Accountable Care Collaborative
Phase III

Vision Stage Engagement Summary

June 2023

COLORADO
Department of Health Care Policy & Financing

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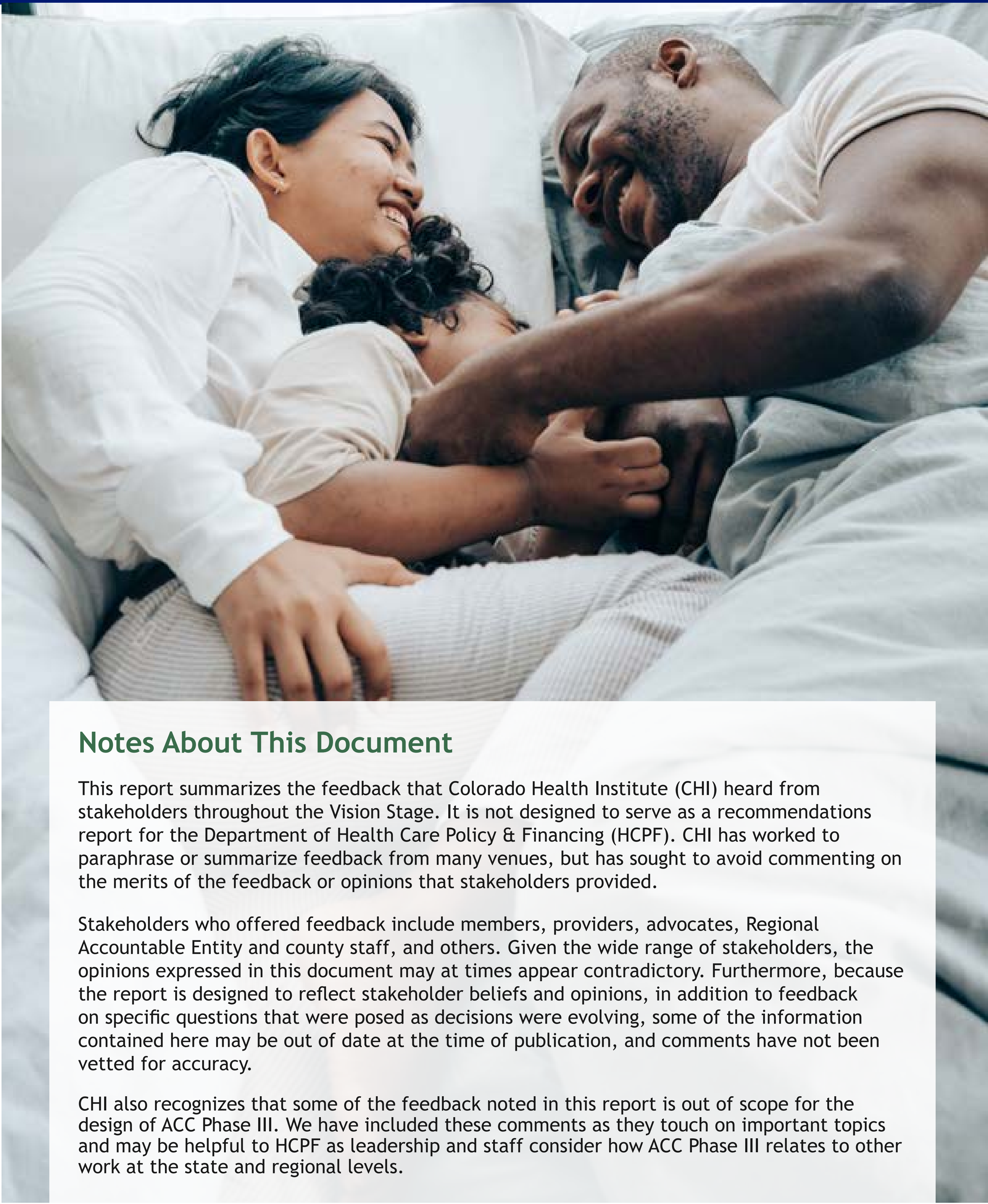
Contents



Notes About This Document

This report summarizes the feedback that Colorado Health Institute (CHI) heard from stakeholders throughout the Vision Stage. It is not designed to serve as a recommendations report for the Department of Health Care Policy & Financing (HCPF). CHI has worked to paraphrase or summarize feedback from many venues, but has sought to avoid commenting on the merits of the feedback or opinions that stakeholders provided.

Stakeholders who offered feedback include members, providers, advocates, Regional Accountable Entity and county staff, and others. Given the wide range of stakeholders, the opinions expressed in this document may at times appear contradictory. Furthermore, because the report is designed to reflect stakeholder beliefs and opinions, in addition to feedback on specific questions that were posed as decisions were evolving, some of the information contained here may be out of date at the time of publication, and comments have not been vetted for accuracy.

CHI also recognizes that some of the feedback noted in this report is out of scope for the design of ACC Phase III. We have included these comments as they touch on important topics and may be helpful to HCPF as leadership and staff consider how ACC Phase III relates to other work at the state and regional levels.

Themes from Stakeholder Feedback

1. Stakeholders would like HCPF to put member experience at the center of all its decisions. One example offered may involve hiring or compensating members to review member communications for plain language, accessibility, and clarity.

2. Stakeholders recommend that the Regional Accountable Entities (RAEs) expand and further support their Member Advisory Councils so the RAEs and their members can be better at sharing information with each other.

3. Stakeholders would like metrics used for key performance indicators and Alternative Payment Models (APMs) to be consistent across time and align with metrics providers track for other initiatives. Some recommended that clinicians provide input on metrics used for APMs. Stakeholders felt that fewe, but more focused, metrics could help providers and RAEs assess meaningful changes in population-level outcomes.

4. Stakeholders say HCPF should consider how to provide additional support to the entities (e.g., RAEs, providers, or third-party agencies) responsible for care coordination and for conducting screenings for health-related social needs. This may include financial support and providing clearer direction and standardization in how these activities are conducted across all RAEs.

5. Stakeholders hope RAEs will be required to hire and train direct service staff who reflect and are equipped to serve a diverse member population, particularly within the realms of care coordination, health-related social needs services and referrals, and behavioral health.

6. Stakeholders hope RAEs and Behavioral Health Administrative Service Organizations (BHASOs) will be aligned, both geographically and through clear referral processes to providers within each system.

7. Current policies for behavioral health integration are promising, but stakeholders think they could be improved by expanding the types of billing codes used and removing the ceiling on the total number of visits permitted.

8. Stakeholders think that data sharing across entities should be improved to be more timely, accessible, and consistent across RAEs. They also recommend that HCPF and RAEs consider best practices to improve transparency regarding how members' data is being captured and who has access to it.

9. Stakeholders want to see HCPF further support children and youth by standardizing services across all RAEs, including those covered under the existing early and periodic screening, diagnostic, and treatment (EPSDT) benefit.

Introduction

In preparation for launching Phase III of the Accountable Care Collaborative (ACC) in summer 2025, the Colorado Department of Health Care Policy and Financing (HCPF) developed a three-step process for engaging stakeholders on key decisions around the ACC's design (see diagram below). These stages, which build upon one another, are the Vision Stage, the Concept Stage, and the Request for Proposal (RFP) Development Stage.

HCPF contracted with the Colorado Health Institute (CHI) to assess stakeholder needs and collect feedback from diverse perspectives, such as members, providers, policy leaders, consumer advocates, and Regional Accountable Entity (RAE) representatives.

The goal of the Vision Stage was to orient stakeholders to HCPF's overarching goals for Phase III and to introduce eight interconnected priority initiatives to focus discussion for future stages.

This report synthesizes:

- The timeline, activities, materials, and reach of stakeholder engagement activities
- Themes within the eight priority initiatives
- Key questions and suggestions for HCPF consideration

The themes presented at the beginning of this document are expanded upon through detailed descriptions of what CHI and HCPF staff heard from stakeholders for each priority area. Note that not all stakeholder comments or opinions are reflected in this document. However, CHI regularly shared summaries of meetings and comments with HCPF throughout the Vision Stage.

