Accountable Care Collaborative Phase III Concept Paper

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I. Introduction

The Department of Health Care Policy & Financing (HCPF) administers Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus* (CHP+) and other health care programs for Coloradans who qualify. HCPF created the Accountable Care Collaborative (ACC) in 2011 to address its mission to improve health care access and outcomes for Health First Colorado members while demonstrating sound stewardship of financial resources. The ACC was designed with a long-term vision in mind and the understanding that to meet members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system.

The ACC currently features managed care entities, called Regional Accountable Entities (RAEs), operating in seven different regions of the state. The RAEs are responsible for promoting members health and well-being through the administration of HCPF's Capitated Behavioral Health Benefit, the establishment and support of networks of behavioral health and primary care providers, and the regional coordination of medical and community-based services. Current contracts with the RAEs will end on June 30, 2025. We are in the process of designing the next iteration of the ACC, referred to as Phase III, which will begin on July 1, 2025. See the end of this document for a timeline of Phase III activities and ways to provide feedback.

A. Purpose of this Paper

This concept paper provides a high-level summary of policies, programs and operational changes under consideration to evolve the program in ways that pursue our mission to improve equity, access and outcomes for our members, while impacting health care costs in a way that creates value for Colorado. Additionally, these proposals aim to align with the advances of other state agencies, such as the new Behavioral Health Administration (BHA). The concepts outlined in this paper have resulted from and been informed by conversations with stakeholders over the past five years. The design of ACC Phase III is a work in progress that is continuing to evolve as we engage with stakeholders; this paper is an important step in that process.

As we greatly value input from our stakeholders, there will be several opportunities to provide suggestions and feedback over the coming months.

1. Using this feedback form, share your comments for individual sections of this paper.
2. Join one of our upcoming public listening sessions to share feedback with HCPF staff directly. The most updated list of public sessions is on the ACC Phase III Stakeholder Engagement webpage.

As you review the proposals in this paper, we ask that you consider the following questions:

- Which proposals are you most excited about for Phase III?
- Where do you see risks for unintended consequences in our design for ACC Phase III?

B. Context for Phase III

As the Health First Colorado delivery system, ACC Phase III is a critical part of HCPF's efforts to improve care quality, service, equity and affordability. Phase III will incorporate, complement and expand on policies and programs being implemented by HCPF and other state agencies to advance health care throughout Colorado. In particular, Phase III will build on investment in the following innovations and advances:

- **Improving member experience.** The members who participate in our programs are at the center of everything we do. We track several metrics to ensure we're improving their experience and collect real-time feedback from our Member Experience Advisory Council.
- **Improving access to care.** Ensuring members have access to affordable, high-quality care is a key priority. HCPF has supported several initiatives to increase the number of providers that see Health First Colorado members, such as increasing payment rates, providing grant funding to improve rural health care access, leveraging ARPA dollars to increase behavioral health access, and streamlining processes and advancing provider tools to reduce administrative burden. HCPF has also supported legislation to help remove cost barriers for members to access the care they need.

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- **Health equity**. HCPF is dedicated to meeting our organization's mission to improve equity and reduce health disparities. While HCPF is working hard to apply a health equity lens across all our programs and initiatives, we have identified four initial health disparity areas of focus: vaccination rates, maternal care, behavioral health and prevention.
- **Home and community-based care.** The federal American Rescue Plan Act provided HCPF with more than $550 million of stimulus funds to implement lasting transformation for people with disabilities and long-term care needs. Our 63 initiatives enhance, expand and strengthen home and community-based services in Colorado through the end of 2024. This includes $138 million in programs that address behavioral health. At the same time, we have been implementing several Case Management Redesign initiatives, including a new care and case management web-based tool, that will help make accessing and coordinating long-term services and supports easier.
- **Behavioral health**. HCPF is partnering with the BHA and all state agencies to transform the state's behavioral health system and in so doing, improve the system for Health First Colorado members as well. This includes adding new crisis benefits, creating new payment models to increase rates for safety net providers, increasing residential and step-down beds, expanding the provider network, improving transparency and reporting, reducing administrative burden, and catalyzing care coordination.
- **Expanding the health care workforce.** HCPF is part of a multi-agency state effort, with providers, advocates, members, families and workers, to expand and support the health care workforce. The General Assembly approved Health First Colorado rate increases for providers and certain health care workers, including a $15.75 per hour minimum for direct care workers and those working in nursing facilities.
- **Affordability.** Actively and innovatively controlling rising health care costs is critical to protecting Health First Colorado coverage, benefits and provider reimbursements. In pursuit of this important quest, HCPF will continue to evolve innovations in provider and member tools,

value-based payments, hospital and prescription drug cost control advances, health improvement programs, provider cost and quality initiatives, case management, care coordination, and more.

The next iteration of the ACC will build on this existing work to focus on achieving the goals in Figure 1 in alignment with our mission.

Figure 1 – ACC Phase III Goals and Pathways to Success

Designing the next iteration of the ACC provides an important opportunity to make improvements to how services are delivered for Health First Colorado members. We have heard from providers, members, and community partners about the importance of reducing the complexity and administrative burden of delivering and accessing care, a challenge that transcends the U.S. health care system. To reach the goals outlined above, our quest has been to simplify systems, create more consistency and standardization across the program, and centralize some elements of the ACC that would improve the member or provider experience or generate efficiencies.

This concept paper reflects new policies and programs that take advantage of new federal authorities and best practices of other health care models, as well as lessons learned from our partnership with stakeholders over the past five years. While this concept paper includes the stakeholder feedback received over the last five years and more intensely over the last nine months, the proposed changes outlined in this paper are not final. Ultimately, many changes for ACC Phase III will require state and federal approval to achieve our shared vision. Additionally, while many changes will be effective on July 1, 2025, effective date of Phase III, the ACC

program will continue to evolve logically and iteratively through the contracting period.

II. History of the ACC

The state began utilizing managed care entities over 25 years ago through the establishment of Behavioral Health Organizations responsible for promoting optimized mental health and wellness for all members and ensuring delivery of medically necessary mental health and substance use disorder services. The first iteration of the ACC was established in 2011. Regional Care Coordination Organizations were designed to work alongside the Behavioral Health Organizations by supporting the physical health of members through the development of formal contracted networks of primary care medical homes and informal networks of specialists and ancillary providers.

Beginning in July 2018, Phase II of the ACC established the RAEs, which combined the responsibilities of the Regional Care Coordination Organizations and Behavioral Health Organizations under one entity to promote an integrated, whole-person approach to members' physical and behavioral health. As the core of Health First Colorado, RAEs:

- **Provide a regionally responsive approach and oversight to care** particularly for members with chronic and complex health care conditions with needs that span multiple agencies and jurisdictions. As regional organizations, RAEs are expected to understand the nuances among populations in the geographic area they cover to create cohesive provider and community support networks that deliver coordinated, whole-person care that improves health outcomes.
- **Administer the Capitated Behavioral Health Benefit** by maintaining a network of providers and providing or arranging for the delivery of medically necessary mental health and substance use disorder services utilizing a community-based continuum of care that adapts to a member's changing needs and provides appropriate access to care.
- **Contract with and support a network of Primary Care Medical Providers (PCMPs)** to serve as medical homes for members, providing whole-person, coordinated, and culturally competent care. RAEs also provide training and practice transformation support to providers to ensure the delivery of

comprehensive, cost-effective, quality care that improves the member and provider experience.

- **Manage overall administration, data and information, and member access to care and support** by leveraging technology and establishing the infrastructure, tools, and resources that enable the timely and cost-effective delivery of health care services and supports that improve member outcomes.

The ACC is designed to be iterative with the flexibility to adjust and respond to changes in the health care landscape, new opportunities, unforeseen challenges, and regular feedback from stakeholders. The following examples highlight the variety of ways the ACC has been able to evolve to support providers and communities and improve members' health and well-being.

- The RAEs successfully implemented a new inpatient and residential substance use disorder benefit which covered more than 3,600 residential, withdrawal management and intensive outpatient services from January 2021 through March 2022.
- The RAEs and HCPF worked together to expand the behavioral health provider network to include more than 11,300 active behavioral health providers.
- During the COVID-19 pandemic, RAEs were critical in supporting the expansion of telemedicine services to ensure members were still able to access needed care.
- RAEs helped rollout the prescriber tool, which is used by nearly 50% of Health First Colorado prescribers.
- RAEs were key partners in collaborating with providers and community-based organizations to increase COVID-19 vaccination rates and close health disparities measured by race.
- As part of their work to build community supports for members, RAEs make financial investments in community organizations such as community centers, community-based recovery programs, educational programs and local public health agencies. In fiscal year 2021–22, RAEs provided more than $24 million in grants.

- RAEs have worked with justice-involved people to increase their rate of engagement with behavioral health services upon release from the Department of Corrections.
- HCPF collaborated with the RAEs and others to implement the Statewide Standardized Utilization Management (SSUM) Guidelines to be used by all RAEs for residential services provided to members under 21.

Phase III of the ACC will build on these successes to achieve HCPF's mission to improve access, equity and outcomes while driving value for Colorado.

III. ACC Phase III Clinical Quality Strategic Objectives

Phase III of the ACC is our opportunity to set ambitious clinical objectives to improve the health for our members. Specifically, we have identified six strategic clinical objectives that will drive our work throughout the duration of the Phase III contracts.

- Improve follow-up and engagement in treatment for mental health and substance use disorders by 20%.
- Close racial/ethnic disparities for childhood immunizations and well-child visits by 30%.
- Improve care for people with diabetes and hypertension by 50%.
- Achieve national average in preventive screenings.
- Reduce maternal disparity gaps for pregnant Health First Colorado members in the lowest performing populations by 50% to the highest performing population.

Built upon the Centers for Medicare & Medicaid Services' (CMS's) Adult and Child Health Care Quality Measures, these strategic objectives align with and complement many of HCPF's existing efforts, particularly HCPF's Health Equity Plan and the primary care Alternative Payment Model 2. The measures will also align with the Division of Insurance's implementation of House Bill 22-1325, Primary Care Alternative Payment Models. HCPF has chosen these clinical objectives based on current performance and the opportunities for achieving at minimum the national average performance standards. By setting specific targets, we will be able to track our progress on these important initiatives over the seven years of the Phase III RAE contracts, resulting in better care for our members and improvements in members' health.

