Improving Member Experience
Comunicación y apoyo para miembros

Opportunity: Improve coordination of services and supports for members so they can more easily and readily access needed resources by better leveraging the contracted partners most closely aligned with members. Improve clarity of communication so members can more easily understand and access their benefits.

Oportunidad: mejorar la coordinación de los servicios y apoyos para los miembros para que puedan acceder más fácil y rápidamente a los recursos necesarios aprovechando mejor a los socios contratados más estrechamente alineados con los miembros. Mejorar la claridad de la comunicación para que los miembros puedan comprender y acceder más fácilmente a sus beneficios.

What would it look like for RAEs to serve as a "one-stop-shop" for members in Phase III? What are some requirements that need to be in place for this to happen?

A good idea for simplification, but it also needs to be able to link to the BHASOs, geographically.

More pressing issue is coordination - mental health to physical health

Think Disney experience and how easy it is for folks to get around. What if accessing our physical health care/behavioral health care needs was as simple?

Different barriers and ways of accessing services for our rural communities. Would like more and better telehealth with providers from anywhere in CO.

As a provider, I'm concerned about inconsistency of requirements between BH cap and phys. health. Specifically when it comes to quality of care/admin

Current rules and regs would need to be adjusted so that it is seamless on the administrative side.

Not sure if having a one-stop shop is a good idea. There are other orgs that have more of a specialty for the type of care members need and may be a better fit.

Need to think about which organizations will be part of this one stop shop, including community mental health centers and other service providers.

What would help increase awareness of the services and supports offered by the RAEs? How can this be streamlined across all the different RAEs?

Leverage technology (app), similar to what UCHealth uses - provides medical information, services, referrals. Comprehensive whole person care.

Would like similar universal app for each RAE, with education to support the app, etc.

The Department is looking to centralize and enhance tools and resources. What type of information, tools, and resources needs to come from the Department? What type of information needs to come from RAEs?

How should the Department work towards further seeking feedback about member experiences within ACC? What are some important considerations?

Accountability for Equity & Quality
Responsabilidad por la equidad y la calidad

Opportunity: Enhance primary care and behavioral health accountability for both providers and RAEs, with the goal of closing health disparities, improving health care quality and outcomes, and driving affordability.

Oportunidad: Mejorar la responsabilidad de la atención primaria y la salud del comportamiento tanto para los proveedores como para los RAE, con el objetivo de cerrar las disparidades de salud, mejorar la calidad y los resultados de la atención médica e impulsar la accesibilidad económica.

How can Phase III promote team-based care and non-traditional health care workers -- community health workers, doulas, peer supports? What are specific considerations?

For successful TBC - care coordination happens at the practice / community level. RAEs are very removed from where care is being delivered.

Reimbursement change for care coordination will help: https://www.fiercehealthcare.com/payers/cmmi-aims-bolster-primary-specialty-care-coordination-new-payment-models

Care coordination funds should be provided to the practices

Consider coverage of interpretation services for all services (including non-traditional health care, care coordination, and education)

Consider ways to compensate providers to directly include non-traditional health care workers within single visits (of course, will be longer visits)

Established standards of practice & assurances for quality

Role of attribution (added 2x)

Consider specialty networks not available for robust team-based care

Ensure the workforce is representative of the Medicaid community/population with lived and living experience and they are reimbursed for their services at a thriving wage

Assure non-traditional health care workers are culturally and linguistically competent

Consider contracting with local non-profits who typically use CHWs, doulas, peers to provide education and support to clients (Added 2x)

Improve data sharing between BH, PH, and specialty care

Point of entry: people not entering system through physical health only but mental health (also through non-traditional HC workers)

HCPF is interested in continuing the evolution of primary care accountability for health outcomes, closing disparities, and affordability. What needs to be considered? How might this work in practice?

Can "progress towards health outcome" be taken into consideration (vs. only meeting health outcome)?

How can you offset accountability for outcomes with attempts to meet needs in complex populations where outcomes may be difficult? (Added 2x)

Do data streams capture patient/member choice to exclude them from 'accountable outcomes'?

Disparities: Keep in mind burden of data collection or duplication of data collection (practices doing SDOH screens etc.) on members.

Practices should receive regular updates on their performance (i.e for practices without fancy data crunching systems or EHRs that create reports) to course correct.

For example, commercial plans send monthly reports that are coded "not met/met" for each metric

Support for tech / data upgrades for providers: Data requirements on practices without high caliber EHRs can make participation / accountability unachievable.