Using this feedback and internal efforts led by Department workgroups, HCPF is working on a concept paper that will lay out several key initiatives of Phase III for consideration. At that point, CHI and HCPF will seek stakeholder input on the changes identified in the concept paper. HCPF will use that feedback to inform both the draft and final versions of the request for proposal (RFP), which will ultimately decide the design of ACC Phase III.

Setting the Vision: An Overview

Vision Stage stakeholder engagement officially launched in November 2022 with a presentation to the statewide ACC Program Improvement and Advisory Committee (PIAC), which includes members, providers, and representatives of local public health and county human services agencies. From that meeting through the end of March 2023, CHI and HCPF presented on Phase III at 22 meetings with nearly 1,000 participants. We supplemented these conversations with a handful of key informant interviews and small-group discussions on focused topics. (See Table 1.)

All meetings were held virtually, with live Spanish and American Sign Language interpretation available for the December 2022 and January 2023 public meetings. Participants at other meetings could request interpretation and other accessibility features. At some meetings, we used interactive tools such as Mentimeter or Jamboard. All participants received an open-ended feedback form at the end of each meeting to share additional comments.

Health First Colorado members who attended meetings beyond those they were already scheduled to attend (such as regular participation in a Member Advisory Committee) were offered a gift certificate following their participation.

Content

While discussion and presentation content varied by audience, facilitated conversations during the Vision Stage focused on sharing HCPF's goals for Phase III and outlining the eight interconnected priority areas. They also included discussion of commitments to continuity from Phase II. Presentation content varied depending on the audience, length of presentation and discussion, and any requests made by the meeting facilitators about topics or areas of focus.

CHI also developed a fact sheet (available in English and Spanish) that was distributed to stakeholders during or in advance of the presentations. This fact sheet is posted on HCPF's ACC website.

Through continued discussion with staff at HCPF, CHI developed new framing for stakeholder engagement materials beginning in February 2023 to highlight specific themes from conversations about key proposed changes.

Ongoing Stakeholder Activities

Fall 2022

Begin stakeholder activities to assist with program development

Summer 2023

Concept Paper

Ongoing community engagement to collect feedback and refine design

November 2023

Draft RAE Request for Proposal

Revise draft request for proposal based on stakeholder feedback

Begin operational implementation

April 2024

RAE Request for Proposal

Proposal review

Implementation work

September 2024

Vendor Awards

Vendor transition activities

Member and provider transition and preparation

July 1, 2025

GO LIVE

Table 1. Overview of Vision Stage Stakeholder Engagement Events

Date	Meeting	Attendees
11/16/2022	HCPF ACC Program Improvement Advisory Committee (PIAC)	55
11/16/2022	HCPF State Medical Assistance Advisory Council	20
12/5/2022	Colorado Access RAE 5 PIAC	27
12/6/2022	Rocky Mountain Health Plans RAE 1 PIAC	50
12/6/2022	Colorado Community Health Alliance RAE 7 PIAC	50
12/6/2022	Colorado Access RAE 3 PIAC	26
12/7/2022	HCPF PIAC Behavioral Health and Integration Strategies Subcommittee	50
12/7/2022	Colorado Community Health Alliance RAE 6 PIAC	35
12/8/2022	HCPF PIAC Provider and Community Experience Subcommittee	40
12/13/2022	HCPF Member Experience Advisory Council (MEAC)	15
12/15/2022	HCPF PIAC Performance Measurement and Member Engagement Subcommittee	38
12/20/2022	Colorado Access RAEs 3 and 5 Member Advisory Council (MAC)	10
12/20/2022	December Public Listening Session	115
12/21/2022	Health Colorado Inc RAE 4 Community Investment Grantees	18
1/4/2023	Colorado Health Policy Coalition	25
1/10/2023	January Public Listening Session	81
1/23/2023	Health Colorado Inc RAE 4 PIAC	18
1/23/2023	Health Colorado Inc RAE 4 Member Group	9
1/25/2023	Northeast Health Partners RAE 2 PIAC	24
2/2/2023	Colorado Health Policy Coalition	25
2/10/2023	HCPF Behavioral Health Hospital Engagement Forum	20
2/15/2023	HCPF PIAC	82
2/22/2023	HCPF Participant Directed Programs Policy Collaborative	42
2/27/2023	CCLP Health Advocates Alliance	14
3/8/2023	HCPF Children’s Disability Advisory Committee	93

This framing sought to organize all ACC Phase III proposals as supporting one of two pathways to success. The pathways — simplifying systems and incentivizing better outcomes — are in service to achieving the goals for Phase III. To date, staff have explained the goals as the "why" for Phase III design, the priority initiatives as the "what," and the pathways — which include many proposals with varying levels of detail — as the "how."

Tools for Engagement

CHI used Mentimeter, an online platform that allows for interactive live polling and surveying, during many meetings. Participants could submit anonymous comments in real time from any web browser on a computer or smart phone. For large public meetings, participants submitted comments to Google Jamboards, which were customized for each meeting and were made available to attendees following the session so they could add more comments if desired. In other meetings where an online platform was less conducive to discussion, such as those where participants joined by phone rather than by computer, CHI facilitated the conversation through spoken comments. Participants were always invited to use the chat.

ACC Phase III Vision for July 2025

Why: Goals

- ★ **Improve** quality care for members
- ★ **Close** health disparities and **promote** health equity for members
- ★ **Improve** care access for members
- ★ **Improve** the member and provider service experience
- ★ **Manage** costs to protect member coverage, benefits, and provider reimbursements

What: Priority Initiatives

- Improved Member Experience
- Accountability for Equity and Quality
- Referrals to Community Partners
- Alternative Payment
- Care Coordination
- Children and Youth
- Behavioral Health Transformation
- Technology and Data Sharing

How: Pathways to Success

- Simplifying Systems
- Incentivizing Better Outcomes

CHI also provided participants with a link to an online feedback form to submit written comments after meetings on any topic related to ACC Phase III. CHI staff reviewed and summarized feedback from all these inputs after each meeting.

At regular intervals, CHI shared de-identified and aggregated themes and comments with HCPF staff, to be shared with ACC Phase III workgroup leads and other key staff. To ensure a responsive approach to this feedback, CHI partnered with workgroup leads to develop specific discussion questions for stakeholders based on initial questions and feedback. During the next stage of stakeholder engagement, the Concept Stage, stakeholders will receive more detailed concepts on which to provide feedback. This will ultimately inform the Draft Request for Proposals, to be shared with stakeholders in late 2023.

Stakeholder Response to Introductory Content

CHI began each meeting by providing background information and asking stakeholders for their feedback on the overall goals and priority initiatives for Phase III. Stakeholders were generally supportive of the goals and priority initiatives, saying that they were holistic, well-aligned with other work, and set the right priorities. CHI acknowledged, and stakeholders agreed, that the initiatives were not mutually exclusive and represented many opportunities for overlapping discussion, such as for behavioral health transformation and children/youth or for care coordination and referrals to community partners. Some stakeholders specifically appreciated the focus on member experience as an initiative, as well as the fact that equity showed up within both the goals and initiatives.

Many stakeholders commented on the children and youth priority. Some liked to see it called out as its own category, while others raised concerns that this meant HCPF would not think about children and youth within each of the other priorities.

Many stakeholders also said these goals and initiatives seemed similar to Phase II of the ACC. Some stakeholders appreciated the continuous focus at a time of many other policy and organizational changes within state government, while others had been expecting to see more changes and questioned the more limited scope.

One concern that stakeholders voiced about the priorities, particularly early in the engagement process, was they seemed too broad to drive useful discussion and feedback. Stakeholders were less likely to voice this concern as HCPF released more details around Phase III and discussions were increasingly tailored to different audiences or concepts for considerations. Stakeholders generally gave positive feedback on the way CHI and HCPF have conducted outreach so far, with many stakeholders eager to begin having conversations around more detailed proposals.

Phase III Priority Initiatives

Initiative 1. Improved Member Experience

Efforts to improve the Health First Colorado member experience in Phase III focus on ensuring that members have appropriate access to communication and supports from their RAE in navigating the Medicaid system. HCPF is also considering how best to meaningfully assess members' experience.

