Member Communication & Support
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.

Where is members' first stop (currently) to get information about health related needs and information?

Google or a similar web search

Family and friends

There are issues around enrollment and systems updates. People go to a doctor or hospital and are told they need to enroll to be seen. Don't get other information

What is working well when it comes to communication between the RAEs and members?

The RAEs' warm-handoff processes

Having co-located enrollment assisters

Having resource navigators in community and/or provider settings

What needs to change or be improved?

RAEs need to have up-to-date member contact information.

There needs to be a no wrong door approach

There needs to be peer-to-peer sharing for non-MAGI (modified adjusted gross income) and non-HBCS (home- and community-based services) members.

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.

Current standardized quality performance indicators for RAEs: What is/is not working well? What are opportunities to promote equity?

CO Access has useful processes and standards. Team has smoothed out key performance indicator (KPI) changes, especially around the potentially avoidable costs KPI

CO Access covers a large percentage of the CO population, and it can be more equitable in its coverage.

Rural areas have different needs than urban ones (especially transportation). The measures are Denver-centric and do not account for the rural challenges.

Need data to support the specificity for equity need

RAEs pass KPIs to providers with a requirement for same-day services but no focused metrics for accountability for specific populations, equity considerations, or kept appointments

Pediatric practices experience frequently changing KPIs (yearly), which makes it difficult for practices to invest in practice transformation.

Currently RAEs are given a playbook at the beginning of the year, goals to meet. Department then moves the goals/goalposts. This negatively impacts providers

As a non-profit agency serving children, standardized RAE accountability is not there - all regions operate differently.

Every RAE contracts differently - pays different, on different timelines. Inequities begin with the Department at the regional/RAE level.

Must standardize the following across RAEs: the ability to contract in a timely manner; payment criteria; contracting processes/access to contracting; and rate reimbursement

Equity discussions should focus on specific populations: individuals with disabilities, refugees, different cultures and ethnicities, previously incarcerated individuals

Equitable access to behavioral health services in different areas of the state, different socioeconomic statuses, or people without housing or transportation.

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.

Referrals to Community Partners: Screening & Data Sharing. Who is best to act as a screener? Should RAEs and providers share data to reduce burden?

Must think upstream for community partners and social needs. If Dept shifts screening/case management work to community, money needs to follow to pay for needed capacity.

Like the idea of "improving coordination" with community partners - reflects that it is a 2-way street.

Behavioral health (BH) providers do a lot of this work and if Dept wants to develop certified community BH clinics, this is a big part. Dept need to pay for this work.

Best screener is the first touchpoint with a client (added 3x).

The more the Department can do to minimize burden, the better.

Agree about the first touchpoint and no wrong door approach. But sometimes people have to be asked more than once. There's a balance.

Should go beyond screening. We need case managers to connect and follow up on accessing services.

Often we are screening for need instead of risk, but we should be doing the latter.

There is duplication of services on the BH side. Crisis provider may do outreach, then care coordinator with RAE. Creates administrative burden for providers and frustrates members.

Need to ensure we are sharing data and workflows to avoid duplication of effort.

Want to identify one entity to own the screening process. Then, can move patients to care coordination or case management.

The best screener is a place everyone can access (whether in primary care, in hospital, or via RAEs).

People's needs should be prioritized by the people themselves, not the service providers.

Look at the model developed by Family Resource Center. Has profiles of individuals' priorities, and includes the ability to coordinate various services related to whole-person health.

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.

What supports and services are required for providers to particpate in alternative payment models?

How do you understand what RAEs are doing with the community-based approaches?

What does state/RAE interface look like? How do you know the ACC is working? And how does that drive overall APM performance?

Is the purpose of RAEs to support primary care medical providers (PCMPs) to be more effective? How are we measuring that? Are we helping PCMPs sustain themselves?

What is working well with current APM models?

Must ensure attribution is accurate, particularly as it transitions from a tool for care management to a tool of payment

Need transparency around attribution.

Consider how federally quality health centers should participate and take into account their unique payment models.

Need to support practices in cash flow management as we move to prospective payment. Need data and training on cash flows, lessons learned from other practices, etc.

Make sure we have accurate data as part of the APM model. Need trust in the data.

Timely access to claims data would be very helpful. Hard to run quality improvement when data is lagging 5-6 months.

Practices may be participating in multiple APMs. Potentially could help to consolidate APMs in some way.

Consolidate measures with those of other programs/other APMs.

Help project out payments in different types of payment models.

Look at improved opportunity for delegation, with PCMPs and behavioral health providers

Pay attention to behavioral health providers and their need for measures/metrics.

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.

What is currently working well with care coordination?

What needs to be improved for care coordination? And for whom?

Flexibility with payments creates administrative challenges.

Payment structure is complicated. Don't always pay for all levels of care coordination that need to be done.

Also don't always pay for CC for members who are contracted with multiple RAEs.

Alignment with all other initiatives and departments doing care coordination.

Interoperability between all of our systems. Need better communication between the hospitals and human services.

Need CC during transitions of care to manage discharge/follow-up care. This process is currently a giant lift with individuals navigating for themselves.

Need to be very clear on what member benefits apply based on the care setting (i.e. occupational therapy in the hospital versus step-down care).

How can RAE requirements and reporting be strengthened to ensure that all people are receiving equitable, quality care coordination?