Assess people getting care/getting into care/access to care

Re: Access to care metrics is important but acknowledging network inadequacy needs to be factored in.

HCPF is seeking feedback on the current PCMP requirements. What is and is not working? What needs to change to promote accountability?

RAEs must:

1) provide credentialing and contracting within 60 days

2) provide electronic claim submission through EHR software and clearinghouse systems. RAEs may not require providers to use RAE specific websites or interfaces, within 7 days of contracting

3) provide direct deposit ACH payment transfer without fees, within 7 days of contracting

4) provide payment information (ERA data) through clearinghouses and EHR solutions. RAEs may not require providers to use Availity, Payspan, or other solutions, within 7 days

5) clean claims must be paid in 14 days, rejected claims or 0$ payouts that are contested must be resolved within 90 days.

6) changes to administrative systems must include notification to HCPF, notification to IPN including estimate of the time needed to accommodate the change, a stakeholder meeting explaining the impacts of the changes, and compensation at $250/hour to all providers impacted by the administrative change.

7) operate a provider support system that reasonably meets the needs of the providers for claim adjudication, electronic data interchange support, and procedure questions.

RAEs must :

7) report quarterly on care provided, including the number of each CPT code provided.

8) report on # of new contracts and length of time to contract

9) report on claims payment including length of time for rejected claims that were eventually paid

10) report on payment dates, frequency of payment, and time between deposit and transfer of electronic data explaining the payment

11) report the size of their provider support team, and the geographic area that team is responsible for, and the number of providers the team is responsible for supporting.

12) make public an escalation list so that providers know who to call about what concerns.

13) make public a record of provider complaints, time to resolve, resolution, with the ability for providers to add their comments

14) publish rates to the general assembly for all CPT codes

15) include "available providers" in the quarterly network adequacy reports

Accountability

14) Any provider will receive $5,000 per day per incident beyond the deadlines for contracting, data setup, claim adjudication, or claim payment. Providers will receive $5,000 per day when inquiries are not responded to within 72 hours.

Improving Referrals to Community Partners
Mejorar las referencias a los socios de la comunidad

Opportunity: RAEs connect members to community supports outside of Medicaid covered services to better address their health-related social needs.

Oportunidad: Los RAE conectan a los miembros con apoyos comunitarios fuera de los servicios cubiertos por Medicaid para abordar mejor sus necesidades sociales relacionadas con la salud.

What should the Department consider as it modifies RAE requirements to a) engage in health-related social needs screening and b) facilitate connections to support services?

Are there tools that could aid in effective screening and/or connections to support services?

Work a lot to connect people to SNAP. Have partnered with institutions for referrals, and have learned providing info for people to contact food resources doesn't work

Strong case to invest not just in referrals but in more providers, staff actually assisting with SNAP applications and some other program.

Most impactful is helping people fill out SNAP applications in real time. Estimated 300K Coloradans eligible but not enrolled. Better health and lower costs.

Have struggled with PEAK for a long time. We have sites and enrollment assistance but often are not real time in locations where people are getting care or other services.

Often, when you reach out to IT for help, you are directed elsewhere (e.g. to county staff). But the help they can provide is limited, doesn't include technical assistance remotely.

Just having systems in place doesn't mean things work really well.

Many churches and CBOs have food banks, but access to food and transportation needs compound the issue. Need variety of healthy foods too.

Fruit and veggie Rx, healthy food boxes are on the radar for other states' Medicaid programs

Socialization as opposed to isolation. Especially during pandemic, many people confined to small spaces alone for months. Is an important SDoH factor.

State saves money if people are not in facilities, but are instead in the community.

AAAs as an opportunity -- many Medicaid members are older adults. Already have databases of resources for food, housing, etc. that RAEs could leverage

Many referrals that are needed aren't Medicaid-specific, like education and other SDOH needs.

Housing prices create major difficulty for supporting people who need transitional housing (e.g., after rehabilitation).

HCPF is interested in RAE requirements to improve health equity and reduce disparities. How might this work in practice? What requirements should the Department consider?

As the Department and RAEs work to address health-related social needs of various populations and leverage complementary partners, what should they prioritize?

Note that populations of focus include high-risk kids, those undergoing transitions of care, members who are dual-insured, pregnant people, and people diagnosed with serious mental illnesses and/or substance use disorders.