Some stakeholder engagement themes for this initiative included:

- Members' preferred methods of communication from both their RAE and HCPF
- Ways to measure member experience and perceptions
- The roles RAEs should play in communicating with and supporting members

MEMBER EXPERIENCE

Members and member advocates provided the following feedback, which has been synthesized under several prominent themes. Feedback is organized similarly for the other seven priority initiatives.

1.1 Members do not have one preferred method of communication, but they believe all information should be in one place.

Based on a variety of factors, including age, geographic area, and accessibility for those who use screen readers or other assistive technology, members reported diverse preferences for their system of communication, including phone calls, emails, the PEAK app, text messages, regular mail, and face-to-face talks. They also expressed preference for a "no wrong door" approach to receiving information about services and emphasized consistency in messaging across these different platforms and formats.

Regardless of where they wanted to receive information, stakeholders suggested that there be one consolidated place for members to check all needed information about benefits, appointments, application processes, and frequently asked questions, perhaps through a website or an app, modeled after apps that large health systems use.

Various members and advocates said it is essential to have a real person answering calls from people who don't want to use an automated phone system. Stakeholders said that, ideally, RAEs would assign members a case manager to help them navigate questions about their benefits and services.

Others suggested hiring peer navigators to visit places where members go, including primary care practices, schools, libraries, and grocery stores.

1.2 Members would like general information for them to be standardized across RAEs and tested to meet accessibility requirements.

Most stakeholders said general information, including onboarding information and trainings, coverage information, and stigma reduction education, should be standardized across the RAEs.

In their opinion, any information that is sent to all ACC members should be both developed and translated by one central source, which could be either HCPF or a single contractor. Although this was a prevailing view, a few stakeholders worried that there was a risk in HCPF over-standardizing member-facing communications. They noted that some communications, particularly related to community-based resources, need to account for regional variation and cannot be standardized statewide.

Members also suggested that member-facing communications and systems, whether statewide or regional, should be required to use plain language and verified for accessibility for those with disabilities. Several stakeholders suggested having member advisory councils (MACs) check communications and delivery methods for both language and accessibility, but they stressed that members would need to be compensated for their time.

A few members said that they often do not look at HCPF and RAE communications because these communications tend to be too long, full of jargon, or do not seem relevant.

1.3 Most members like having advisory councils and want to see more of these groups.

Members who serve on advisory councils, whether MACs or PIACs, expressed appreciation for these councils. Many complimented the staff running these groups, saying they had relevant lived experience, created a safe space for open discussion, and took the time to ensure members understood all concepts during meetings. Stakeholders suggested that RAEs should be incentivized to hire outside advisory council facilitators with lived experience.

Some members wished MACs met more frequently or had longer meetings, and that contracts had stricter requirements about the frequency that MACs and PIACs meet.

Other members mentioned that, while MACs are a valuable resource for members to learn about ACC services and Medicaid benefits, only a very small number of members can participate in them. They suggested creating more statewide and regional groups, or requiring RAEs to create peer support forums to help members learn about their benefits. These groups also offer an important avenue for members to provide feedback to RAEs and HCPF.

One stakeholder was frustrated that MACs seem to solicit members' advice but do not often implement that advice. That stakeholder suggested RAEs be required to have stronger partnerships with members and greater accountability for making changes that stem from member feedback.

MEMBER EXPERIENCE

1.4 Stakeholders recommend methods for collecting feedback on member experience and ensuring that feedback leads to change.

Stakeholders broadly supported HCPF's focus on member experience and on finding better ways to collect feedback about it. Some stakeholders were curious about HCPF's plans in this area and said they would need more information before providing recommendations.

Members suggested using focus groups or surveys to get more feedback. These members said RAEs should have a minimum requirement for asking members for feedback. Others said HCPF should use the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey or field its own surveys to members more frequently. One stakeholder recommended that RAEs develop a budget line specifically for collecting feedback, which they could do through simple surveys sent directly to members after any significant interaction with their RAE or providers.

Stakeholders said HCPF or RAEs need to follow up with members who provide feedback and "close the loop." Lastly, members cautioned HCPF about making changes that directly affect member experiences without soliciting feedback. In their words, "nothing about us without us."

1.5 Stakeholders disagree on the scope of the RAEs' roles in supporting and communicating with members.

CHI asked stakeholders whether RAEs should serve as a "one-stop shop" for members. Stakeholders disagreed about whether this was an ideal role.

A few stakeholders supported the concept but noted that it would require careful alignment with both providers and other state agencies.

Many disagreed, noting that they see providers or community-based organizations as the appropriate “one-stop shop.” These stakeholders mentioned that they would prefer that RAEs actively build relationships and networks with trusted community partners who already talk to stakeholders. One stakeholder said the value of a regional RAE is to provide education on and referrals to community-specific services. Some stakeholders recommended that RAEs have a narrower role, focused on care coordination and referrals for health-related social needs. We discuss this point more in the Care Coordination section.

Many members said they do not know anything about their RAE and do not ever communicate with them, highlighting a potential need for a different outreach and education approach from RAEs and HCPF. Some of these stakeholders felt that RAEs should not be helping with care coordination. One stakeholder pointed out that members may only be enrolled for a short time and said they should be able to receive care without knowing about or engaging with their RAE.

1.6 Members would like to have more up-front support when enrolling in Medicaid.

Several members said they had the most problems when they were first trying to enroll in Medicaid. They reported that much of the enrollment and eligibility information is confusing, and members said they had a hard time getting important questions answered about their benefits. According to some advocates and members, clearer communication during the enrollment and onboarding process could reduce the confusion members experience post-enrollment.

Initiative 2. Alternative Payment Methodologies

PAYMENT

In the Vision Stage’s stakeholder engagement sessions, CHI and HCPF staff asked participants to provide feedback on HCPF’s aim to implement “member incentives and advance alternative payment models (APMs) across the spectrum … to enhance quality care, close disparities and improve member health outcomes while driving affordability.” Specifically, CHI asked stakeholders about supports and services for providers to participate in APMs, primary care administrative payments, and incentives for the integration of physical and behavioral health services. Providers had many thoughts about lessons learned from APMs and how those lessons could be applied to ACC Phase III. Several stakeholders said HCPF should not design APMs without input and review from those with clinical backgrounds.

2.1 Stakeholders believe that APM-related data, particularly around attribution, must be improved.

A wide range of stakeholders expressed their concerns about the extent to which HCPF uses attribution to determine payments for APMs. Many said that they think attribution is inaccurate across the ACC. They also said that, in their experience, many providers lack trust in attribution methods because the attribution methodology does not seem transparent. Stakeholders noted that, if attribution is not made more accurate, they believe APMs should quantify and account for attribution errors. One stakeholder said HCPF should align attribution and risk adjustment methods with commercial payers as much as possible.

Many providers said they need more accurate and timely data from RAEs or HCPF before they can meet their APM benchmarks.

PAYMENT

2.2 Stakeholders have a range of suggestions for defining measures for APMs.

Stakeholders did not always agree about how HCPF should set APM measures. Several members said measures for APMs should be developed based on member input. Other stakeholders suggested prioritizing health outcomes, population-level health measures, member engagement, access to health care, or cost control. One stakeholder, however, cautioned that any APM benchmarks need to measure things that practices can impact, rather than measuring things over which they do not have control. Providers asked HCPF to align with other payers’ APMs to reduce the administrative burden.

Additionally, stakeholders recommended new APMs for mental health and substance use disorder treatment providers and dental providers. Other stakeholders recommended incentives for providers who address health-related social factors.

2.3 Many stakeholders suggest incentives for behavioral health integration.

A number of stakeholders raised concerns over the ACC’s separate payment approaches for physical health and behavioral health. Stakeholders repeatedly said HCPF should have additional incentives or PMPM payments for physical health practices that have fully integrated behavioral health care. One stakeholder said incentives for integration should include coding on claims that align with behavioral health incentive measures. However, another stakeholder cautioned that integration takes significant early investment, and they recommended that HCPF provide incentives or investments only if practices fully integrate behavioral health care.

