COLORADO
Department of Health Care Policy & Financing
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Accountable Care Collaborative Phase III Care Coordination Tiers

June 2025

Overview

The Department of Health Care Policy and Financing (HCPF) administers Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus* (CHP+) and other health care programs for Coloradans who qualify. Created in 2011, the ACC is the primary delivery system for Health First Colorado. Regional Accountable Entities (RAEs) are responsible for promoting member health and well-being by administering the capitated behavioral health benefit, establishing and supporting networks of providers and coordinating medical and community-based services for members in their region. Current contracts with the RAEs, referred to as Phase II, end on June 30, 2025. New contracts, ACC Phase III, will launch July 1, 2025.

Care coordination is the backbone of the ACC. In an increasingly complex health care environment, care coordination is essential to support care access, members' navigation across multiple agencies, and members' quality of life. In Phase III, we are continuing to build on the foundational aspects of the ACC to ensure that care coordination programs within each RAE:

- Are available to all Health First Colorado members.
- Address the full range of members' physical health, behavioral health, oral health and health-related social needs.
- Occur at the point of care whenever possible, with RAEs providing wraparound support as necessary.

As part of the commitment to ensure comprehensive care coordination support is available for members who need it, the following are key features in ACC Phase III:

1. **Increased requirements around care transitions** to support members moving between different agencies and/or levels of care.
2. **Increased emphasis on collaborating with other agencies** (such as community-based organizations, Case Management Agencies, the Behavioral Health Administrative Service Organizations, etc.) to improve outcomes and reduce gaps in care.
3. **Improved monitoring and oversight** of care coordination through deliverables, performance metrics, key performance indicators and a care coordination policy guide.
4. **Consistent three-tier model** applied across all RAE regions and aligned with the Behavioral Health Administration to outline the eligible populations, required activities and monitoring for each tier.

The following page shows the Phase III Care Coordination Tiers. Each column represents the tier level (1, 2 or 3) and the rows represent the different requirement categories for the program. Each category has expectations that span all three tiers.

Phase III Care Coordination Tiers

	Tier 1: Care Navigation	Tier 2: Care Coordination	Tier 3: Care Management
Population	**All members not in other tiers.**	**Members with rising risk:** • Members with rising risk as identified by RAE tools and providers.	**Members with complex needs:** • Highest risk members as identified by RAE tools. • Children/youth eligible for Colorado System of Care.
	Specific contractual requirements for monitoring and oversight of: • Children and youth: Foster care out-of-home placements, emancipation from foster care for up to one year, and complex health needs • Individuals enrolled with Case Management Agencies (those on waivers and receiving home-based services) • Individuals post release from Department of Corrections and Youth Offender System for one year • Individuals identified for Department of Justice At-Risk Diversion and Transition • Maternal health (pre- and post-natal) • Individuals who are unhoused		
Required Activities	Proactive and responsive interventions to assist members in accessing evidence-based preventative care services.	• Interventions to prevent members from requiring higher levels of care. • Care/Treatment plans	• Longitudinal, evidence-based and proven programs involving multidisciplinary care approaches. • Comprehensive Care Plan (unless they are not the lead care coordinating entity).
	• Care Transitions (including inpatient, residential, skilled nursing facility and other acute care settings) • Condition Management (including maternity, diabetes, asthma, hypertension and COPD)		
Monitoring/ Accountability	• Dental visits • Adult screenings • Well child visits • Child/adolescent immunizations	Tracking of: • Care/Treatment plans • Engagement	Performance standards for: • Care plans • Engagement
	• Hospital All-Cause Readmission • Transition of care follow-up appointments • Emergency department visit reduction • Behavioral health discharges		