Alternative Payment Methodologies
Metodologías de pago alternativos

Opportunity: Implement member incentives and advance alternative payment models across the spectrum — such as primary care, maternity care, behavioral health, prescription drug, specialty care, and more — to enhance quality care, close disparities and improve member health outcomes while driving affordability.

Oportunidad: Implemente incentivos para los miembros y avance en modelos de pago alternativos en todo el espectro, como atención primaria, atención de maternidad, salud del comportamiento, medicamentos recetados, atención especializada y más, para mejorar la calidad de la atención, cerrar las disparidades y mejorar los resultados de salud de los miembros mientras impulsa la accesibilidad económica.

1. What should the Department consider as it continues to improve Primary Care Medical Provider (PCMP) administrative payments?

APM measures may need to be adjusted for people experiencing homelessness. It's a challenge to provide care coordination for members with no home or phone (x2)

Incentivize caring for attributed patients who are unhoused and unique challenges for follow-up visits, etc.

APMs for most common conditions of disadvantaged populations

Consider APMs for mental health and SUD

Tiered PMPM payments rewarding PCMPs that meet the highest standards of quality, access, member engagement, and cost control

Complex Care Management incentives

Consider adjusting payment methodology for those serving more complex demographics/acuity

segment out administrative PMPMs for medically complex children

Standardize administrative PMPM payments and how they are earned across RAEs - there is significant variability from RAE to RAE

Restrict RAE ability to make changes to admin PMPM programs to 1x/year or consider something even longer term - it is hard to make meaningful change with many changes

Providers are notified, ahead of time, when rates are changing or more work is being added to contracts for same PMPM previous to receiving the contracts

Reduce administrative burden through standardization

Member acuity and monthly data be sent from HCPF to Provider.

Reporting tools that allow providers to understand risk, payment and population health in near real time

Translation and interpretation needs for those serving a more diverse population increases cost of care significantly

Payment for addressing SDOH factors (added 3x)

Prioritize and financially reward integrated behavioral health care

Consider additional PMPM for fully Integrated Behavioral Health

Why separate mental health from health? How can changes promote a comprehensive concept of health? (x2)

Incentives/rewards to include coding on claims that aligns with behavioral health incentive measures

Include clinical experts at the State when building programs. All work to be carried out in a healthcare setting should have clinical review

Align attribution and risk adjustment methodologies with commercial payers (HB22-1325) where possible.

Need to add dental providers as they carry one of the KPI performance requirements (x3)

Pediatricians have more limited access to opportunities through programs like PRIME, and less flexibility with APM. Need more opportunity for those who serve 0-21 yrs

2. What should the Department consider as it works to leverage payments and existing funding to promote behavioral health integration?

Expand PRIME in western CO

Need increased clarity around same-day visits

Care Coordination
Coordinación de Atención

Opportunity: Establish standards for care coordination for populations with unique needs, such as pregnant people and individuals with disabilities.

Oportunidad: Establecer estándares para la coordinación de la atención para poblaciones con necesidades únicas, como las personas embarazadas y las personas con discapacidades.

How can the Department and RAEs ensure care coodinators are addressing the unique needs of various populations and leveraging the right partners?

Populations of focus include high-risk kids; those receiving transitions of care; members who are dual-insured; pregnant people; and people diagnosed with serious mental illnesses and/or substance use disorders

For people with complex and diverse needs (different types of need), we need to avoid siloing, recognize complexity

Referrals to non-Medicaid partners/resources (e.g. educational advocates) are important for youth with disabilities or other needs.

Importance of access to health food - key component for health/wellbeing of members and address healthcare cost

This is especially important in communities with limited access to healthier foods.

Other states are innovating by integrating provision of tailored provision of healthy food as part of care coordination to meet the health needs of different populations.

Expand care coordination to meet not only medical/clinical needs, but to address social determinants of health that impact health outcomes

Ensure that care coordinators have a realistic caseload number so they are able to have time to spend with patients across all levels of care (complex to simple)

Duplication happening between clinic and RAEs; clinic CC is much more comprehensive b/c they have full medical history/understand social needs.

Needs to happen in real time - clinics can do this (and they do!), but aren't being paid for it (Added 2x)

Care coordination is best integrated within the clinic because of established trust w/ providers and ease of coordinating (team-based care) in clinic. (Added 2x)

Assure care coordinators are culturally and linguistic diverse and competent (to match client population)

RAEs are not doing care coordination well, however, they are receiving the majority of the dollars. They are removed from where care is delivered.