2.4 Stakeholders would like more attention to risk adjustment, with increased incentives for providers serving specific populations.

One widely repeated comment from both providers and member advocates was that HCPF’s payment methodologies must take into account hard-to-reach or medically complex populations, with additional incentives for providers who serve these groups. Specifically, stakeholders called out incorporating risk adjustment methods that account for providers serving children, especially children with medical complexity. They also suggested increased incentives for those serving members experiencing homelessness, who often do not have phones and are harder to contact.

2.5 Stakeholders want to see APMs expanded beyond clinical staff.

Different stakeholders suggested that HCPF explore APMs for non-clinical staff and partners, such as peer support providers, care coordinators, community-based organizations that address health-related social needs, interpreters, those providing postpartum home visits, and public health agencies that engage in prevention activities. In addition to these suggestions, several advocates and members recommended that HCPF explore member incentives for activities such as wellness visits and well-child visits.

2.6 Practices report needing sufficient funding and support to implement APMs.

Several stakeholders said RAEs’ PMPM payments to practices are too low to cover the administrative burden of implementing APMs. Many specifically noted that, in their experience, PMPMs are inconsistent across RAEs or that RAEs change PMPMs frequently and without advance notice to practices. Providers said this lack of standardization makes it difficult for them to work toward improving the measures called out in APMs. Some providers also stated that practices with less funding cannot withstand increased administrative requirements and financial risk of APMs. One provider noted that smaller practices need support on cash flow management in the form of assistance from RAEs.

Initiative 3. Care Coordination

Members, providers, advocates, and other stakeholders provided substantial feedback on care coordination. Some stakeholders said they do not know what care coordination entails or how HCPF defines it. Stakeholders also stressed that care coordination should take a more holistic approach and include health-related social needs, a concept addressed in more detail in the Referrals to Community Partners section.

CHI asked which populations most need care coordination, how stakeholders understand care coordination services, what members' experiences have been with care coordination, and where there is room for improvement.

CARE COORDINATION

3.1 Stakeholders have a wide range of suggestions for which members need better care coordination.

Stakeholders had two general ideas about why people need care coordination — clinical diagnoses or social risk factors. According to some stakeholders, diagnoses that might require care coordination include disabilities, multiple chronic conditions, pregnancy, serious mental illnesses, serious emotional disorders, substance use disorders, and unmet oral health needs. Others said HCPF should ensure care coordination for members who use the emergency department multiple times each month, youth and families involved with foster care/family services, recent immigrants, members with limited English proficiency, people experiencing homelessness, members leaving prison or jail, Native and Latino members, newly enrolled Medicaid members, those transitioning between levels of care or discharging, and older adults, who are at higher risk of health complications generally.

Several stakeholders praised HCPF's focus on care coordination for children with complex health needs. However, others said HCPF should also prioritize children with rising or emergent needs, and some suggested that all young children need more care coordination. They suggested that part of this service should include connecting children with prevention resources to lessen the risk of chronic health problems later in life.

Others called out unique care coordination needs for members living in rural areas. They noted that rural areas often lack resources to refer to, and noted that care coordinators often face additional barriers in trying to meet with members face-to-face.

3.2 Many stakeholders think care coordinators should be responsible for maintaining up-to-date information about the network of providers and community partners in their geographic area.

Several stakeholders agreed that care coordinators have a responsibility to be knowledgeable and up to date about the networks of both providers and community partners involved in members' referrals and service navigation. In their opinion, care coordinators should also be expected to facilitate communication between members and others providing care or services. With that said, these stakeholders stressed that care coordinators could be more successful if they rely on existing networks built by trusted community partners instead of having untrusted agencies, potentially including new RAEs, try to build their own networks. One stakeholder said part of this network-building should be assessing where community services do not work well or are not well utilized. Related responsibilities, according to stakeholders, should be closing the loop with referring agencies and communicating with RAEs about network adequacy and service provider capability.

Others suggested that, as part of building and maintaining this network, care coordinators should be meeting with patients in-person and going to appointments with members when desired. While most stakeholders agreed that in-person care coordination is preferable, some rural stakeholders said distance and transportation challenges can prevent in-person care coordination in their communities and can even require members to be referred to services outside their area.

3.3 Stakeholders, particularly members, report that both care coordinators and members need more information on what coordination resources are available through the ACC.

Several stakeholders suggested that RAEs provide training to coordinators and other care navigators. Some parents said providers and care coordinators need more education on coordinating care for children with complex health needs, as well as for children and adults with disabilities. Others said coordinators should be trained in best practices and expected to understand the various resources available through the RAEs, HCPF, and within their local communities.

A range of advocates and members felt that members are often unaware of what care coordination services are available to them or how to access services. These stakeholders said that RAEs are responsible for sharing that information with members in an easy-to-understand manner. Other members said they did not understand the difference between care coordination, case management, and discharge planning, or whether there was a clear difference. These members suggested HCPF be clearer with members about the different roles of care coordinators, case managers, and others.

CARE COORDINATION

3.4 Many members say they are functionally responsible for coordinating their or their child's care.

Many of the members, even those with complex health needs, said they had not received formal care coordination services from a RAE. These members said they regularly had to coordinate their own care and act as the bridge between their various providers. Other members said they had received short-term care coordination assistance from their RAE but felt that this coordination was inadequate. One member felt their RAE care coordinator was just trying to close their case, even though the member had a chronic condition that required long-term care coordination.

One provider speculated that this may result from current policies. As an example, they mentioned that some RAE care coordinators will call a member twice, one day apart, and will close the case entirely if they do not connect with the member within a day of those calls. Another provider said the situation can be worse for members who do not have a means of consistent communication. Both suggested that RAEs should change their outreach policies to allow for more successful care coordination, with the latter suggesting that RAEs pay for phones for members who do not own them.

CARE COORDINATION

As several stakeholders explained, problems with care coordination can be worsened when members transition between RAEs or providers. Stakeholders shared that these individuals can find their care coordination cut off and end up coordinating their own care, either because they are not connected to new coordination resources or that starting over with a new coordinator feels like too much work.

3.5 There is broad agreement across stakeholders that HCPF needs to provide more financial support for care coordination.

Stakeholders stressed that HCPF needs to pay care coordinators enough to let them spend adequate time supporting members and help prevent high rates of burnout. Many mentioned that while care coordinators often have many responsibilities, practices lack sufficient funding or infrastructure to meet those requirements.

Stakeholders also pointed out that care coordinators are expected to manage overly large caseloads. Many felt that larger budgets for coordination would allow entities to hire more staff and decrease each individual coordinator’s caseload. Members stressed that this would allow care coordinators to spend more time with members and let HCPF incentivize care coordinators to provide warm handoffs and additional support for complementary services.

3.6 Stakeholders want care coordinators to use an equity lens and better reflect the populations they serve.

Many stakeholders, including members, would prefer to have care coordinators who have shared backgrounds with the populations they serve, are peers who have themselves navigated the Health First Colorado system, or are community health workers. As they explained, members are more likely to trust people with shared experiences. One stakeholder pointed to the Latino community as an example and said Latino members would largely prefer to have coordinators who speak their language and come from a similar cultural or ethnic background.

When it is not possible for care coordinators to reflect the populations they serve, stakeholders suggested that coordinators receive equity-focused training. Various stakeholders defined this as hiring multilingual coordinators and training them in language justice, or as training stakeholders in cultural validation techniques. According to stakeholders, HCPF may need to set aside dedicated funding for these kinds of trainings.

3.7 Stakeholders disagreed about whether care coordinators should be employed by providers or by RAEs.

Most stakeholders suggested that practices employ care coordinators. Several stakeholders, including members, said providers are closest to the point of care and are ultimately responsible for a member's treatment, so they should have the responsibility for coordinating their care. Others said care coordination is most successful when it comes from a trusted source, like a provider, and when it happens in the same place a member receives care. Several providers said this is a proven model and that many practices already coordinate care, but that they are not paid for this important work.