IV. Payment Structure

To achieve the ACC Clinical Quality Strategic Objectives, HCPF requires a payment model that combines strong accountability for member health outcomes with flexibility for providing care in the manner that best meets the needs of members. HCPF will leverage a variety of aligned payment strategies to best enable RAEs and providers to improve outcomes, reduce disparities and drive affordability in the Health First Colorado program. These payment strategies include:

- Capitated Behavioral Health Benefit to encourage the effective utilization of the full continuum of behavioral health services and to provide the platform and flexibility to address health-related social needs.
- Administrative payments to the RAEs for care coordination, provider support and management of whole-person care including health-related social needs.
- Incentive payments that tie a portion of RAE funding to achieving established outcome targets associated with the ACC Clinical Quality Strategic Objectives as well as other HCPF and state priorities.
- Alternative payment models for providers that enable them to earn additional funding in a flexible manner while being held accountable for improvements in member health outcomes. Enable flexibility in responding to emerging federal targets, currently established at achieving 50% of Health First Colorado payments in the form of value-based payments by 2030.
- Shared Savings resulting from RAE successful support of providers participating in the Primary Care Alternative Payment Model 2.
- Leverage and advance current efforts in the areas of hospital transformation program, prescription drug and nursing home value-based payments.

A. Capitated Behavioral Health Benefit

Since 1995, Colorado has leveraged a managed care behavioral health program to promote the growth of a continuum of services for people with mental illness and substance use disorders. This risk-based payment model has historically enabled members to receive the majority of their services in the community, reduced utilization of more restrictive inpatient

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settings, and provided wraparound services and social supports that are difficult to cover in a fee-for-service arrangement. Because of the flexibility of this model, HCPF will retain the Capitated Behavioral Health Benefit for Phase III. This provides a solid and more sustainable framework in which we can partner with the BHA in transforming behavioral health in Colorado.

At the same time, HCPF has been listening to providers and members over the past few years and is recommending critical improvements in the administration and oversight of the capitation model to address many of the concerns and opportunities that have been raised. Table 1 identifies some of the more frequent feedback we have received along with our proposed changes. Many of these policies will be described in more depth throughout this concept paper.

Table 1: Recurring Feedback of the Capitated Behavioral Health Benefit and Proposed Solutions

Recurring Feedback	Contract, Program, or Policy Options
Concerns that payment rates vary by RAE.	• Create a minimum fee schedule for select services that require directed payments to build and support access. • Change rates for Federally Qualified Health Centers, Comprehensive Safety Net Providers, and Essential Safety Net Providers so they are set differently from the minimum fee schedule to reflect expanded responsibilities and state and federal regulations.
Concerns that payment rates are not transparent.	• Make public a minimum fee schedule for directed payments. • Follow federal changes to managed care regulations regarding rate transparency.
Concerns that utilization management practices vary by RAE.	• Increase use of standard assessment and utilization management tools for higher cost services. • Use independent assessments to determine medical necessity for higher cost services for youth and children. • Increase application of standardized tools for utilization management in fee-for-service behavioral health services.
Concerns that contracting with multiple RAEs creates administrative burden for providers.	• Reduce the number of RAEs. • Centralize provider credentialing. • Require the use of universal contracting provisions developed in collaboration with the BHA.

Recurring Feedback	Contract, Program, or Policy Options
Concerns that more costly services are not always adequately reimbursed.	• Require directed payments for critical services. • Enhance payments for Essential Safety Net Providers that serve priority populations.
Concerns that high acuity services are not included under the RAE's capitation responsibilities (e.g., substance use disorder emergency department visits, cirrhosis, foster care).	• Ensure youth in foster care are covered equitably under the Capitated Behavioral Health Benefit. • Develop a review process for hospitalization codes associated with behavioral health to ensure behavioral health hospitalizations are represented in data and financing. • Explore amendments to 1115 waiver for additional services for individuals with serious mental illness.
Concerns that RAEs may be limiting access to care.	• Publish data on RAE authorizations and denials of services through a utilization management dashboard. • Publish BHA performance metrics.
Concerns that delays in receipt of claims and outcomes data challenge HCPF's ability to appropriately monitor RAEs.	• Require RAEs to submit claims into interChange monthly. • Establish meaningful and actionable data reporting. • Improve quality reporting by using national outcome measures and benchmarks.
Concerns that there are delays in access to care, especially for children.	• Add requirements for new children's intensive case management program, including independent assessments for medical necessity. • Require the use of standardized assessments for authorizing residential care and intensive outpatient care.
Concerns that RAEs are not meeting contractual requirements (with HCPF or with providers).	• Add penalties for contract non-compliance. • Add BHA-led universal contracting provisions. • Add clearer, more prescriptive contract language for certain RAE functions. • Create clearer, more meaningful deliverables that streamline reporting requirements.
Concerns that RAEs will stay aligned with Behavioral Health Administrative Service Organizations (BHASOs).	• Create contract and fiscal flexibilities to ensure RAEs pursue the current 19 state established behavioral health priorities, as well as newly emerging priorities, in collaboration with the BHASO. • Work with the BHA to ensure alignment, efficiencies, and coordination between the RAEs and the BHASOs as appropriate.

HCPF will continue to monitor RAE performance, along with member and provider grievances, to identify opportunities for improvements in the administration of the Capitated Behavioral Health Benefit. In combination with CMS's efforts to continually evolve managed care regulations, HCPF expects to provide a cost-effective behavioral health benefit that continually improves in its responsiveness to member and provider needs.

B. Administrative Payment to the RAEs

We will continue to distribute an Administrative Per-Member Per-Month (PMPM) payment to the RAEs to operate the ACC, primarily as it relates to managing members' physical health services and ensuring whole-person care. This non-risk-based, monthly payment funds significant activities for the RAE, such as:

- Maintaining and financially supporting a network of PCMPs to be accountable for member well-being and improving member health outcomes.
- Providing data, trainings, education, and other tools and resources to help providers in delivering evidence-based, cost-effective, culturally responsive care, while propelling participation in alternative payment models.
- Ensuring care coordination is available to members either at the provider level or through the RAEs, particularly for those members with chronic health conditions and complex needs.
- Providing health improvement, case management and affordability programs as directed by HCPF, including building upon the current prenatal, diabetes and complex case management services.
- Assisting member access to local networks of health care providers and community-based organizations.
- Addressing the health-related social needs of members and reducing health disparities in their regions.

RAEs will be expected to distribute a portion of their Administrative PMPM payments to their PCMP network for collaborating with the RAEs to achieve ACC program goals and for providing delegated care coordination or health improvement program services to members. RAEs will tier their payments

to PCMPs based on their capacity to deliver advanced team-based care, such as proactive population health management, health improvement programs, and effective coordination of behavioral health and physical health care. A modernized factor that will significantly influence PCMP payments is a medical acuity adjustment for alternative payment models. This will increase payments to more appropriately compensate PCMPs for managing the medical needs of our most complex members, including those with disabilities.

RAEs will also be encouraged to distribute additional payments to community-based organizations and other providers within the health neighborhood to meet members where they are and to address the full range of members' medical and health-related social needs.

C. RAE and PCMP Incentive Payment Program

HCPF will continue to leverage performance-based payments to hold the RAEs accountable for their and their provider networks' performance in achieving quality and affordability measures. The majority of incentive payments will be linked to the ACC Clinical Quality Strategic Objectives in order to drive progress on those targets. Additional metrics may be chosen to meet federal or state statute requirements and/or to incentivize critical improvements in health care networks and the delivery of care. Where appropriate, incentive payments will be distributed quarterly. HCPF will also continue to leverage funds not earned by the RAEs to promote health-related state priorities, similar to how HCPF leveraged funds during the COVID-19 public health emergency to support providers and increase vaccination uptake.

HCPF will choose performance measures that align with strategic objectives from the CMS Adult and Child Health Care Quality Measure set to the greatest extent possible. Incentive measures under consideration are outlined in Table 2.

Table 2 - Proposed Incentive Payment Measures for ACC Phase III

Phase III Strategic Objective	Proposed Incentive Payment Measures
Improve follow-up and engagement in treatment for mental health and substance use disorders by 20%.	• Follow-up after hospitalization for mental illness (7 days). • Follow-up after emergency department visit for alcohol and other drug abuse or dependency (7 days). • Initiation and engagement of substance use disorder treatment.
Close racial/ethnic disparities for childhood immunizations and well-child visits by 30%.	• Childhood immunization status combo 10. • Immunizations for adolescents combo 2. • Well-child visits in the first 30 months of life (0-15 months, 15-30 months). • Child and adolescent well-care visits. • Oral evaluation, dental services.
Improve care for people with diabetes and hypertension by 50%.	• Hemoglobin A1c Control for patients with diabetes • Controlling high blood pressure.
Achieve national average in preventive screenings.	• Screening for depression and follow-up plan. • Breast cancer screening. • Colorectal cancer screening. • Cervical cancer screening. • Chlamydia screening in women. • Contraceptive care for all women.
Reduce maternal disparity gaps for pregnant members in the lowest performing populations by 50% to the highest performing population.	• Timeliness of prenatal care. • Postpartum care. • Contraceptive care for postpartum women.
Measure for fiscal stewardship objective under development.	• Plan all-cause readmissions. • Ambulatory care: emergency department visits. • Transitions of care. • Shared savings goals.

Performance measures are being chosen in alignment with other federal and state quality payment models in an effort to reduce administrative burden and enable providers to focus on similar targets across multiple payers. This includes partnering with the BHA as we evolve payment for behavioral health services, aligning with the Division of Insurance's implementation of House Bill 22-1325 Primary Care Alternative Payment models and partnering on the Center for Medicare and Medicaid Innovation's (CMMI's) Making Care Primary model. HCPF is advancing cost and quality provider measures through emerging technology, such as

eConsults, to maximize primary care performance and referral impact. All metrics will be based on available data and updated in final contracts to reflect reasonable and achievable targets.

In addition to the RAE incentive measures listed above, the RAEs will be expected to pay PCMPs directly for their performance on incentive metrics, including those from APMs as noted in the next section. The intent is to provide a streamlined incentive structure for PCMPs that recognizes the supporting role the RAE performs. Lastly, the RAEs will be accountable for improving the region's performance on all CMS Adult and Child Health Care Quality Measure set.

D. Alternative Payment Models for Providers

CMS has set targets to have 50% of HCPF's Health First Colorado payments in the form of value-based payments by 2025 and the vast majority of Health First Colorado beneficiaries enrolled in accountable care arrangements by 2030. HCPF is supporting this target through the implementation of alternative payment models (APMs) for our providers that prioritize value over volume.

Colorado is partnering with CMMI on their Medicare payment reform initiative, Making Care Primary to encourage participation in a primary care alternative payment model and to reduce the administrative burden for providers. HCPF is working closely with both CMMI and the Colorado Division of Insurance on primary care payment reform, to align our Health First Colorado payment strategies and performance measures with other payers. Aligning payment models across markets, including Medicare, Health First Colorado and commercial insurance, is a crucial step in improving quality of care, health equity and health outcomes. Such collaboration across major payer segments will further differentiate Colorado from other states to the betterment of quality outcomes and affordability for all Coloradans.