Patients lack trust w/ RAE, many see it is a government affiliated organization. And outreach approach via phone calls are not effective

We think all MH providers are the same, but there are important differences by type, geography, etc. We need more nuance of understanding.

Utilize (and reward/compensate) for ACTIVE referrals (helping clients access the desired resource) versus PASSIVE referrals (go to XYZ organization)

What should the Department consider as it works to standardize data collection and reporting on care coordination across RAEs?

Think about what data should be collected; how data should be shared and between whom; what should be standard across RAE contracts; etc

Need support for tech/data upgrades for providers. Data sharing requirements from Medicaid on practices without high caliber EHRs can make participation unachievable.

This is especially true for smaller clinics or rural clinics

Important metrics: referrals made; satisfaction (would you refer your family member/friend to this provider)

Data collection needs to be transparent; clients need to know what is being collected and shared. (Added 2x)

Education among clients for certain programs (quality programs) about data collection

Do any other states have best practices on this? Any resources with https://patientnavigatortraining.org/ that are applicable?

https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html

Children & Youth
Niños y Jóvenes

Opportunity: Improve access and outcomes for children and youth, particularly those in child welfare, involved with the justice system, or with special health care needs. Improve the experience of the caregivers and providers who support them.

Oportunidad: Mejorar el acceso y los resultados para niños y jóvenes, en particular aquellos en bienestar infantil, involucrados con el sistema de justicia o con necesidades especiales de atención médica. Mejorar la experiencia de los cuidadores y proveedores que los apoyan.

What programs are needed to improve pediatric care and preventive care performance? What needs to be considered? How might this work in practice?

Need more resources for RSV, and support addressing RSV in child care settings

Increasing supports for pandemic response/RSV

Need standardized definition of medically complex-home care

More support for pregnant/parenting youth

Adequate medication supports, financial support to obtain medications

Need comprehensive care coordination (CCC).

However, it's hard to pay for CCC - must use integrated BH teams, social workers, etc.

Need more availability of team-based care and team supports

Need a model that recognizes preventive care as addressing rising risk via care coordination, connection to resources, and more.

Preventive support for food insecurity, access to healthy nutritious foods.

Meaingful, detailed SDOH screening and reimbursement

Should contract requirements for coordination and management of high-risk children and youth be standardized? What needs to be considered with this approach?

What does it mean for a pediatric practice to hold complexity?

Ensure definition of medically complex is not based on claims or missing other indicators (ie SDOH, mental health needs, teen parent, home care, DME, etc.)

Consider medical and behavioral health complexities

Support needed for kids "in the middle" or who have "rising risk", but may not be high risk/complex currently.

Value in standardization - mimimizing # of changes that RAEs can make

Cons - changes in requirements and variations

Rural practices with limited access to in-person acute/complex care have different experiences. Utilize tele, have to deliver more services directly.

Behavioral Health Transformation
Transformación de la salud conductual

Opportunity: Align with and support the work of the Behavioral Health Administration to achieve shared goals, increase overall care access, and implement a more effective system of safety-net behavioral health services. Increase access to culturally competent community-based services by addressing gaps in the continuum of mental health and substance use disorder services.

Oportunidad: Alinearse y apoyar el trabajo de la Administración de Salud del Comportamiento para lograr objetivos compartidos, aumentar el acceso a la atención general e implementar un sistema más eficaz de servicios de salud del comportamiento de la red de seguridad. Aumentar el acceso a servicios basados en la comunidad culturalmente competentes al abordar las brechas en la continuidad de los servicios de salud mental y trastornos por uso de sustancias.

How can the Department effectively and responsibly grow the peer and unlicensed workforce as part of its goal to better address members' behavioral health needs?

As a provider, peer specialists are crucial. A way to grow that pop'n is to have a scholarship program or other way to pay for the training.

Some of the most productive members of our staff and clients love interacting with them/having them as part of groups. Their voice is important.

Echo the comment that peer supports are among most effective resources we have.

Look for opportunities for peer supports to expand their role and what they can do, plus need to create sustainable payment models given the work they do.

People who don't have Medicaid don't have access to peer support resources. Figuring out alignment and how to provide that service to anyone is really important.

When capitation went away, could no longer include everyone, only people for whom we could bill for the services provided.

Could there be an incentive for providers who mentor unlicensed provders?

State put a lot of work into creating the certification so now there is a need to better access the training.

We could also consider levels of growth for unlicensed workforce, so there is a career path.