However, some members said they would prefer to see care coordinators connected to a government entity or RAE. In their eyes, this would allow a care coordinator to ensure different state programs are linked and to oversee all the pieces of a member's care without being aligned with any one aspect. Others said that RAEs would be the best entity for care coordination because providers tend to be very busy and lack the infrastructure for coordination. One member suggested that there be care coordination available at both levels, which would give members more flexibility.

3.8 Stakeholders worry that care coordination was not adequately aligned with other HCPF programs or with the work of the Behavioral Health Administration.

Given the work of the new Behavioral Health Administration (BHA), stakeholders worried about miscommunication between different programs and agencies. Some stakeholders said many practices are burdened by a wide range of metrics for various programs, including the ACC and the Hospital Transformation Program. They would like to see aligned care coordination metrics between these different programs. In addition to aligning metrics, stakeholders suggested aligning funding so that more care coordination dollars reach those coordinating care for members with the highest acuities. They said the current method of paying for care coordination creates confusion and can leave some needed care coordination services uncompensated.

CARE COORDINATION

Others called for a functional alignment among ACC care coordinators, BHA care coordinators, and case managers from agencies like community-centered boards and other HCPF programs, including long-term services and supports. Several stakeholders mentioned that, when members have multiple case managers or care coordinators, they often work in silos and fail to talk with each other. This was true both for members who had several care coordinators associated with HCPF and for members with care coordinators both within and outside of HCPF. In both situations, stakeholders would like to see HCPF suggest opportunities to improve this communication.

3.9 HCPF may need to better define care coordination requirements, including for different levels of acuity.

Many stakeholders emphasized that HCPF must clarify care coordination definitions in advance of Phase III and suggested that both members and providers be involved in creating these definitions. Stakeholders said care coordination differs from RAE to RAE. Specifically, several stakeholders highlighted a need for clearer standards for different levels of care coordination. This would include clarity on what diagnoses fall at what level and on what services are provided at each level. Some stakeholders said this work should align with the work of the BHA care coordination workgroup. They suggested using the BHA's model of tiered care coordination services, which involves higher reimbursements for more complex work.

Stakeholders also suggested the following possible additional requirements for care coordination to improve consistency. First, care coordinators should have reasonable time frames for engaging members and completing referrals. Second, HCPF may need to provide additional funding and create more expectations for regions that lack the resources to address health-related social needs. Third, care coordinators may need to be required to engage in detailed, one-on-one conversations or screenings for health-related social needs with anyone referred for care coordination.

Others suggested defining specific metrics to measure what successful care coordination looks like, including the rate of completed referrals and member satisfaction scores. Partners said care coordinators will be more likely to improve on these metrics if they are incentivized as key performance indicators.

Initiative 4. Referrals to Community Partners

Members, providers, advocates, care coordinators, and partners at community-based organizations provided suggestions on how HCPF could improve referrals to community partners in Phase III. CHI sought feedback on referrals to partners who address non-clinical, health-related social needs, such as food, housing, education, and transportation. Stakeholders called out food banks, partners providing supportive housing, human services like Supplemental Nutrition Assistance Program (SNAP) enrollment, schools, and Area Agencies on Aging. Several partners also said that screening and referrals should include isolation and socialization needs, especially since the COVID-19 pandemic damaged social connections.

Therefore, much of the conversation focused on screenings and referrals for health-related social needs. However, during these conversations, a few stakeholders also suggested HCPF explore work by other states' Medicaid agencies to become directly involved in health-related social needs, such as initiatives for providers to prescribe healthy food boxes directly to members.

Stakeholders' discussion on this initiative often overlapped with that in the Care Coordination initiative, and many people see these referrals as an essential piece of care coordination.

REFERRALS

4.1 Stakeholders suggest screenings take place where members receive care and that results are shared to minimize duplication.

Many stakeholders acknowledged the importance of providing screenings for health-related social risks. Most stakeholders agreed that these screenings should occur upon a member's first interaction with the health care system, whether that be in a clinic, at a RAE, or with a community partner. Many stressed that one entity should create a statewide screening tool that is used by all providers, RAEs, and community partners.

They also recommended that screening results be shared with other providers, care coordinators, RAEs, and community organizations so that others potentially involved in a member's care do not unnecessarily repeat screenings (although one stakeholder said repeated screenings can sometimes be necessary to assure critical needs are not missed). Some stakeholders said repeat screenings are especially burdensome on the behavioral health side, where many practices have already implemented screening systems for health-related social needs. One stakeholder said improved data sharing could allow health care partners to avoid conducting repeat screenings, which would reduce both administrative burden and member frustration. Several stakeholders recommended the Unite Us Application to improve data sharing for health-related social needs.

Some community partners said screeners should be trauma-informed to ensure the questions asked do not appear to cast judgment on members or cause them additional trauma. Part of this, according to stakeholders, is listening to patients about their priorities and being clear about how data from the screening will be used. In a member-centered approach, even if patients' screenings reveal food insecurity, stakeholders recommended that members not be referred to a food bank if they do not agree that it is a priority for them.

REFERRALS

4.2 Stakeholders want to see more warm handoffs and co-located support.

Several partners expressed frustration that, when screenings indicate a health-related social need, providers often give nothing more than a phone number or referral to a community organization. They noted that simply receiving referrals with no additional support can be overwhelming to members and that members are more likely to complete referrals if they receive resource navigation or, at minimum, a warm handoff.

Several case managers reflected on their personal experiences, saying that physically accompanying members to non-clinical appointments or making an initial phone call was particularly helpful, though time-consuming. Those providers who receive referrals also stated that merely receiving a referral and then attempting to cold-call a patient rarely succeeds in making a new connection.

Several stakeholders stressed that for certain health-related social referrals — especially to services like SNAP, which requires an application — the most successful strategy is to have a resource navigator co-located in the same space in which the screening occurs and to have that navigator help members complete their applications on site.

Many stakeholders said resource navigators, care coordinators, case managers, or even providers need additional time and funding to complete warm handoffs and help members navigate non-health resources. In their view, this requires HCPF to pay RAEs more, so RAEs can pass through funding to those helping with referrals to community resources. Timing was also reported as a significant barrier in rural areas, where warm handoffs can require staff to drive several hours to an organization to accompany a member in person.

As part of this resource navigation, stakeholders stressed the importance of closing the loop, so the providers who first administered a screening or provided a referral know whether that referral was completed. Currently, providers say that they are often unaware of what happens after their conversation with a patient.

4.3 Stakeholders recommend that RAEs be responsible for building networks, evaluating success, and supporting services provided by community partners.

Similar to feedback related to care coordination, CHI heard feedback that RAEs should be responsible for building relationships and networks of community partners who can help members address their health-related social needs, although perspectives on RAEs' ideal responsibilities varied. Several stakeholders suggested that RAEs oversee monitoring of user-friendly lists of community partners, with one person mentioning the Family Resource Center's approach as a potential model. One stakeholder said these lists should include data on current caseloads and waiting lists of community organizations to ensure members are not waiting too long for referrals. As part of these user-friendly lists, other stakeholders suggested that RAEs should be responsible for giving guidance to providers on which community partner may be the most appropriate based on a member's specific needs.

Finally, as part of this responsibility, some stakeholders noted that RAEs need to fund community organizations and programs that support members' health-related social needs. In addition, if RAEs are providing funding, stakeholders said they need to track how successful organizations are at addressing members' health-related social needs when they receive referrals. This may be tracked by asking about members' satisfaction with the community organizations they are referred to.

REFERRALS

4.4 Stakeholders would ideally like to see community organization staff and resource navigators reflect the populations they serve.

One theme that appeared across multiple initiatives is that stakeholders would like to see a diverse provider community that is culturally responsive to members' needs. For this initiative, several members want a resource navigator who is a peer or has a firsthand understanding of what members are experiencing. They also recommended working with community organizations where staff are already trusted by the communities they serve.

Other stakeholders said they would like to see screeners and resource navigators who are trained to be trauma-informed and culturally responsive, with specific requests for those who speak Spanish or use American Sign Language.