RAEs will be critical to the success of providers participating in more advanced models of payment outside of the Capitated Behavioral Health Benefit. RAEs will be expected to provide practice transformation support for PCMPs participating in APMs, in addition to the improvement work done

at the health neighborhood level. At the same time, RAEs will be responsible for continuing to evolve payment for behavioral health services covered under the Capitated Behavioral Health Benefit in collaboration with providers and the BHA. ACC Phase III will be designed to complement the following current and planned alternative payment programs:

- **APM 2** is an existing HCPF program where participating providers may choose to receive some or all their revenue as PMPM payments to provide stable revenue and allow for increased investment in care improvement. With the passage of the state fiscal year 2023-2024 Long Bill, providers participating in APM 2 will be eligible to receive 100% of the Medicare rates for services covered under the model. They are also eligible to share in the savings that result from improved chronic care management by meeting episode cost reduction targets. Federally Qualified Health Centers are eligible to participate in a modified version of this program that accommodates federal payment requirements for these entities, advanced through the collaborative evolution of these APMs through Phase III.
- **Payment Alternatives for Colorado Kids (PACK)** is an APM tailored to the provision of pediatric primary care that is currently in development. While HCPF has rolled out primary care APMs over the past several years, we've heard from the pediatric stakeholder community that adult-focused quality and payment models do not meet the needs of and capture the hard work of pediatric primary care providers across the state. This APM is intended to address the unique circumstances of pediatric primary care by incentivizing quality care specific to the pediatric population.
- **Maternity Bundled Payment Program** is HCPF's first episode-based payment program that continues to support the transition from traditional fee-for-service payments to value-based payments. This program aims to raise the quality and lower the cost of maternal care, while advancing maternal health equity, and will cover all prenatal, labor and delivery, and postpartum care for Health First Colorado pregnant and birthing parents. Eligible providers participating in this voluntary program may receive incentive payments depending on their ability to manage the cost of each episode. These incentive payments

allow providers to make choices about care delivery and related investments to improve quality and health equity outcomes.

- **Behavioral Health APMs** are being designed in collaboration with the BHA to support the implementation and sustainability of new behavioral health safety net providers throughout the state. For Comprehensive Safety Net Providers that will be accountable for delivering the greatest range of services for members, HCPF has designed a cost-based, prospective payment model. This funding arrangement is designed to ensure that Comprehensive Safety Net Providers can provide the full continuum of services to members, even those services that may not be used frequently but are considered essential treatment models, especially for those diagnosed with serious mental illness. Additionally, the state is working to develop alternative payment models for Essential Safety Net Providers that are licensed to provide a more limited scope of services critical to the statewide behavioral health network compared to Comprehensive Safety Net Providers, but still meet BHA standards and serve priority populations.
- **Prescriber Tool APM** incentivizes use of the Real Time Benefits Inquiry (RTBI) module to promote Health First Colorado pharmacy benefit compliance and cost efficiency in pharmacy utilization. The RTBI tool reduces administrative burden by providing real time Preferred Drug List information for prescribers and electronic prior authorizations. The RTBI tool also includes an Opioid Misuse Risk Module, which supports risk reduction for members who are prescribed opioids. This APM is expected to go live by January 2024.
- **Member Incentives** are a form of alternate payment methodology or value-based payment that rewards members for engaging in Health First Colorado in ways that assist providers, RAEs, and HCPF in achieving shared equity, outcome and affordability goals. Phase III is intended to incorporate and evolve member incentives into the ACC program.

HCPF has a number of delivery system advances under construction to propel the achievement of HCPF's mission to improve equity, outcomes and affordability. This includes the release of eConsults, cost and quality indicators for Health First Colorado providers and APMs that reward both

referring providers and outcomes driven by higher performing providers identified within the Health First Colorado provider network. In addition, Phase II of the Prescriber Tool, sometimes referred to as the Social Health Information Exchange (SHIE), will enable physicians, nurse practitioners and others to prescribe health improvement programs such as a prenatal program or diabetes management program or a health-related social needs program such as Supplemental Nutrition Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Community support organizations will also be able to use the SHIE to support Health First Colorado members in accessing programs addressing health-related social needs, in collaboration with the RAEs.

E. Shared Savings

In addition to the incentive payments described previously, RAEs will be eligible to earn a percentage of shared savings generated from APM 2 based on their support of PCMPs in achieving performance metric targets and their action to reduce unnecessary costs in their region. HCPF recognizes the valuable role RAEs perform in the health neighborhood with coordinating care, creating and using actionable data analytics, recruiting providers, and strengthening the connections between primary care, specialty care, and tertiary care. As a result, we are pursuing how RAEs may share a percentage of the available APM 2 shared savings that were previously retained by HCPF and distributed to PCMPs.

V. Accountable Care Collaborative Structure and Tools

The ACC was designed with the premise that regional entities are best able to invest in community infrastructure that supports care teams and care coordination to effectively identify and address member needs and to deliver efficient health care. This regional framework will continue to be foundational for Phase III, but with some important changes to address reported challenges, achieve HCPF's goal of simplifying systems, and advance the evolution of health care in areas like health-related social needs and prevention.

A. RAE Regions

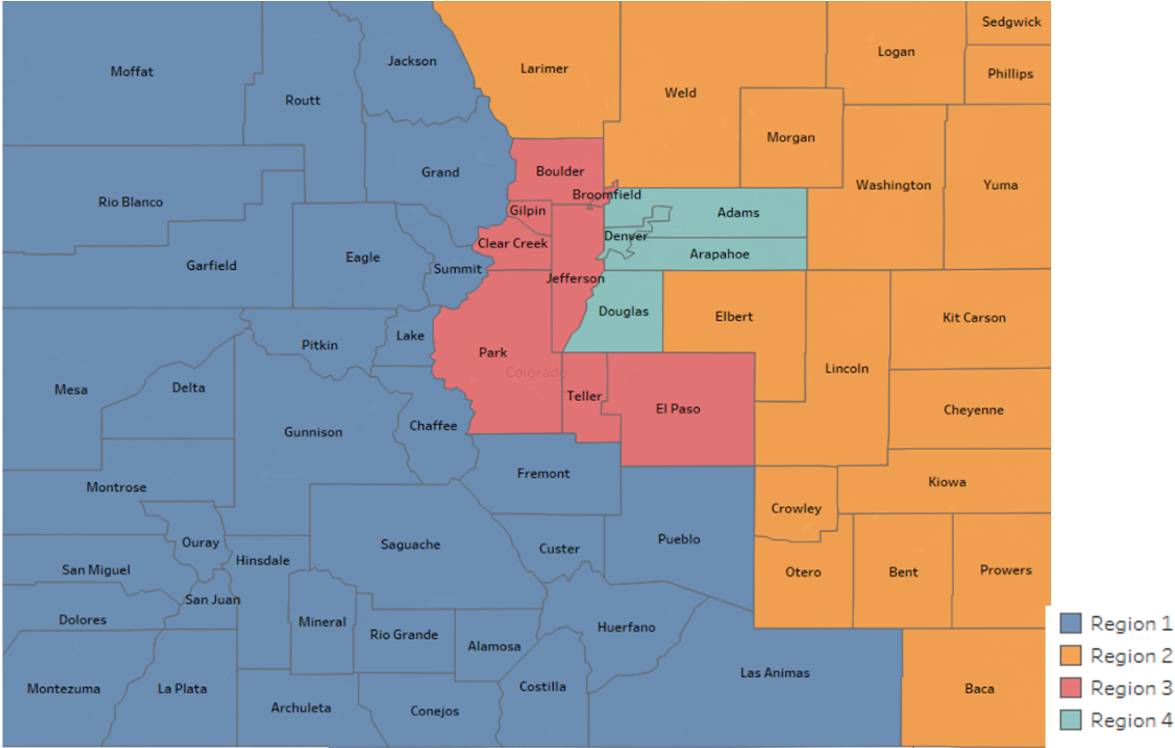
HCPF is proposing a four-region model for Phase III. We believe this will ensure appropriate and sustainable investment in regional infrastructure

and will better leverage efficiencies of the RAEs, while also enabling RAEs to meet the unique needs of the various communities within the regional boundaries. This change will also partly address the challenges providers have reported as they navigate variations in contracting, reimbursement rates, performance measurement and utilization management processes between the current seven regions. Larger populations will provide RAEs with the economies of scale necessary to meet HCPF contractual requirements. Having fewer RAE regions, along with other proposed changes to standardize utilization management and centralize credentialing, is designed to reduce the administrative burden on providers.

As part of HCPF's collaboration with the BHA and alignment with their creation of the new Behavioral Health Administrative Service Organizations (BHASOs), HCPF participated in several engagement activities with stakeholders during the first half of calendar year 2023 to discuss potential regional models. We received valuable feedback regarding specific county placement within proposals for two and three region models, and reservations about the imbalanced population sizes of a three-region model. The new four-region model creates more balanced populations for the regions and seeks to leverage vendor expertise in serving urban, rural, and frontier counties. The intent is to continue to work with the BHA to align RAE and BHASO regions where practical.

Figure 2 shows the most recent map proposal as of June 21, 2023. Region 1 (in dark blue) covers the western and much of the southern side of the state, Region 2 (in orange) covers the eastern side of the state, Region 3 (in red) covers the western Denver Metro area, including south through Teller and El Paso counties, and Region 4 (in light blue) covers the eastern Denver Metro area.

Figure 2 - Four Region Proposal for ACC Phase III, update June 21, 2023



We also heard from our stakeholders about the importance of maintaining the regional and localized approach to care, especially for those in rural areas, that we have established over the past two iterations of this program. As regional organizations, RAEs are expected to understand the nuances among populations in the geographic area they cover. They are also expected to develop a network of trusted, local providers and community organizations so that they are serving members in ways that are most comfortable for them or better suited to provider core competencies while coordinating health-related social needs. By creating the regions above, we hope to group the different areas of the state in a way that allows organizations with expertise serving urban, rural and frontier populations to act as RAEs. HCPF will also actively work with RAEs to ensure that they maintain a localized focus to address the unique needs of all their communities by including specific programmatic considerations and responsibilities within the contracts.

B. Managed Care Organizations

In the ACC, most physical health care is delivered and billed as fee-for-service. However, two physical health managed care capitation plans are currently used in the ACC under state authority C.R.S. 25.5-5-415: Rocky Mountain Health Plans (RMHP) Prime and Denver Health Medicaid Choice. RMHP Prime is operated as part of the Region 1 RAE contract with HCPF. HCPF contracts directly with Denver Health, which delivers physical health care and partners with the RAE in Denver County to administer the behavioral health benefit. Both initiatives are designed to integrate behavioral health and physical health services for enrolled members.

