addressing social determinants of health, boosting capacity, and improving performance on key performance indicators.

7.0 Conclusion

This Concept Paper document is just one step in a multi-year conversation around how to reform Colorado Medicaid. As the State Agency receives information from our federal, state, and local partners, the State Agency intends to revise, clarify, and expand upon this concept. The State Agency is eager to work with our partners to take full advantage of this opportunity to make a significant step in reducing costs and improving quality for clients in the ACC program.