Initiative 5. Behavioral Health Transformation

Stakeholders readily shared feedback about the HCPF's priority initiative of behavioral health transformation, including how the HCPF pays for behavioral health services, which is discussed in detail below in the Additional Feedback of Note section, as well as alignment with the BHA, the behavioral health workforce, and behavioral health integration.

BEHAVIORAL HEALTH

5.1 According to stakeholders, HCPF should prioritize specific populations in its behavioral health work.

Stakeholders noted specific populations who currently experience behavioral health service gaps. These included members with alcohol use disorders, co-occurring substance use disorders and serious mental illness, and autism or other intellectual and developmental disabilities. Other members brought up the unique behavioral health needs of veterans, members living in rural communities, members experiencing homelessness, and members who use illicit drugs. HCPF may be able to help the BHA by using its experience working with these populations to improve service experience and quality.

5.2 Stakeholders want RAEs to align with Behavioral Health Administrative Service Organizations (BHASOs).

Many stakeholders stressed a need for the RAEs to be as aligned as possible with the BHA's structure, including both procedural and geographic alignment.

Many stakeholders are concerned that, with these two parallel entities, Coloradans will have trouble accessing care if they enter through the wrong door. Others worry there will not be a clear division of responsibilities. Stakeholders expressed hope that increased alignment between the two can alleviate these problems through clear roles and expectations and a defined process for making warm handoffs between the two entities.

Stakeholders stressed that they would like to see alignment between the RAE and BHASO geographic boundaries. Many stakeholders also recommended that the RAEs and BHASOs align their intake processes, definitions for care coordination, authorization and payment processes, administrative systems, and documents. Some even suggested that the BHA and HCPF contract with the same organizations to serve as both BHASOs and RAEs.

5.3 Stakeholders recommend higher, more consistent reimbursement and growth opportunities to address workforce shortages.

Many stakeholders said a significant barrier to care is workforce shortages and high turnover rates, particularly among peer support specialists, community health workers, and the prelicensure workforce.

Many stakeholders, particularly providers, recommended higher reimbursement rates for behavioral health workers. Some pointed out that providers are not paid for time they spend on non-billable tasks, including research, travel time to meet clients, and providing some care coordination and referrals for health-related social needs.

Stakeholders pointed out that some behavioral health providers have stopped contracting with Medicaid. Their understanding was that it may have been either because of low reimbursement rates or because payments can be delayed.

In addition to better pay, some stakeholders recommended building growth and mentorship opportunities for nontraditional behavioral health providers, particularly peer support specialists and the prelicensure workforce. For instance, one stakeholder mentioned a peer support certification process that many peers cannot access or afford to complete and recommended that HCPF provide financial support to those peers.

Others mentioned that many community mental health centers cannot afford to provide mentorship or living wages for the prelicensure workforce and recommended that HCPF provide incentives or loan forgiveness to mentors or to providers who remain after receiving their licenses.

5.4 Stakeholders recommend increased supports for nontraditional, culturally responsive behavioral health workers and services.

Many stakeholders stressed peer support specialists, as well as doulas, promotoras, and community health workers, as essential parts of the behavioral health workforce that would ideally be formally incorporated into Phase III.

They pointed out that the current payment model does not adequately pay these individuals for their work. Some stakeholders also stressed that these types of providers are important because they are more likely to be trained in providing person-centered, trauma-informed, culturally responsive care.

BEHAVIORAL HEALTH

In addition to expanding the types of providers who can bill for behavioral health services, stakeholders also recommended expanding the types of services that can be billed as behavioral health care.

Recommendations included mentorship programs, group therapy, home visitation programs, a broader range of prevention activities, and behavioral health care that occurs through outreach, including outreach in schools and to people experiencing homelessness. One stakeholder suggested that HCPF allow providers to bill for culturally tailored behavioral health care, such as talking circles for Indigenous people.

5.5 Stakeholders recommend more investment and requirements for culturally responsive training.

Stakeholders, particularly member advocates, mentioned that RAEs need to have dedicated funding to ensure behavioral health providers are trained in language justice and cultural validation. One stakeholder suggested RAEs train providers to ensure they can deliver culturally responsive care to members from historically marginalized groups.

Others recommended incentives for hiring diverse providers who reflect the communities they serve. Specifically, some advocates mentioned a need for more multilingual behavioral health providers. Others mentioned that the nontraditional workforce, particularly peer support specialists and community health workers, are more likely to reflect the communities they serve.

BEHAVIORAL HEALTH

5.6 Stakeholders say lessons learned on behavioral health integration largely focused on billing codes.

Many stakeholders commented on HCPF’s work to integrate physical and behavioral health in primary care settings and shared suggestions on how to improve integration. Stakeholders appreciated HCPF’s recognition of the need for services to be provided in one location with streamlined billing. They applauded HCPF for giving incentives to encourage integration but noted that they would like to see policy changes that further increase integration.

When discussing the six-visit threshold for reimbursing behavioral health in primary care settings through a fee-for-service model, a few stakeholders thought that this approach was a good first step. However, some stated that HCPF should increase the number of behavioral health benefits that HCPF can reimburse through a fee-for-service model or should even make that number unlimited. One stakeholder stated that many members prefer to receive behavioral health care in a primary care setting for more than six visits.

Others expressed frustration with this policy. One stakeholder said barriers remain to switching from a primary care practice to a behavioral health clinic at the end of those visits. Others said this policy has overemphasized reimbursing fee-for-service codes for therapy without integrating other types of behavioral health care into primary care settings. Specifically, many providers expressed frustration that they cannot bill fee-for-service for many other types of behavioral health care in primary care settings.

To promote better integration, some stakeholders suggested that primary care practices be able to use other integrated codes beyond just therapy codes. They recommended that HCPF reimburse for integrated fee-for-service code sets like health and behavior codes and collaborative care codes.

5.7 Stakeholders flagged several issues related to access to behavioral health care.

CHI asked stakeholders about current pain points and successes in accessing behavioral health services. Telehealth was seen as generally improving access, and several stakeholders applauded HCPF's increased focus on telehealth. However, stakeholders mentioned concerns that some patients may either have unstable broadband or low digital literacy. Other stakeholders noted transportation as a major barrier to accessing behavioral health services and would like to see HCPF provide additional support in this area.

Several stakeholders recommended HCPF send more support to communities that are "behavioral health deserts" with few providers or long waitlists for care.

Providers mentioned that administrative procedures can create an access to care barrier. One stakeholder mentioned the required intake and assessment process and related paperwork as a significant barrier. Others said prior authorizations for mental health and substance use disorder treatment can cause delays, and some stakeholders called for smoother or more automated processes to speed up authorizations for treatment.

5.8 Stakeholders supported HCPF's proposal to standardize behavioral health systems.

Several stakeholders emphasized a need for statewide standardization of specific requirements, calling out the challenges for providers needing to follow different processes with different RAEs. A few stakeholders specified a need for similar behavioral health authorization processes across all RAEs, as well as similar payment requirements. Other stakeholders applauded the proposal to standardize provider credentialling and utilization management.

Initiative 6. Accountability for Equity and Quality

HCPF wants to make sure RAEs and providers are held more accountable for the health of their members in Phase III. Phase III goals include promoting equity and improving quality of care, while also reducing administrative and reporting burden on providers.

CHI asked stakeholders about metrics and reporting requirements, including key performance indicators, that could improve quality and equity. Some stakeholders also talked about contracting changes that could reduce the burden on either RAEs or providers while still holding everyone accountable for health outcomes.

ACCOUNTABILITY

6.1 Stakeholders want to see more stable, standardized, and specific metrics and reporting requirements.

Providers and member advocates expressed concern that current metrics change too frequently to be useful in identifying trends and improvements. They stated that, because these indicators often change yearly, providers do not have time to make progress on any one indicator before they are expected to switch their focus to a different indicator. More than one stakeholder recommended that these indicators be held consistent throughout Phase III.

These same stakeholders also expressed frustration that performance metrics are not standard across RAEs. Providers who contract with multiple RAEs must work toward varying metrics simultaneously, adding to their administrative burden. Advocates said this makes it difficult to compare data and performance across RAEs.