To support continuity of care for members, HCPF intends to offer the managed care organization operated by or under the control of Denver Health and Hospital Authority, created pursuant to article 29 of title 25, the option to continue operating a physical health managed care capitation plan as part of ACC Phase III. The physical health managed care capitation plan currently operated by RMHP Prime will need to be officially procured as part of the Region 1 procurement process for Phase III. The ACC Phase III Request for Proposal process will allow offerors for the Region 1 contract to propose a limited managed care capitation initiative for the current RMHP Prime counties. The addition of children to the current RMHP Prime agreement is also under consideration. Under C.R.S. 25.5-5-415 and the current federal authority, HCPF is not able to guarantee continuation of the existing RMHP Prime contract as the authority is tied to a particular awardee, not a region.

C. Member Enrollment and Attribution

For Phase III, HCPF will continue to automatically enroll all full-benefit Health First Colorado members, excluding those enrolled in the Program for All-Inclusive Care for the Elderly (PACE), into the ACC. In addition, HCPF will comply with House Bill 22-1289 requirements for Cover All Coloradans and enroll into the ACC anyone not eligible for Health First Colorado who is eligible for state-funded health and medical care.

Attribution, the process by which members are assigned to a RAE and associated to a provider that serves as a focal point of care, is being

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modified in response to stakeholder feedback and as part of the ongoing effort to improve the accuracy of these assignments. The changes outlined below are intended to simplify the attribution process for providers, while incentivizing both providers and RAEs to better engage with members. These changes are also designed to better support providers participating in alternative payment models as attribution should more accurately reflect members' current and active engagement in care. Members will always be able to choose their preferred provider and they may change that selection at any time.

Members will be assigned to a RAE in one of two ways.

1. Members who have established a relationship with a provider, either by choice or through a history of utilization, will be attributed to the provider who can serve as their focal point of care, referred to as a PCMP within the ACC. Based on the location of a member’s PCMP, the member will be assigned to the RAE region where that practice site is located.
2. Members who do not have an established relationship with a PCMP and have not chosen a PCMP will be assigned to the RAE covering the member’s home address.
    a. For members who are utilizing health services, the RAE will be responsible for supporting the member in establishing care with a PCMP.
    b. For members who are not utilizing health services, the RAE will be responsible for promoting members’ engagement in preventive services.

Additional changes under consideration include:

- Allowing certain behavioral health providers, likely Comprehensive Safety Net Providers and those offering integrated physical health services, to serve as a PCMP for individuals with serious mental illness who almost exclusively utilize behavioral health services.
- Attributing members to a PCMP based on their two most recent PCMP visits in the past 18 months to better reflect a member’s current care

patterns. This should result in more timely updates to a member's attribution, particularly when a member moves.

- Improving communication to members about PCMP attribution and increasing transparency of the attribution process for providers.

The Administrative PMPM payment to the RAEs will be distributed by HCPF based on the members assigned to the RAE. As previously mentioned, RAEs will continue to be responsible for distributing a portion of the Administrative PMPM to PCMPs based on the members attributed to the PCMP. We will continue to partner with RAEs and providers to identify appropriate factors or variables that determine the payment amount by PCMP. This may include variables that reflect member acuity/risk score, delegated responsibilities such as care coordination or delivery of programs in complement to payments that reflect quality, equity, access, affordability and related outcomes. Both the RAE and PCMPs will be responsible for coordinating care for their members and will be held accountable for performance using the RAE and PCMP Incentive Payment Program and other metrics.

D. Provider Tools and Resources

Care providers are critical partners in achieving Phase III goals of improving equity, access, outcomes and affordability while improving the member experience. Accordingly, HCPF is investing in and rolling out innovative tools to meet the goals of Phase III of the ACC. Such tools are financed by the federal government in its support of achieving these goals, at a 90% match in development and design efforts and at 75% from a maintenance perspective. Accordingly, HCPF is continuing to invest in and advance tools that help reduce the administrative burden for providers, improve the member experience and provide the insights and infrastructure necessary to achieve shared equity, outcomes and affordability goals. RAEs and provider partners are expected to increase the adoption and utilization of the following tools as such tools evolve:

- Phase 1 of the **Prescriber Tool** (already in place) is important for improving prescription drug affordability, improving patient health, driving appropriate opioid use, and reducing administrative burden for providers. This tool allows providers to send prescriptions

electronically to pharmacies, receive real-time, transparent pricing hierarchy insights related to the medications they're prescribing. This tool also simplifies and automates the authorization process making it easier for providers to see and treat Health First Colorado members. The OpiSafe module of the Prescriber Tool was implemented in January 2021 to mitigate over prescribing of addictive opioid and benzodiazepines narcotics to Health First Colorado members (and all Coloradans) thereby reducing addiction and its consequences. The Real Time Benefit Inquiry Affordability module, implemented in June 2021, creates transparency into the hierarchy of medicinal prices while easing provider burden in prescribing to Health First Colorado, as well as commercial, members.

- The **Social Health Information Exchange** (SHIE), or Phase II of the Prescriber Tool, is being developed in collaboration with the Office of eHealth Innovation and is expected to be live before the launch of Phase III in 2025. This tool is a platform to help providers connect and refer their patients to health improvement programs available in the Health First Colorado program (e.g., diabetes condition management or prenatal care) as well as health-related social need supports available in the member's local community, such as housing supports or food banks. State-based programs will be identifiable to providers, enabling them to recommend such programs to their Health First Colorado patients as appropriate (e.g., SNAP for a patient with diabetes, etc.). All such features available through the tool will enable Health First Colorado to significantly advance care delivery priorities towards prevention, health-related social needs and whole-person care. Community by community, local health-related social needs support programs will be identified and accessible through this tool. In addition to RAEs and health care providers, this tool will be available to Case Management Agencies and other community organizations.
- **Facility Cost & Quality Indicators** is an ongoing project to provide Health First Colorado members with information about the quality of care and patient experience at hospitals and other health care facilities so that they can make the most informed decision about where to access their care. HCPF is exploring how to make this

information easily accessible to members through the Find-a-Doctor tool and to provide referrals to the highest performing facilities. Concurrently, HCPF has selected a vendor partner through a thorough Request for Proposal process to support price transparency for a variety of services and procedures where members and providers can leverage such insights, such as colonoscopies, maternal care and deliveries, and orthopedic procedures. Such cost and quality indicators will be provided to PCMPs and across the continuum so that all providers and stakeholders can leverage time-tested and proven performance insights to drive referrals and care to higher preforming providers in a way that improves health equity, closes disparities and improves affordability within the Health First Colorado program.

- **eConsult** is a tool that facilitates e-communications between a Health First Colorado member's PCMP and a specialist to expand specialist care at the primary care practice. This helps PCMPs in providing more care at the primary care level, accordingly reducing appointment "no shows" at the specialist level and improving member equity, access and outcomes. The tool also helps PCMPs make informed decisions about when it may be appropriate to refer a member to a specialist and helps them leverage cost and quality indicators designed to improve member equity and close disparities by referring members to higher performing providers. This tool is under development and expected to go-live in 2024, prior to Phase III.

VI. Health Equity

In 2020, HCPF emphasized the importance of focusing on health equity by incorporating it into our mission statement: to improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado. As such, reducing disparities and advancing health equity is a foundational aspect of the ACC and will be a core component of Phase III program design.

Disparities in access to care and health outcomes persist within the Health First Colorado membership. While current RAEs have made efforts towards addressing these disparities, we have the opportunity to standardize and set stronger expectations for this work in Phase III. We have also heard from our

stakeholders, including Health First Colorado members, that advancing health equity should be a central component of ACC Phase III. Given that feedback, and our HCPF-wide commitment to health equity, we are proposing the following strategies to address health equity while also incorporating this focus into the other initiatives we are pursuing.

- **Health equity plan:** RAEs will be required to submit health equity plans, in alignment with HCPF's health equity plan, that identify the unique disparities members face in their region and local communities, while developing specific interventions to address those disparities. We are also exploring options to increase transparency around the plans that RAEs have developed and their progress against those plans and achieving established goals.
- **Equity key personnel position:** RAEs will be required to have a lead staff member who is accountable for their health equity work and serves as the point-of-contact for their organization. Exact requirements for this role are still under development.
- **Health equity trainings:** RAE staff will be required to complete annual Equity, Diversity, Inclusion, and Accessibility (EDIA) trainings to ensure the cultural competency, including disability competency, of staff, and to ensure they are providing culturally responsive services and business practices at all levels of the agency. We are also exploring what role the RAEs should have in supporting providers with EDIA training and support services without duplicating existing practice activities. HCPF is committed to partnering with RAEs to provide trainings and resources as necessary.
- **Equity-focused metrics:** Outlined previously in the ACC Clinical Quality Strategic Objectives and Incentive Performance Program sections, we are setting equity-focused goals aimed at reducing health disparities across regions for the duration of the Phase III contracts. HCPF will be evaluating a wide variety of performance metrics for priority populations to continually monitor for disparities and identify interventions.
- **Equity taskforce:** RAEs will be required to create their own task force of internal staff, community partners, providers, and members, including members with disabilities, to discuss equity and disparity issues within their region. Activities for this task force will be included in the health equity plan deliverable.

- **Navigation program:** Detailed further in our Care Coordination section to follow, RAEs will be directed to build a network of community-based organizations with local staff acting as navigators to support members. The goal is to invest in local, trusted organizations who serve historically marginalized groups to ensure we are connecting with members in the places they are most comfortable.
- **Advancing Phase II of the Prescriber Tool.** Like with Phase I of the Prescriber Tool, RAEs will be required to drive provider adoption of Phase II of the Prescriber Tool, or SHIE. This tool will help physicians, nurse practitioners and others prescribe health improvement programs like prenatal or diabetes management, as well as health-related social needs supports like SNAP. Community partners will also be able to use the tool to better coordinate these supports for Health First Colorado members. The evolution of this tool and its use will be critical to achieving shared goals in the areas of improving health outcomes, improving health equity, and reducing health disparities.
- **Cost and Quality Indicators and Alternate Payment Methodologies.** To improve health equity and close disparities, it is critical to identify and create awareness around providers who are achieving those shared goals and to advance tools and referral capabilities that make this process easier on referring providers. Directing care to higher performing providers and rewarding those results through value-based payments at all levels, the RAE, the referring PCMPs, and higher performing providers, will be a critical component of Phase III to improve quality outcomes and equity while reducing disparities.

VII. Improving Member Experience

Our primary focus is to ensure that Health First Colorado members can access the care they need, when they need it, while ensuring they have a positive experience. We recognize the complexity of the health care system and have received significant feedback from members about the challenges of self-navigating between HCPF, counties, the RAEs, providers, the Enrollment Broker, and our multiple online systems and portals. Specifically, members have shared that they have limited knowledge of their RAE or how the RAE can help members. Members have also shared that standardizing and centralizing

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the information they receive, especially for newly enrolled members, could help make the system easier to navigate.

HCPF is exploring strategies to simplify and improve the technology and communication used to reach members. HCPF may lead some initiatives in collaboration with RAEs, such as standardizing communications campaigns to minimize duplication or creating a more seamless experience for members calling for assistance by establishing HCPF's member call line as the initial contact for all members. Other initiatives being explored would create more defined standards for RAEs around expected follow-up time to address new members' immediate health needs and supporting providers in meeting language access requirements.