Burnout rate is quite high. Work ramps up very quickly in terms of # of clients. Many clients are high acuity or dealing with persistent mental illness.

Sometimes unlicensed providers stick around long enough to get licensed and then are done. Leave for private practice or other settings where acuity is lower.

So we need better education on the front end, more training opportunities, and lower caseload for providers.

What steps should the Department take to create greater consistency in behavioral health provider rates among the RAEs? What are important considerations?

Payment parity for virtual behavioral health services will allow for sustainable models of care and therefore greater access.

Another vote for parity

Consistency doesn't necessarily mean the same. It's about the same approach. Different methodologies might be applied by provider type.

BH providers is a broad category. There are many different types, so when we talk about consistency, need to first consider different types and consistency within types

In a perfect world, RAEs should have contracted with all of the BH centers but did not happen.

Providers struggle with different reqs for payment from each RAE.

Some RAEs would not pay provider for months until the provider began refusing service to members in those regions.

How can the Department best increase access points and fill service gaps for members who need high-intensity behavioral health outpatient services?

Supporting preventive BH services, especially those that take place in PC clinics, is really important.

Technology & Data Sharing
Tecnología e intercambio de datos

Opportunity: Leverage technology to improve access to services and data sharing among HCPF, the RAEs, and providers to enhance coordination, reduce duplication, and propel data-driven decision-making.

Oportunidad: Aprovechar la tecnología para mejorar el acceso a los servicios y el intercambio de datos entre HCPF, RAE y proveedores para mejorar la coordinación, reducir la duplicación e impulsar la toma de decisiones basada en datos.

1. How can the Department work towards improving data sharing among various parties and strive for real-time data exchanges?

What partners need to be considered? What tools and resources can be leveraged? What should the Department keep in mind?

Non-duplicative data needs to be shared. For example, share data across programs and requirements instead of asking for unique data feeds for each program. (Added 2x)

Continue to work on Interoperability with CDHS and other State agencies

Monthly claims data

Frequent shared claims data, timely enough to impact incentive payments

In order to reduce readmissions and manage total cost of care, we need to see all claims for our empaneled patients, not only claims for our practice. (Added x2)

Leverage CCMCN/AZARA data tools (best real-time data analysis we receive using EHR and claims data). (Added 2x)

Use Payer-to-Payer FHIR

How to deal with HIPAA 'release' to provide for sharing specific information for members appropriately to enhance quality and completeness of care.

Comply with proposed CMS mandate on data sharing and automated prior authorization (Added 2x).

Immediate (real time) notification to PCMP when patient is in hospital or ED

2. What is important to consider as the Department works to standardize risk stratification methods?

Get clinical engagement

Clinical review must go into this work

Medicaid reimbursement levels do not always match the costs of providing care.

Make the logic and process around the risk stratification as transparent as possible.

Will there be appeals mechanism for questions about severity levels for a patient by a provider?

Standardize the tools that RAEs and providers use to interpret risk and incorporate that risk into APMs (Added 2x)

Mental Health and Substance Use Disorder

Stigma around MH & SUD is a huge barrier, in society and in healthcare

PAM follow up requirements need to be adjusted for people who are homeless. For example, there is no home to visit them at for complex care coordination

Incontinence, is not currently considered in risk strat I believe. If a person experiencing homelessness is incontinent they can't go into a shelter or respite. They are literally on the street

Health literacy

Members with brain injuries and cognitive disorders are super vulnerable

Frequent hospitalizations

Age, by itself, is not the same as an indication of frailty.

3. What is important to consider as the Department explores incorporating social needs into risk stratification methods?

CRN (Community Resource Network) and PRAPARE (CCMCN) are great SDOH tools

Would like one uniform tool like CCMCN's (Added 2x)

Must foster a universal understanding of importance of the 'social determinants of health.'

Consider driving prospective payments based on SDOH risk stratification to support providers serving the neediest populations (Added 3x).

Overlap with APMs and priorities in these programs, such as SDoH screening domains

Consider lack of any family or friends support, past trauma (ACE score), etc.

Social needs assessment should include 'socialization/isolation relief.'

Incorporate alternative data sets as SDOH data matures and there are limitations driven by self-reporting

Incentivize partnerships addressing SDOH (Added 2x)

Barriers with written communication for non-English speaking patients (unable to read/write in their native language) extends beyond exam room/phone interpretation needs

Members with physical disabilities

Members who suffer from urine & stool incontinence

Follow-up with unhoused patients is more costly and challenging

People experiencing homelessnes