Providers would like to see metrics and reporting requirements standardized with federal requirements, including around performance indicators, to reduce the burden on their practices. One provider said standardized measures are easier for practices to understand and track, while RAE-specific metrics can be confusing.

Finally, many stakeholders said there are too many metrics and that some of the metrics are not valuable. Some stakeholders believed certain metrics do not collect useful information, as they are primarily driven by the external environment and context, rather than meaningful improvements or changes made by a provider or RAE. One advocate stated that some of the metrics are “so easy” to hit that they are effectively useless. That person recommended using fewer but more meaningful metrics. Providers also said they are being asked to make progress on too many fronts simultaneously and would like to see fewer key performance indicators to incentivize progress on what matters most.

6.2 Stakeholders applaud a focus on equity metrics but worry that this would be difficult to measure.

CHI led several discussions on ways to measure improvements in health equity among Health First Colorado members. Many stakeholders liked the idea of holding RAEs and practices accountable for equity measures but disagreed on how best to assess this. Nevertheless, many stakeholders agreed that any measurements would have to be long-term, saying that it would be too difficult to make measurable and meaningful short-term equity improvements.

Many stakeholders suggested equity metrics should focus on specific populations, like individuals with disabilities, people experiencing homelessness, people of different ethnicities, and previously incarcerated people. Others said it’s essential to define specific disparities before deciding on the most relevant performance indicators.

When asked about specific metrics to track, a few stakeholders suggested measuring how utilization rates of certain services, such as mammograms, vary among different populations. Others suggested focusing on access across different populations, such as availability of same-day appointments for all members. One person suggested that RAEs track the backgrounds and identities of providers in addition to patients. Another suggested that there should not be metrics specific to equity, but that health equity should be at the core of all other metrics.

When discussing ways to track progress, several stakeholders recommended post visit surveys for all patients, especially for patients of color or for those from other demographic groups who tend to experience worse health outcomes. However, members mentioned that these surveys would need to be sent immediately after the visit without any lag, and that HCPF would need to take concerns over patient burden and trust into account. Members noted they would be more willing to provide feedback if HCPF regularly closed the loop on how their feedback was being used.

As part of this discussion, many stakeholders highlighted rural versus urban divides. They said many metrics are inequitable because they are focused on urban communities that do not face certain challenges in the same way as rural areas, such as transportation barriers or severe workforce shortages. They recommended modifying equity and other metrics for rural communities to account for these variables.

ACCOUNTABILITY

6.3 Providers hope HCPF continues to support practice transformation, including through more timely data.

Several stakeholders praised HCPF for its practice transformation support. One stakeholder specifically praised HCPF for helping coach providers on how to meet different metrics. Nonetheless, many providers would like to see HCPF focus its efforts on disseminating data to practices more quickly. As one provider stated, many practices do not have the data to track progress on metrics on their own, and it often takes months or years for practices to receive data on their progress from HCPF. Data that are years out of date are not useful for practice transformation efforts, so providers think timelier data are essential. These stakeholders recommended additional support for practices without sophisticated electronic health records.

Some stakeholders said that even with practice transformation support, it is difficult for practices to meet all Primary Care Medical Provider requirements. Stakeholders articulated that this challenge is partially due to high rates of staff turnover and partially due to the costs associated with different requirements. Some stakeholders felt this was an area where HCPF could better support practice transformation, with one suggesting HCPF mandate and pay for national certifications for patient-centered medical homes. Others mentioned that they would like to see more HCPF support for primary care medical providers that are working toward integration or that serve children.

6.4 Stakeholders would like more public, transparent reporting from HCPF, RAEs, and providers.

Several stakeholders expressed discontent with the amount, frequency, and clarity of information made public by HCPF, RAEs, and providers.

Several stakeholders recommended that RAEs track and report on data on the behavioral health workforce, particularly what proportion of services are provided by fully licensed providers; spending on and reach of various mental health programs, including assertive community treatment and residential care for substance use disorders; and providers who could take on new members but choose not to. One stakeholder suggested that RAEs be required to report quarterly on their number of new contracts, the length of time required to complete each contract, their claims data and payment dates, and the size and scope of their provider support team.

A different stakeholder said providers should be required to report more metrics more transparently to increase provider accountability.

6.5 Some providers would like to see more standardization in how RAEs contract with providers.

Many stakeholders, who were largely but not entirely providers, expressed frustration with the lack of standard processes across different RAEs. Specifically, stakeholders said RAEs should have standard processes for rate setting, credentialling and contracting, paying and rejecting claims, and communicating with providers on upcoming changes or appeals processes.

One provider also suggested that RAE contracts with providers often change quickly and that providers do not have adequate time to review new contracts. Providers would like to have time to review contracts with RAEs and suggest changes before those contracts are finalized.

Initiative 7. Data and Technology

Discussions about data often came up within broader discussions about the other priorities, particularly Referrals to Community Partners, Accountability for Equity and Quality, and Alternative Payment Methodologies. Many of the themes mentioned below were identified as ways to support priorities or proposed changes. Additionally, these suggestions came from stakeholders with a wide range of technology skills, and some suggestions may be met through education on existing technologies.

TECHNOLOGY

7.1 Stakeholders would like to see more timely data sharing between RAEs and HCPF with providers, particularly for claims data.

As discussed in the Accountability section, many providers said timely data sharing is essential to making practice improvements. Many providers called out a need for more timely access to claims data. Others pointed out that primary care providers need real-time notifications when their patients enter hospitals or emergency departments.

One stakeholder also brought up needing timely care coordination data, particularly regarding health-related social needs, to be shared with primary care providers by those helping members with system navigation (see the Care Coordination section). Another stakeholder said Federally Qualified Health Centers have made progress on real-time data sharing and may be a model to learn from.

7.2 Stakeholders suggested a single statewide platform for sharing health data.

Many stakeholders mentioned a need for data to be more easily shared among providers, community partners, RAEs, HCPF, other state agencies, and members. Stakeholders cited many benefits of data sharing, including better referral processes and avoiding duplication of services and screenings.

Some stakeholders proposed the use of a statewide care coordination platform or a statewide platform for all electronic health records. Others said there needed to be better interoperability between platforms used by different organizations, which may require addressing regulatory barriers. Some stakeholders specifically suggested that HCPF be more involved in social health information exchange work.

7.3 Some stakeholders would like to see more accurate and comprehensive data.

Stakeholders recommended that both providers and patients be able to edit their own data within RAE- or HCPF-managed data systems to address data inaccuracies. Member advocates also said they would like more comprehensive and accurate data to be collected on language, race and ethnicity, and medical necessity.

7.4 Members want data collection practices and processes to be transparent and member-centered.

Many members and member advocates stressed that any improvements HCPF makes to its data collection activities must be person-centered. Several noted that most patients do not know what data is collected about them, nor can they see most of the data shared about them.

Several stakeholders recommended that members be made aware of who is collecting data, what data they are collecting, and why. Ideally, members would like to have access to the data being shared, with options to opt in or out of certain components. One stakeholder said there should be an entity responsible for data education for members.

7.5 Smaller practices report needing support to make technology improvements.

As discussed in the Accountability section, some smaller practices report having trouble making program improvements because they do not have high quality electronic health record systems. Several stakeholders suggested that HCPF financially support these practices to improve their technology infrastructure. According to a couple of stakeholders, this may include support for securing more sophisticated technology.

7.6 Stakeholders suggested using a standardized tool for risk stratification.

Many stakeholders would like to see HCPF implement a standardized tool for risk stratification that can be used by all RAEs and practices in Phase III. Various stakeholders agreed that health-related social need should be considered in risk stratification (and therefore accounted for within the tool) and that any logic or processes for determining risk stratification should be transparent.

Stakeholders also identified specific populations that may need special considerations when conducting risk stratification. Specifically, stakeholders felt that these members may have higher risk levels, which should be accounted for in any risk stratification tool (and may lead to higher resources or incentives for providers working with these members). These included people experiencing homelessness, people who are incontinent, people with traumatic brain injuries or cognitive disorders, people without a support system or with past trauma, members with physical disabilities, and members who are frequently hospitalized.