In addition to simplifying communication, we also aim to increase how RAEs engage with the members in their region for Phase III. All RAEs will be required to establish their own Member Advisory Council and host regular meetings, with guidance from HCPF on meeting structure and recruitment standards, among other requirements. RAEs will be required to test certain member communications in English and Spanish with their advisory councils to ensure they are creating clear, appropriate messaging. RAEs may also be asked to participate in regular meetings with HCPF specifically to discuss work being completed with their advisory councils.

To improve RAE awareness of members in need, Phase III will create avenues for earlier member engagement closer to or during the member enrollment or renewal process. This will build, maintain and improve member awareness of RAE supports available to members so that access is readily facilitated when the need arises, thereby improving the member experience and the effectiveness of RAEs overall.

A. Long-Term Services and Supports (LTSS)

Colorado's system of Long-Term Services and Supports (LTSS) provides comprehensive services to people with many types of long-term care needs, including those with physical disabilities, serious mental illness, and developmental and/or intellectual disabilities. The LTSS system works to support members in the least restrictive setting possible and leverages waivers with CMS to provide eligible members with home and community-

based services (HCBS) that include personal care services, access to alternative care facilities, home modifications, and adult day programs. HCBS programs are authorized and organized by Case Management Agencies (CMAs) contracted with HCPF.

We have received feedback from members and advocates that CMAs and RAEs have an opportunity to better coordinate their efforts in serving Health First Colorado LTSS members. Phase III will endeavor to dramatically improve communications and alignments among these organizations within shared regions to the betterment of the member experience, quality outcomes, and health equity. This is an important aspect of care coordination changes proposed later in this document.

In 2021, HCPF was awarded more than $550M in American Rescue Plan Act (ARPA) dollars from the federal government to enhance, expand, and strengthen HCBS in Colorado. These services encompass critical supports to help older adults, people with disabilities, and people with behavioral health needs live and thrive in their communities. In collaboration with stakeholders, HCPF identified 63 projects focused on improving access by expanding availability of services, increasing wages for frontline workers, streamlining processes, and enhancing quality of care for members and their families. Of the total ARPA funding awarded to HCPF, $138M has been prioritized for programs that improve services and access for individuals with mental health and substance use disorders.

Building on lessons learned through the ARPA-funded projects and in response to stakeholder feedback, there are several initiatives under consideration to better support members utilizing these services as part of ACC Phase III. We are considering requiring training for RAE staff to improve their competency in working with members with a wide range of abilities. RAEs will also be expected to support providers in receiving these trainings as part of their practice transformation efforts. We are also pursuing the capacity to track denials of care for HCBS members to ensure they are being treated appropriately at both the RAE and provider levels, as well as evaluating the payment models used for intellectual and developmental disabilities diagnoses.

HCPF is continuing to engage in cross-office collaboration to address barriers and services gaps for people with disabilities needing access to behavioral health services and assistance coordinating care. Currently, we are working to provide more guidelines and standardization to the RAEs and providers around the behavioral health diagnostic tools and treatment for members with intellectual and developmental disabilities, dual diagnoses, and other special considerations.

B. Members Enrolled in Dual Eligible Special Needs Plans

Dual Eligible Special Needs Plans (D-SNPs) are managed care plans for people who qualify for both Medicare and Health First Colorado. For these members, Medicare is the primary payer for services and Health First Colorado helps cover the gaps in Medicare coverage (e.g., behavioral health, LTSS). While D-SNPs and their coordinating Medicare Advantage (MA) plans operate outside of the ACC, members who receive full Health First Colorado benefits are enrolled with a RAE as part of our normal process. With this structure, members face the challenge of navigating between their RAE and their D-SNP to coordinate their services.

As we consider options for improving the D-SNP program structure and the member experience for those enrolled in these plans, our objective is to improve the coordination of care for these members, reduce the confusion and challenge of navigating disparate systems, and align with guidance from CMS that encourages state Medicaid agencies to integrate Medicare and Medicaid services. To achieve this, we will build upon the current D-SNP contractual requirements to achieve the appropriate level of integration between these two programs. Active engagement with D-SNPs and other stakeholders will be critical to identifying the specific initiatives and pathways to improve the member experience and quality outcomes. At minimum, we are exploring options to enhance the expected level of data sharing and care coordination between entities.

VIII. Behavioral Health Transformation

Thanks to General Assembly and the Polis-Primavera Administration support of transformative legislation and programs, HCPF is partnering with the new Behavioral Health Administration (BHA) within the Colorado Department of

Human Services (CDHS) to create a more coordinated, cohesive, and effective behavioral health system in Colorado. Many efforts have begun to expand behavioral health services for our members, including adding new crisis benefits, adult and youth residential beds, expanding the provider network, increasing provider payments, improving transparency and reporting, and catalyzing care coordination.

ACC Phase III will incorporate and build upon the 19 priorities identified by the original Behavioral Health Task Force appointed by Governor Polis, leverage the ARPA dollars allocated in support of the Behavioral Health Transformational Task Force's recommendations report and the many bills passed since that time to fulfil those recommendations. It will also propel many of the behavioral health changes currently underway, while implementing a variety of new improvements. Overall, HCPF and the RAEs will focus on the following areas for the Health First Colorado behavioral health system.

A. Increasing Collaboration and Accountability with the BHA

As the largest payer of behavioral health systems in the state, HCPF is partnering closely with the BHA, along with local communities, safety net providers, advocates, members and families, to inform the design and implementation of policies and reimbursement strategies that can assist in creating a coordinated, cohesive, and effective behavioral health system in Colorado. To strengthen the collaboration between HCPF and the BHA and to improve operations and insights into the state's behavioral health system, we are in the process of:

- Establishing data collection and reporting requirements that will align with the BHA's performance monitoring system to track capacity and performance of all behavioral health providers, including those that contract with managed care entities or BHASOs.
- Collaborating on the creation of universal contracting provisions that will be used by every state agency, including the RAEs, when contracting with behavioral health safety net providers for services.
- Creating alternative payment strategies to encourage providers to participate in the state behavioral health safety net and expand member access to care.

- Aligning on service definitions, including care coordination, and reviewing the RAE and BHASO responsibilities. The departments would like to ensure Coloradans moving from Health First Colorado coverage are able to continue accessing affordable behavioral health services.
- Executing a formal data sharing agreement with the BHA to create a system-wide behavioral health grievance system that will include RAEs. The data sharing and operational agreements between RAEs and BHASOs will also be required to ensure individuals moving between these agencies have smooth transitions of coverage.
- As these activities are implemented and new policies and procedures are developed, HCPF will incorporate new requirements into the ACC Phase III contracts to ensure compliance and to leverage the RAEs in educating providers about ongoing changes and supporting the establishment of an effective state behavioral health system.

B. Increasing Access, Capacity, and Strategic Expansion of the Provider Network

HCPF will leverage the RAEs and the flexibility of the Capitated Behavioral Health Benefit to expand the provider network. First and foremost, HCPF will create new Health First Colorado provider definitions and types that align with the BHA's new licensing strategies, with an emphasis on those providers that can enhance behavioral health service availability and continuity of care. Most of these new provider definitions and types will be linked to the new payment framework to support the long-term sustainability of the behavioral health safety net.

One particular focus for improvements to the provider network is increasing availability of high intensity outpatient services. These high-frequency, community-based, member and family-centered services are designed to engage adults and youth with severe mental health and/or substance use conditions in extended and consistent treatment in an effort to prevent the development of significant physical health problems, developmental challenges, involvement in criminal and juvenile justice systems, and/or institutionalization. HCPF and the RAEs have begun work to improve the availability of high intensity outpatient services utilizing ARPA funding, but additional time and initiatives are required to overcome the barriers that currently exist. For Phase III, HCPF will partner with the

RAEs to develop solutions that fill gaps in the continuum of high intensity outpatient services, to improve transitions between levels of care, and to add care levels that better reflect member needs. Using a combination of strategies that includes new payment models, we will learn from the current ARPA project to implement strategies that support the long-term sustainability of these higher-cost services. Strategies will be designed to encourage existing providers, particularly those working in traditionally underserved areas, to become Health First Colorado providers, add new services, and expand service availability and quality.

Another area of critical importance identified by the 2019 Behavioral Health Taskforce is the strengthening of Colorado's crisis continuum of services. HCPF and the BHA are partnering through ARPA section 9813 to expand and improve the community-based mobile crisis intervention service and to implement a new Secure Transport Benefit. Both services are designed for individuals experiencing a behavioral health crisis, which can include both mental health and substance use related issues, while reducing the need for unnecessary law enforcement or emergency medical services. In ACC Phase III, the RAEs will be responsible for administering both services under the capitation behavioral health benefit. Mobile crisis and secure transportation providers will achieve state and federal standards and maintain accountability for transparency in utilization of funding under the capitated benefit.

C. Reducing Administrative Burden for Members and Providers

Where possible, HCPF is implementing processes to reduce administrative burden faced by providers to allow for more equal participation among different sized practices, especially for those in the Independent Provider Network. We are considering strategies to centralize the credentialing process for all providers. Currently, providers are credentialed separately by each RAE. In Phase III, providers would be credentialed through a single entity and those credentials would be accepted by each RAE. The ultimate goal is to reduce the administrative burden that comes from credentialing with multiple entities and therefore encourage more providers to participate in the ACC.

Members and providers have identified that consistent and standard utilization management is key to improving member and provider experience and reducing administrative burden. Provider and RAE education, updates to assessments for substance use disorder, and identification and use of standard statewide tools for children and youth and mental health services are all key activities to improve standardization. The goal of this effort is to ensure that a single member with a specific need would be approved for the same level of care across all RAEs, even if the RAEs have their own processes for utilization management and service authorization. Similarly, HCPF is working to improve consistency and transparency on reimbursement rates for behavioral health services. This includes use of directed payment models for key services, which sets a minimum payment amount RAEs must follow when contracting with providers. It also includes use of value-based payment models so providers have more flexibility to support complex and essential services tied to the joint BHA and HCPF quality strategy, with a focus on closing disparities and serving priority populations. Based on draft federal rules, HCPF anticipates additional public reporting requirements for behavioral health rates, which fully aligns with the behavioral health transformation efforts around accountability and transparency.

The Universal Contracting Provisions are another joint project led by the BHA to reduce administrative burden for safety net behavioral health providers. The Universal Contracting Provisions will define expectations for behavioral health providers and state agencies when contracting for behavioral health services. It will standardize contract content expectations for both providers and RAEs around items such as data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission and billing procedures. The Universal Contracting Provisions, overseen by the BHA, will be required for any provider that wants to participate in behavioral health alternative payments models.