CBOs who coordinate care on behalf of RAEs have difficulties spending the time needed to be successful. CBOs can have capacity issues for case management.

These CBOs can feel like another revolving door for members

RAEs should all be paying for the same *level* (or type) of practitioner. This is particularly important given the diversity of practitioner types.

Need more stability/consistency in member benefits and payments.

Align programming with what is being asked of the RAEs (e.g. HTP at the hospitals); some measures overlap with RAEs, but still feel very siloed/misaligned.

SDoH screening is an example of this misalignment.

According to DRCOG, 32% of referrals at PCP were followed through on. People need more assistance to get to/complete those referrals.

Need to pay care coordinators (CCs) more to spend more time with people; people need to be walked through the navigation of resources.

Some providers are better set up to provide these supports than others. In some cases, RAEs may be best place for CC and in other cases, a provider/CBO may be best place for CC.

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.

Behavioral Health Transformation: Needs and Gaps. What are the most pressing needs for behavioral health services? What are rural considerations?

Care coordination related to specialty hospital entry/exit. Behavioral health providers need to be reimbursed well for care coordination services.

Transportation is a huge consideration for members across state (metro and rural). (Comment added 2x)

Linguistic access is a major barrier, along with cultural accessibility.

Providers no longer want to provide services to Medicaid members because reimbursement is low and/or is delayed.

Must provide care to individuals who need it but are resistant to long/rigorous assessment processes. Make more services available with less administrative burden.

Behavioral Health Transformation: Alignment Opportunities. How to ensure consistency for services, access across populations? How should RAEs align with new BHASOs?

Make sure that the regions are geographically aligned. Also need alignment across BHASOs and RAEs to reduce administrative burden on providers.

Must make it easy for someone who goes to a BHASO for assistance to be easily connected to RAE, and ensure their information is shared.

Goal is to make sure it doesn't matter who someone's payer is. If agencies use same intakes, authorization processes, etc., then it goes a long way to ensure a no wrong door approach.

Would be great to have documentation alignment so entities aren't navigating multiple systems. Providers currently must submit documents through many different places

Ensure there is a robust process for BHASO awards, so proven groups are providing services.

Consider drive times in areas with rural needs.

Behavioral Health Transformation: Building on Success. Lessons from integrated care payment models? Opportunities to leverage the peer/unlicensed workforce?

Are there unintended consequences related to coding in behavioral health (BH)?

By an overemphasis on essentially therapy codes (short-term care), have we deemphasized providers' ability to use non-therapy codes that some clients need?

Just having therapy codes is not integrated care. Better to get care as quickly as possible.

Short-term BH benefit emphasizes talk therapy over other models that may work better for certain individuals.

Agree with comments about benefits. Some folks are high users of BH visits in primary care settings. That helps them get care right away and decreases barriers to care.

Noticed that there isn't a consistent training method for peer support professionals. Worth considering specific type of training.

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 should be standardized as part of RAE contract requirements for coordination and management of children and youth, particularly around EPSDT (Early and Periodic Screening, Diagnostic and Treatment) benefits and Child Welfare?

Effective healthcare for children and youth requires a proactive approach, and for more complex members there is more care coordination needed

This is an upfront investment for providers and Medicaid, and if the reimbursement supports this, it would prove to benefit all.

And we must break down the State's silos for entities involved in children's lives, so care and access can be "in real time," not once the denials/approvals are processed

When thinking about integrating BH and PH, the system is not set up to support kids with autism and parents of these children

According to the EPSDT standard, medically necessary care for a child is automatically applied to whatever providers ask RAEs to approve.

EPSDT's current process may require a prior authorization request. Dept should consider changing this and other overall changes of things included in the RAE contract.

Something else to consider changing: Getting permission from a case worker to refer families to EI is currently an additional barrier.

Ex: With CO Access, certain codes are pre-authorized if you have a contract with them. If providers get an emergency case, they can see patients ASAP and don't need RAE approval.

There are two components (early/periodic screening and diagnosis/treatment). RAEs should play a role in the early and periodic screening.

Parents may not see the well visit as important but should know this is a Medicaid benefit. RAEs should also facilitate access to these services.

What should RAEs' roles be in improving pediatric care or to improve perinatal health?

Perinatal systems should be separate from child/youth systems. There is value in aligning them but not sure how to do it.

Post-partum depression and stress are also important to address.

CHWs and doulas are workforces that can support perinatal health

RAEs must support family practices as well as pediatric practices.

RAEs must emphasize immunization and well-child visits.

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.

How are the RAEs currently supporting the use of technology and data sharing between providers, RAEs, and members?

Will end of PHE create a possibility for more data changes? Medicaid churn has not been an issue for the past few years

Is this a person-centered approach? ITN seems to be more narrow than that

IT procurement on referrals for social needs seems to be suggesting screening and then solving that concern. Note: HCPF is funding a broader approach, in addition to this

What could be improved in phase III?

What is the lag in claims data? Can this be improved upon? More timely data would be helpful. The lag may be partially due to practice submission delays.

What could be changed to address claims delay? The potential solution could be part of another procurement process

ADT feeds could be standardized to simplify processes across RAEs

HTP should add fields. QHN and Contexture could possibly align more, especially on analytics data (HTP). Should share coordination data.

Should share aggregate state-wide data publicly. Share more outward facing data on key performance indicators.

Very little data is available to members. Consider ways to get data shared for members to make decisions. Sometimes members are told they can't access data.