TECHNOLOGY

Initiative 8. Children and Youth

The children and youth priority initiative is distinct from the other priorities because it is focused on a population group rather than a component of care delivery. Therefore, both HCPF and stakeholders recognize that children need to be considered within the context of each of the other initiatives. Providers, parents, and other stakeholders stressed that children and youth should not be considered “little adults” but that children and youth have specific needs when it comes to care coordination, behavioral health integration, and health-related social needs, which are all discussed in earlier sections.

CHI’s discussions within this priority initiative focused not only on the needs of children but also on the needs of their families, and many stakeholders affirmed that this discussion should be family-centered, not merely child-centered. Thus, some of the themes below are focused on families and parents, not just on children.

CHILDREN

8.1 Some stakeholders expressed concerns regarding HCPF policies for and RAE knowledge of the EPSDT benefit.

Many stakeholders, particularly pediatricians, questioned whether there would be changes in Phase III to the ACC’s approach to services covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Several said they did not think the Department was optimizing EPSDT benefits. One stakeholder said services that RAEs require approval for should be automatically approved under the EPSDT benefit. More generally, others agreed that many children must wait too long for care to be approved, and they want the Department to address this delay.

In addition, some stakeholders said RAEs do not have a deep understanding of the EPSDT benefit and do not promote the benefit to members. One stakeholder suggested that RAEs be required to understand the EPSDT benefit and educate members and their families about the benefit. Another said that, in their opinion, RAEs have an active role to play in connecting children with the screening piece of the EPSDT benefit and suggested that RAEs should incentivize members for completing well-child visits.

8.2 Stakeholders want HCPF to implement standardized and increased supports and benefits for children with medical complexity.

Several stakeholders expressed frustration that there is not a standardized definition of “medical complexity” among children and youth. One person said that claims history should not be used to define medical complexity, nor should health-related social needs.

Other stakeholders expressed a desire for more standardization in the set of services included for children with medical complexity and highlighted home-based services. A few stakeholders mentioned variations among RAEs, which creates inequities for members and confusion for providers. Many stakeholders agreed that children with medical complexity need comprehensive care coordination and team-based care, including integrated social workers and behavioral health supports. They said that HCPF should improve reimbursement for team-based care for these children. One member even suggested HCPF create a specific RAE for children with medical complexity.

Beyond these general comments, several stakeholders, especially parents, stressed a need for more supports for children with intellectual and developmental disabilities, particularly those with co-occurring mental health problems. They said current efforts to integrate physical and behavioral health do not account for the unique needs of children with intellectual and developmental disabilities. They would like HCPF to pay more for services like specialized sitters and multisystemic therapy — an intensive intervention for children and youth with serious delinquency and substance use problems. Others mentioned the need for more providers and more flexibility for applied behavioral analysis services — a psychological intervention commonly known as ABA therapy — particularly for children in schools.

8.3 A range of stakeholders mentioned a need for more funding for prenatal, perinatal, and postpartum care.

Parents and advocates said they would like HCPF to reimburse prenatal and perinatal services provided by doulas, midwives, and community health workers, including home births.

Others, particularly providers, said HCPF should encourage providers to integrate perinatal care into well-child visits or that HCPF should encourage the enrollment of newborns in Health First Colorado before leaving the hospital. One stakeholder pointed out that pregnant and parenting youth, in particular, need additional services and supports from RAEs and providers.

8.4 Providers recommended HCPF pay for certain preventive services for children and youth that are not currently covered.

Several providers and advocates stressed that prevention is important for children and youth to lessen the risk of developing chronic or severe health conditions later in life. Several providers said timely prevention services are important for children with emergent health needs to prevent those emergent needs from becoming complex health needs. To improve prevention, some stakeholders encouraged further funding to reimburse for services not currently covered by Health First Colorado. Stakeholders identified a few examples, namely home visitation services, screening for health-related social needs, and referrals to address those needs.

Additional Feedback of Note

Some of the feedback stakeholders provided was focused on the overall design and structure of the ACC or did not link directly to one of the priority initiatives. While this section does not capture all feedback shared by stakeholders during the Vision Stage, notable themes from that feedback are summarized below.

A few stakeholders expressed concerns about the ACC's current payment model.

Several stakeholders questioned why HCPF is committed to continuing its approach of paying for physical health as fee-for-service and for behavioral health through a capitated payment model. According to these stakeholders, this approach leads to inequities between mental and behavioral health care in both quality of care and administrative burden, as well as misdirected incentives. They also said the behavioral health capitation model leads to less accountability for RAEs and makes it harder to appeal denials.

A few stakeholders called for the ACC to move away from a regional model.

These stakeholders said a regional model inherently creates inequities, citing vast differences in performance among RAEs. Some stakeholders said having multiple RAEs creates administrative challenges for providers who see members from more than one RAE. They feel it can also limit expertise within a given RAE on caring for certain types of patients, such as children with medical complexity.

Several stakeholders had questions about the award process for RAE contracts in Phase III.

Some stakeholders raised concerns about existing RAEs and wanted to know whether and how HCPF would evaluate those RAEs' performance to decide whether they could bid for Phase III. Some stakeholders advocated for transparency in the metrics HCPF will use to evaluate RAEs during the Phase III consideration and award process. One stakeholder said they would prefer not to see for-profit RAEs in Phase III. HCPF staff acknowledged that more about this process, including opportunities for feedback on the draft RFP, would be forthcoming.

Stakeholders had many concerns about workforce shortages and low salaries for providers.

Across all priority initiative discussions, participants brought up workforce shortages and high rates of burnout as barriers for providers, which in turn impacts members. There was a particular emphasis on a lack of providers who are culturally or linguistically responsive to members' needs. These stakeholders stressed that a full and diverse workforce is an essential component of achieving HCPF's goals for Phase III.

To grow and support the workforce, many stakeholders recommended HCPF ensure providers have growth opportunities and can earn a living wage. This recommendation included medical assistants, care coordinators, peer support professionals, and other members of the nontraditional health care workforce. Other stakeholders specifically mentioned that staff members such as personal care providers and registered behavior technicians be paid even when they are completing non-billable activities, like research and planning, as these are a crucial part of supporting patients. Others said HCPF should recruit more diverse providers across the continuum of care and train all providers in cultural responsiveness.

Rural stakeholders said their communities have diverse needs that must be considered in all priority initiatives.

Stakeholders representing rural Colorado focused on the severe workforce shortages in their communities, as well as heightened transportation challenges that make some activities difficult or infeasible. Some stakeholders shared specific requests for HCPF to keep expanding and allowing flexibility for telehealth services, offer more transportation support, and do more to help develop a local workforce in these communities. Others recommended incentivizing providers to visit and serve in rural areas to mitigate some workforce challenges.

Other Considerations

CHI staff heard additional comments that were outside the framework of the priority initiatives but were relevant to the design of Phase III or the future of the ACC more broadly. For example, these included prioritizing dental care integration and access to specialty care in Phase III, as well as aligning Phase III design efforts with the end of the Public Health Emergency and preparing for future pandemics. As appropriate, CHI shared these comments with HCPF staff in regular summaries from stakeholder engagement activities.

All involved acknowledge that the scope of these conversations can be quite large. Stakeholders are encouraged to direct ongoing questions and feedback about Health First Colorado to HCPF by visiting the contact information page on HCPF's website:

https://hcpf.colorado.gov/contact-hcpf

Next Steps for Stakeholder Engagement

CHI has routinely shared takeaways and themes from stakeholder conversations with the internal ACC Phase III workgroups and other relevant staff at HCPF. Throughout the Vision Stage, these workgroups have refined specific proposals for changes in Phase III and identified opportunities to build on success with the current approach. Several proposals will be highlighted through a concept paper to be released in summer 2023. CHI will continue to convene stakeholder engagement sessions and offer other avenues to solicit feedback around these proposals, and to capture stakeholder input as HCPF staff develop the draft RFP later in the year.

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