D. Paying Providers for Improving Patient Health

Alternative payment models are currently in development to support the establishment of the new behavioral health safety net as defined in C.R.S

Title 27, Article 50. In collaboration with stakeholders, HCPF has designed a prospective payment system model to support the sustainability of comprehensive behavioral health providers. Prospective payment systems have been successfully used throughout the country to reimburse community health centers and Certified Community Behavioral Health Clinics based on the cost of services. Under this form of prospective payment, clinics receive a payment for each day or month based on delivery of services. HCPF is continuing to work with the BHA and stakeholders on the prospective payment model details. Conversations with stakeholders have just begun to identify an appropriate alternative payment model for essential behavioral health providers. RAEs will be required to reimburse participating safety net providers using HCPFs established value-based payment framework and guidelines.

HCPF will need to get authority from CMS in order to direct the RAEs to reimburse comprehensive and essential behavioral health providers using the approved value-based payment model. We are also considering using the federal directed payment authority to support access to underutilized or new services. For these services, HCPF would require RAEs to pay a minimum rate for a limited set of specific services. An example being explored is whether a tiered rate structure for out-of-home placement facilities for children and youth could better incentivize state providers to admit Health First Colorado members and reduce the utilization of out-of-state facilities.

E. Identifying and Filling Historical Service Gaps in the Care Continuum

HCPF is committed to continually evolving the Capitated Behavioral Health Benefit by either adding new services or improving the RAE contracts and operations to fill gaps in the continuum of care for both mental health and substance use disorder services. Gaps can occur for a variety of reasons, including lack of state and/or federal authority to cover a service, provider capacity and availability of certain services, differences in reimbursement models, and RAE processes and procedures. We are working closely with the BHA to identify where critical gaps are occurring within the state network of safety net behavioral health services while identifying the most appropriate potential solutions. Over the last couple of years CMS has

expanded the ways states may leverage managed care contracts to address some gaps that are consistent across the country, such as supporting members being released from incarceration. Some specific changes include:

- Increasing the types of behavioral health services and diagnoses covered under the behavioral health capitation to reduce member and provider confusion and reduce the risks of RAEs transferring risk to fee-for-service benefits. For example:
  - Cover residential services for all youth populations (including Child Welfare) to promote greater accountability and incentive for the RAEs to fully leverage community-based services for members to reduce potentially avoidable inpatient and residential services.
  - Improve standard screenings for youth and cover outpatient treatment for members under 21 without a covered diagnosis in alignment with Senate Bill 23-174.
- Exploring federal opportunities available to improve transitions of care and to address health-related social needs, such as:
  - Covering the first 15 days of member stays in Institutions for Mental Diseases (IMDs) regardless of total length of stay.
  - Adding coverage of pre-tenancy housing supports, including housing navigation, peer support, and tenancy support for all members with a behavioral health diagnosis who qualify for permanent supportive housing.
  - Covering for incarcerated individuals 90 days before their release to establish care plans and connect individuals with care services immediately upon release from incarceration, as outlined in Senate Bill 22-196.

F. Children and Youth Specific Service Continuum

There are additional changes being considered in order to address gaps and challenges for meeting the care needs of children and youth, including:

- Defining a set of benefits that should be afforded to all children, youth, and families that are Health First Colorado members,

including those who need that behavioral health service to successfully thrive.

- Identifying definitions and utilization standards for high intensity outpatient programs for children and youth within HCPF's Statewide Standardized Utilization Management (SSUM) Guidelines for Children Under 21 Years Old. These guidelines have been established in collaboration with stakeholders to standardize how the RAEs assess the most appropriate level of care for children and youth. Initial guidelines have been focused on children referred for residential treatment and will be expanded over the coming years.
- Standardizing when children and youth need to receive a comprehensive assessment to define their treatment needs and recommended level of care. The assessment should be defined by HCPF, so the same assessment is utilized across regions and different agencies, such as county child welfare agencies and youth corrections.
- Creating a tiered approach to care coordination, so children and youth with very complex needs that include behavioral health needs can receive an intensive level of care coordination. Intensive care coordination is a hands-on approach that provides multi-agency involved, high fidelity wraparound services. This level of intensity is needed to assist children and families to successfully navigate the health system and complete treatment recommendations.
- Incorporating high fidelity wraparound services as part of the service array available to children and families. This service is an evidence-based approach to team planning across different disciplines for children and families involved in multiple systems, such as county child welfare agencies or youth corrections.
- Exploring how to leverage home and community-based waiver support services for family members as a way to potentially complement clinical services for children with complex needs. These support services can assist families in keeping children home by providing respite services, family peer support services and

additional supports that help families apply treatment approaches in the home.

IX. Behavioral Health Integrated Care Benefit

HCPF is committed to advancing the integration of physical and behavioral health care to provide whole-person care for our members. Integrated care addresses the quadruple aim by improving outcomes, patient experience and care team experience while also reducing costs. As a part of the State Innovation Model (SIM) we found that integrated physical and behavioral health resulted in improved care delivery and cost savings. Not only are these findings, and the overall value of integrated care, validated by national and global findings, stakeholders are supportive of the move towards physical and behavioral health integration. Colorado is among many states across the nation facing significant behavioral health system challenges that have been exacerbated by the COVID-19 pandemic. Supporting integration of these services can increase access to critical behavioral health interventions.

There have been considerable efforts to advance integrated care over the years including joining the administrative responsibilities for behavioral health and primary care under the RAEs, participation in SIM, the implementation of the Six Short-Term Behavioral Health Benefit, and the House Bill 22-1302 grant funding pilot. To support the integration of care where members need it most, we are proposing the development of a distinct Integrated Care Benefit. This benefit is intended to align and advance the various efforts to encourage integrated care over the years and would fold in the current Six Short-Term Behavioral Health Benefit. We are currently exploring potential ways to allow reimbursement for standard Current Procedural Terminology (CPT) code sets often used to support integrated care models, such as the Health and Behavioral codes and/or the Collaborative Care Model service codes.

While creating an Integrated Care Benefit is specific to our design for Phase III, the House Bill 22-1302 grant funding pilots are just being distributed. This funding project is designed to gather lessons learned and best practices from providers actually implementing integrated care solutions. Over the next one to two years, we will be engaging these providers and other stakeholders to design the Integrated Care Benefit for implementation as part of ACC Phase III.

X. Enhancing Care Coordination and Case Management Standardization and Expectations

Care coordination and case management support for members are the backbone of the ACC and critical to ensuring the achievement of quality, equity and affordability outcome goals associated with Phase III. In an increasingly complex health care environment, care coordination is an essential function in supporting care access, members' navigation across multiple agencies to address their medical, behavioral and social needs and to improve their quality of life. Where health care service providers are often focused on a single aspect of a member's care, care coordinators have the time to build trust and stronger relationships so that they can provide the holistic support a member may need. They further have the ability to leverage data and insights to connect members with appropriate health improvement programs and supports for health-related social needs to achieve ACC goals of improving member health, closing disparities and driving Health First Colorado affordability.

For ACC Phase III, we aim to improve care coordination and case management within our system by enhancing and standardizing the requirements for RAEs. Care coordination and case management overlap with every aspect of Phase III program design, so we believe it is essential to develop clearer expectations and requirements to ensure members are receiving the care and support they need. We are exploring opportunities to differentiate expectations for pediatric populations compared to adults to ensure appropriate interventions. Key components for care coordination in Phase III will be centered around the following objectives:

- Improve the quality, consistency and measurability of interventions for care coordination and case management.
- Improve the quality, consistency and measurability of interventions for health improvement program engagement and the availability of system data insights (claim utilization, member demographics, gaps in care, etc.) that connect member needs with appropriate programs and supports.
- Increase member, provider and key partner awareness and understanding of care coordination and case management services, roles and responsibilities in relation to other parts of the system.
- Increase equitable access to care coordination and case management.

To ensure the effectiveness of the program, we are evaluating methods to improve care coordination quality, system capabilities, member engagement expectations, program consistency and outcomes measures. Relative to behavioral health, stakeholders have recommended that we align our care coordination standards with the BHA, so we are jointly developing the following tiered approach to care coordination (also detailed in Table 3):

- **Level 1** coordination involves brief, temporary support as well as preventive care, such as outreach for childhood immunizations.
- **Level 2** coordination focuses on condition management for specific populations. The goal is to ensure these populations are receiving the medical and behavioral health care and interventions they need to remain healthy. The conditions selected for this tier are those that can be most impacted by care coordination and that align with the conditions of focus for APM 2. This may include connecting and engaging a member in a diabetes management and support program or to SNAP as a social determinant of health medium that enables the purchase of healthy food.
- **Level 3** coordination focuses on the most complex and high-risk members experiencing physical and/or behavioral health conditions. While previously RAEs have been able to create their own definitions for complex members, we plan to create a standardized, baseline definition that can be monitored across all RAEs. Coordinating care at this level will include increased accountability for assisting hospitals in coordinating the discharge of members with complex behavioral health conditions and other complex needs into step down levels of care or home care that includes proper supports.

Additionally, there will be clearer, more explicit requirements within the RAE contracts for transitions of care from acute clinical settings, regardless of tier, with National Council of Quality Assurance Healthcare Effectiveness Data and Information Set measures used for accountability. Creating consistent definitions and expectations will increase accountability for appropriate management of behavioral and physical health by allowing us to use the same metrics to measure the progress of each RAE. Transitions of care guidelines will also be set for non-clinical transitions, such as transitions post-incarceration or from congregate residential settings.

Phase III intends to include the centralization of a limited set of specific care coordination services within a single RAE, or within HCPF or a third party for the most complex types of care. HCPF is looking specifically at centralizing care coordination for medical transplants and the placement of high-risk children and youth with complex behavioral health conditions. This could aid in the development of a network of in-state and out-of-state Medicaid transplant centers of excellence. It will also support evolving insights into the needs of hard to place behavioral health populations, enabling directed and state-based investment in the expansion of related behavioral health beds, facilities and capabilities in Colorado – a critical goal of our behavioral health transformation efforts.

Table 3 - Proposal for Standardized Care Coordination and Case Management Tiers

Tier	Target Populations (includes behavioral and physical health)	Care Coordinator	Activities
Level 3	• Uncontrolled conditions • Multiple diagnoses • Multi-system involvement • Difficult to place • Private Duty Nursing (PDN) • Client Overutilization Program (COUP)	Clinical Care Coordinator	• Care plan and active case management through the patient's care continuum • Specific assessments based on population type/need • Active connection to appropriate care support • Monthly coordination with member/treatment team • Long-term monitoring and follow-up • Leveraging all evolving technologies to improve health outcomes, including utilizing higher performing providers based on cost and quality indicators and coordinating health-related social needs
Level 2	Condition management (heart disease, diabetes, depression/ anxiety, asthma/COPD, maternity)	Clinical Care Coordinator	• Condition-specific care plan and assessments • Case management engagement to mitigate disease escalation, improve outcomes and control costs • Quarterly coordination with member/treatment team • Long-term monitoring and follow-up

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			• Creation and member engagement in available health improvement programs • Connection to and member engagement with health-related social needs supports • Leveraging all evolving technologies to improve health outcomes (e.g., eConsults, Prescriber Tool Phase II (SHIE), cost and quality indicators)
Level 1	Anyone	Not clinical, no staffing ratio	• Brief needs screening (Health Needs Survey) • Support accessing services & benefits • Determining need for higher level of care coordination • Brief monitoring and follow up

HCPF will be better able to monitor how care coordination is being implemented and how it is impacting member health by utilizing clearer definitions around what populations should be considered for each level of care coordination and the types of care coordination activities that should be available to members at each level. We are proposing the following combination of process and outcome measures to hold RAEs accountable for regional care coordination performance:

- Increased requirements for RAE care coordination and case management system and reporting capabilities.
- Increased insights into member case management engagement, care coordination engagement, health improvement program participation, and measures related to quality outcomes, health disparity closures and savings.
- Monitoring of provider behaviors and member access to services to identify where network access is the impediment to improving member quality outcomes and health equity while furthering HCPF's ability to hold providers accountable for seeing Health First Colorado members.
- Performance Metrics:
    - Percentage of members identified by HCPF for care coordination levels 2 and 3 who are actively engaged with the RAE or their delegated or subcontracted care coordination entity.

- Regional performance on the transitions of care measure set established by the National Council of Quality Assurance for all eligible members.
- Plan all-cause readmissions measure from the CMS Adult and Child Health Care Quality Measure set.
- Ambulatory care: emergency department visits measure from the CMS Adult and Child Health Care Quality Measure set.

Increasing awareness and understanding of care coordination will be a multi-pronged approach aimed at educating care coordinators, providers, members and other pertinent stakeholders. HCPF will develop and provide a Care Coordination Policy Guide that outlines best practices for the following expectations:

- Foundational program and system requirements.
- Roles and responsibilities (internally and in relation to other organizations such as CMAs and D-SNPs).
- Target populations.
- Levels of care and their respective interventions.
- Transitions of care.
- Inter-system data sharing.
- Reporting requirements.

RAEs will be responsible for having their own comprehensive Care Coordination Policy Guide that addresses all HCPF's expectations for a comprehensive care coordination program, including the care coordination system and program capabilities to meet those requirements and documented agreements between RAEs and critical CMA, D-SNP and MA programs designed to improve the members experience and achieve access and outcomes goals.

To educate providers, members, key partners (CMAs, D-SNP, MA plans etc.) and other stakeholders, we are developing materials that clearly describe the purpose and function of care coordination as well as case management. These materials will also describe how care coordinator roles and responsibilities differ from or complement other agencies in our system, including but not limited to the BHA, CMAs, D-SNP, MA plans, and community-based organizations.

Requirements will be established to ensure effective RAE reporting and related dashboards that highlight outcome measures, member engagement with health improvement programs and health-related social needs supports, provider access (with a special focus on medical specialty care, eConsults, and behavioral health) and the overall effectiveness of those services. We are exploring various processes to do so. We believe that providing clear information about these expectations and dashboards that measure performance against these expectations will help improve member experience, equity, access, outcomes and affordability across the Health First Colorado ACC systems of care.

One of HCPF's ARPA-funded projects to strengthen case management best practices will be leveraged to support this work by developing materials that clarify roles and responsibilities between RAEs and CMAs. This is a stakeholder-informed, process improvement initiative aimed at increasing collaboration, communication, and cross-agency coordination for HCBS members who work with CMAs for their HCBS services and supports or nursing home care, but who also could benefit from RAE assistance in coordinating standard Health First Colorado physical and behavioral health services. The same work can be leveraged to improve the member experience, equity, outcomes and access provided to dually eligible members served by D-SNP and Medicare Advantage programs. Ultimately, this project will clarify care coordinator-case manager roles and responsibilities, develop core competencies, identify methods for inter-agency and key partner data sharing and communication, create educational materials for stakeholders, and develop trainings for care coordinators and case managers. To facilitate a coordinated and improved approach to member engagement in health improvement programs, case management, and care coordination, HCPF is considering options for key providers, such as CMAs, to access RAE systems and supports.

To increase equitable access to care coordination, case management, health improvement programs, and health-related social needs, we are exploring processes for RAEs to build out networks of local, trusted community organizations. The Center for Health Care Strategies explains that simply outreaching members in need of care coordination by traditional risk stratifications or utilization will inherently lead to inequities. Members who are

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experiencing homelessness, for example, typically cannot be reached via phone or mail. Often, these members over-utilize emergency departments rather than receiving preventive primary care. The way to identify and connect these members to care coordination and related supports is by developing relationships with the local CBOs where they are already accessing social services such as shelters, food banks, and syringe exchange sites. Given the evidence in support of developing these community networks, we are determining requirements for RAEs around establishing a CBO network with staff of these organizations acting as navigators for members, allowing members to continue working with the people they trust in organizations they already frequent. Ultimately, RAEs would be required to work with these navigators to ensure members are being reached and to provide care coordination and case management in partnership with the CBO navigator. This model has the added benefit of improving equity, access, and outcomes while reducing Health First Colorado costs by helping the most marginalized members connect to appropriate care and support.

As previously mentioned, stakeholders have requested alignment between RAEs and the BHA. Therefore, we are working closely with the BHA to align care coordination and case management to support members who may move between the Health First Colorado ACC/RAE and BHASO systems. In addition to establishing a similar tiered approach to care coordination and case management, we are developing joint standards of care and have shared expectations for transitions of care. We are also developing a transition plan for members that switch between a RAE and the BHASO (or vice versa) in order to make that change as seamless as possible for members, providers and key partners.

XI. Addressing Health-Related Social Needs

ACC Phase III will support several ongoing initiatives across HCPF to address the health-related social needs of Health First Colorado members. Passed in the most recent legislative session, House Bill 23-1300 directs HCPF to explore options for how to better meet the health-related social needs of our members. Senate Bill 23-174 also directs HCPF to allow members under 21 to access psychological services without a covered diagnosis. This allows youth to

receive care for health-related social needs that may be impacting their functioning but have not yet met the criteria for a clinical diagnosis.

Phase II of the Prescriber Tool, sometimes called the Social Health Information Exchange (SHIE), will be awarded this quarter through a collaborative effort between the Office of eHealth Information (OeHI) and HCPF. Operationalization is targeted for 2024, well in advance of the effective date of ACC Phase III. This tool will enable prescribers, RAEs and community organizations to connect members to health improvement programs offered by the RAEs, such as prenatal or diabetes management programs, as well as health-related social needs supports like SNAP, WIC, housing and food supports for those who are housing or food insecure, and more. This innovation will enable local health-related social needs supports available in a community to be identified and accessed by users of the tool to the betterment of members needing these critical supports. The tool is evolving to directly meet our shared goals for member equity, access and outcomes. CMS has been financing 90% of the design and evolution of the Prescriber Tool.

Medicaid is being looked to by the federal government to advance the nation's health care system. By investing in the front end of the health care continuum and including health improvement programs and health-related social needs into the Health First Colorado program, we are prioritizing prevention and member supports as part of our Phase III modernization. Ensuring that RAEs, providers and community organizations have the right tools to connect members to such programs is a critical part of Phase III. The Prescriber Tool Phase II (SHIE), once available, will be accessible by care providers and community organizations to improve supports to all Coloradans, such as those eligible for Medicare, the uninsured, and those with commercial coverage.

In recent years, and in addition to advances of the Prescriber Tool, CMS has created opportunities and authorized Medicaid programs in other states to use Medicaid funding to address a variety of health-related social needs, specifically for housing and food insecurity. House Bill 23-1300 has tasked HCPF with investigating how it might leverage new federal flexibilities to meet the health-related social needs of Health First Colorado members and to engage stakeholders in this process. Additionally, we are exploring options for RAEs to

support member enrollment in government assistance programs, such as SNAP, and to cover other food-related assistance like medically tailored meals.

Further, we hope to build on work already active throughout the ARPA project to provide permanent supportive housing assistance for members. We are considering an 1115 waiver amendment and budget request to expand on the work that has started. This would include providing reimbursement for services such as locating individuals in need of assistance, providing support as they look for housing, assisting in any paperwork needs, and more. We would also like RAEs to take more of an active role in supportive housing services by entering into partnership agreements with regional continuum of care housing organizations.

There is continued effort to ensure that individuals involved with the justice system are receiving the physical and behavioral health care that they need. HCPF has spent recent years improving coordination and relationships with the entities in this system from the Department of Corrections to county jails. For Phase III, we will be building on that improved coordination and will be expecting RAEs to dedicate resources to supporting this work. Additionally, recent legislation through both House Bill 23-1300 and Senate Bill 22-196 have directed HCPF to explore strategies to provide services prior to release or to provide continuous coverage for up to one year after release. The results of those initiatives, recommendations and related funding will be appropriately incorporated into ACC Phase III.

XII. Improving Support for Children and Youth

Children and youth require different approaches to care delivery, from the delivery of frequent, ongoing preventive services to multidisciplinary, multi-agency coordination of care for children with special health care needs. To best meet the needs of all children and youth, ACC Phase III aims to build a system of care that is family-centered, trauma-informed, and complete across the continuum for children, youth, families, and caregivers that recognizes the distinct needs of this population, from identification of need to treatment.

HCPF is proposing a comprehensive approach that includes alternative payment models for pediatric PCMPs (the PACK model described previously) while implementing specific interventions targeting children and youth with special

health care needs. To tie all of the pieces together, we are recommending the development of a Standardized Child Benefit to address different health needs at different levels of complexity. This potential model would use uniform processes to identify a child's level of health needs and risks and link those levels with a suite of services that would be available based on the child's specific needs, along with different degrees of care coordination services that would be made available. Similar to the previously outlined recommendations for care coordination and case management, a Standardized Child Benefit would strive to systematize, simplify, and enhance care for children and youth.

A particular focus for HCPF and our partners is to implement interventions that can better serve children and youth with more complex needs, such as involvement with the justice system, child welfare, and/or extended or frequent hospitalizations. To reduce out-of-home and out-of-state placements and to improve access to community-based services, we are pursuing the following solutions:

1. **High Fidelity Wraparound Services:** Senate Bill 19-195 directs HCPF to implement High Fidelity Wraparound services for children and youth ages 0-25 that are at risk of or in an out-of-home placement. This is a nationally recognized, evidence-based model that formalizes care coordination across child-serving systems to support community-based treatment and help families strengthen their own natural supports. This approach focuses on the individual by using team-based interventions, peer-based family supports, and coordination with schools or other involved agencies to help children and their families reach success. While HCPF is currently engaged with stakeholders to identify how best to define and finance these services, the RAEs will ultimately be responsible for covering high-fidelity wraparound services for children and youth determined eligible for the model.
2. **Conflict-Free Intensive Care Coordination and Case Management:** For children with the most challenging needs that aren't easily addressed through existing treatment programs and models of care, we are designing a conflict-free intensive care coordination and case management model. Under this model, children would receive an independent assessment to determine the right care plan that would be required. RAEs would be

required to work with external service providers with demonstrated expertise in providing intensive care coordination for these children and youth, and working with multiple agencies and systems, including the juvenile justice system and special education. We believe it's most effective for children and their families to have their care handled by experts in multi-agency pediatric care coordination and who understand the unique capabilities of providers to serve the complex needs of these children and youth. HCPF will define the criteria RAEs should follow when children and youth who meet established criteria are identified, including warm handoffs to newly identified expert partners contracted to provide these services. This expertise will be contracted via a separate third party.

XIII. Primary Care Medical Providers (PCMP)

The ACC is built on the premise that primary care is the foundation of a high-performing health care system. When members are connected with a regular, ongoing focal point of care, or PCMP, we have found that our members have better outcomes and lower expected costs than those members who were not engaged with a PCMP. The medical home model will continue to be a key aspect of Phase III to ensure that members have a focal point of care to help coordinate and address their clinical and social needs. For Phase III we will evolve from the traditional patient centered medical home (PCMH) model developed decades ago to the more modern Accountable Care Organization (ACO) model. In ACC Phase III, we are defining the primary care ACO model as the prioritization and achievement of results and outcomes over the steps intended to achieve outcomes. HCPF is not requiring RAEs or PCMPs to be certified or licensed as an ACO or PCMH. This evolution from a PCMH to an ACO model also aligns more directly with the Phase III goals of improving and rewarding better outcomes in the areas of equity, access, quality outcomes, affordability and the member experience. This transition is further supported by our APM and value-based payment advances that reward outcomes and results, and our provision of innovative tools that enable providers to achieve outcomes.

HCPF acknowledges the variety of pressures facing primary care and is designing the ACC as a resource to provide PCMPs with enhanced finances, data, practice supports, and assistance coordinating members' care. For Phase

III, we are reinforcing the role of the RAEs as a vital support to the success and sustainability of PCMPs. As with evolution toward the ACC Phase III vision of the ACOs, we see the RAEs serving as an essential resource to PCMPs to enable them to achieve higher performance on metrics that are tied to incentive payments and/or the shared savings available through APMs. RAEs will have greater requirements for support to PCMPs, including:

- Sharing RAE-developed health improvement programs that meet HCPF requirements, at the PCMP's option.
- Helping PCMPs understand their performance against their peers so that gaps can be addressed, and best practices can be shared to improve the performance of other PCMPs.
- Sharing actionable data with PCMPs to improve their ability to prioritize member engagement.
- Working with PCMPs to meet regional access, quality (CMS Core Measures), other outcome and equity goals (traditional ACO outcome metrics).
- Helping PCMPs identify and address affordability opportunities or gaps (traditional ACO outcome metrics).
- Working with PCMPs to understand gaps in access, such as specialist or behavioral health access; enabling RAEs and HCPF to address such gaps in each region.
- Establishing processes for improved coordination with behavioral health and other specialty providers.
- Wrapping around care coordination, health improvement programs, case management and other resources to engage members in care and connecting them to additional services and supports.
- Assisting PCMPs on integrating new tools and best practices into their workflows, such as utilizing HCPF's new electronic consultation (eConsults), the Prescriber Tool Phase I (OpiSafe and Affordability RTBI modules) as well as the emerging Phase II of this tool (SHIE), emerging cost and quality indicators, and other innovations that evolve through Phase III of the ACC.
- Offering learning opportunities so practices can effectively utilize community health workers, integrated behavioral health providers, and other health care providers in a comprehensive, team-based manner.

- Building established networks of community-based organizations and other local and regional services to make available to PCMPs and their members.
- Supporting PCMPs to improve their ability to leverage APM2 and earn value-based payments as an ACO provider within Health First Colorado.

A critical role of the RAEs will be to support providers in transitioning away from fee-for-service and the older PCMH model to the more modern ACO-like model, and to earn rewards associated with HCPF's evolving APMs and related value-based payments (VBPs). Such payments can create more flexibility in care delivery, while financially rewarding improvements in member health equity and outcomes, and improving the cost-effectiveness of health care delivery. To support this transition, HCPF is aligning with other payer initiatives on quality and measurement to reduce administrative burden for providers. In June, Colorado announced its collaboration with CMMI on the Making Care Primary (MCP) multi-payer model supporting the delivery of advanced primary care services. HCPF and the Division of Insurance are partnering on developing primary care payment reform models in Colorado that align with core design features of the MCP Model. The combined goals of our agencies are to provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while driving equitable access to care.

The RAEs will continue to distribute financial payments to PCMPs based on practice capabilities; however, HCPF is proposing to establish guardrails for RAEs to use a tiered approach to payment of PCMPs that will ensure alignment with the MCP and intended ACO model. To support the full range of providers in Colorado, we are proposing the following three-tier model of payment:

- Level 1 PCMPs will be those practices with little or no experience with value-based payment and who provide essential access to our members, particularly in rural and frontier areas. These PCMP practices may receive more services and supports from the RAEs, such as care coordination and health improvement program access. The RAE will make it easier for the PCMP to continue serving members and to evolve along the ACO and intended Health First Colorado PCMP continuum.
- Level 2 PCMPs will be those practices with some experience with value-based payment who are interested in expanding their capacity. The RAEs

will provide more practice support, such as data analysis and dashboards to identify members in need, access to health improvement programs, comparisons with similar type PCMPs to help PCMPs understand their opportunities and gaps against peers and options to close those gaps, and help incorporating new innovations (tools) and processes into their workflows.

- Level 3 PCMPs will be those practices that have strong experience with value-based payments and are operating advanced primary care models. The RAEs will focus on payment models that can support the sustainability of advanced models of care delivery, such as integrated behavioral health care, while helping to incorporate Health First Colorado innovations, such as cost and quality indicators, eConsults, and health-related social needs supports.

In addition, we are exploring the best ways to expand the definition of a PCMP to include behavioral health providers who take primary responsibility for caring for members with serious mental illness. These providers often deliver the majority of Health First Colorado services for these members, are already actively engaged in coordinating services for the members, and have established strong, trusting relationships with the members. We are considering adding requirements for ensuring members receive necessary preventive, physical health services and that eligible providers have established relationships and communication mechanisms with primary care providers to enable smooth transitions when physical health services are required.

We are also exploring means to improve PCMP performance, resources and tools in rural communities to help those providers respond to Phase III. While the $10.6 million in stimulus grants through Senate Bill 22-200 being provided to rural hospitals in 2023 did not leverage this opportunity (submitted applications from rural hospitals did not ask for funding to support needed and shared case management, care coordination, or other related software investments across rural hospitals and rural clinics), HCPF is working with rural providers to pursue this critical core competency. This will include leveraging the newly passed Senate Bill B23-298, which enables rural hospital collaborative agreements and shared investments in related technologies, such as shared case management and care coordination systems or nurse case

managers and care coordinator staffing to utilize those systems to better manage care for rural Health First Colorado members. Leveraging this bill would be in complement to the Hospital Transformation Program's Rural Support Payment, which is providing $12 million a year to rural providers to help them develop the tools and resources necessary to fully participate in value-based payments and other alternative payment methodologies. This is in addition to the $17 million in initial funding provided in partnership with the Office of eHealth Innovation and the associated yearly incentives for rural providers to connect to the state Health Information Exchanges, maintain those critical connections, upgrade existing technology infrastructure and participate in shared the Community Analytics Platform, which provides real-time individual and population health data and analytics. Active collaboration between HCPF, rural hospitals, rural clinics and the Colorado Rural Health Center will be critical in the next few years to ensure rural providers are fully engaged and prepared for ACC Phase III.

XIV. Conclusion, Next Steps and Opportunity for Feedback

Developing the design of ACC Phase III has been, and will continue to be, an iterative process of engagement and conversation between HCPF, stakeholders, and other state agencies. The proposals contained within this document have been informed by conversations with stakeholders over the years, as well as the stakeholder engagement efforts over the past months exploring the initial vision for Phase III. (For a summary of stakeholder feedback, see ACC Phase III Vision Summary.)

HCPF has contracted with Colorado Health Institute (CHI) to conduct external stakeholder engagement on behalf of and in partnership with HCPF staff, subject matter experts and leadership. While CHI has already hosted many opportunities to share feedback, stakeholders will continue to have significant opportunities to engage in the development and refinement of Phase III initiatives. Sharing this concept paper is one more step in our process to design ACC Phase III.

Following further stakeholder engagement and program design work, HCPF will release a draft request for proposal for RAEs by the end of the year. While we hope to achieve the concepts outlined in this paper, none of these proposals

are final as many may require additional input, refinements and state or federal authority. We value the input from our stakeholders and would like to incorporate suggestions and feedback as we are able. We ask that those who have read the proposals in this paper consider the following questions:

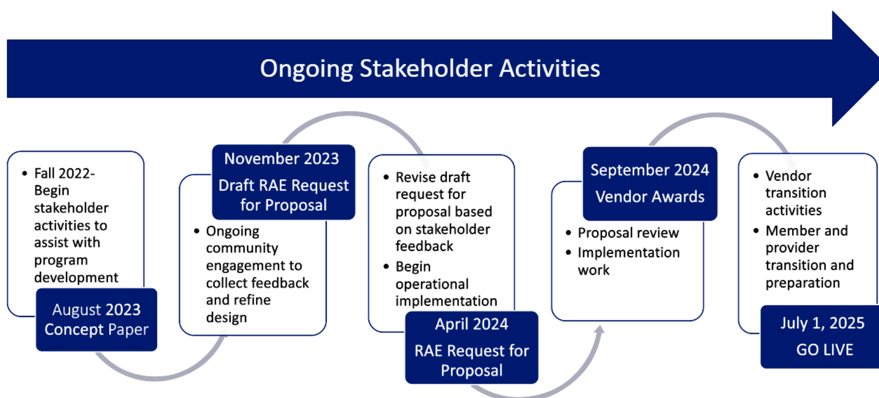
- Which proposals are you most excited about for Phase III?
- Where do you see risks for unintended consequences in our design for ACC Phase III?

HCPF will continue to have significant opportunities for stakeholder engagement, see Figure 2 below. Stakeholders have the following opportunities to provide feedback on this paper:

1. Using this feedback form, share your comments for individual sections of this paper.
2. Join one of our upcoming public listening sessions to share feedback with HCPF staff directly. The most updated list of public sessions is on the ACC Phase III Stakeholder Engagement webpage.

We look forward to continued engagement with stakeholders as we work to refine the design of ACC Phase III.

Figure 3 - ACC Phase III Timeline



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