Accountable Care Collaborative

Phase III

Concept Stage Engagement Summary

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COLORADO
Department of Health Care Policy & Financing

COLORADO HEALTH INSTITUTE
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Notes About This Document

This report summarizes the feedback that Colorado Health Institute (CHI) staff heard from stakeholders throughout the Concept Stage of stakeholder engagement on the Accountable Care Collaborative (ACC), which took place during the summer and fall of 2023. It is not designed to serve as a recommendations report for the Department of Health Care Policy and Financing (HCPF). CHI has worked to paraphrase or summarize feedback from many venues and stakeholders but has sought to avoid commenting on the merits of the feedback or opinions that stakeholders provided.

Stakeholders who offered feedback include Health First Colorado (Colorado's Medicaid program) members, providers, advocates, Regional Accountable Entity (RAE) and county staff, and others. Given the wide range of stakeholders, the opinions expressed in this document may at times appear contradictory. Furthermore, some of the information contained here may be out of date at the time of publication because some questions were posed as decisions were evolving. Stakeholder comments included in this summary reflect that stakeholder's perception about different aspects of the ACC and may not always be accurate about the true nature of the program.

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

Themes from Stakeholder Engagement

While these themes capture majority opinions, there is no proposal on which all stakeholders entirely agree.

1. Providers are generally supportive of the Concept Paper's proposal to align metrics for incentive payments with existing metrics, although there is not total agreement on which metrics they should follow. They specifically requested that the number of total metrics tracked be reduced for Phase III.
2. Generally, stakeholders are in favor of the proposal to lessen the number of RAE regions, but they do not agree about the specific map that they would like HCPF to use in Phase III.
3. Most providers are in favor of eliminating geographic attribution, although not all stakeholders support this proposal. Some providers have concerns that doing so may reduce administrative payments such that providers have more difficulty treating their patients.
4. Stakeholders like the focus on health equity. Members and other stakeholders would like to see accountability for health equity but they do not agree on the extent to which HCPF should create standard health equity requirements, as opposed to letting

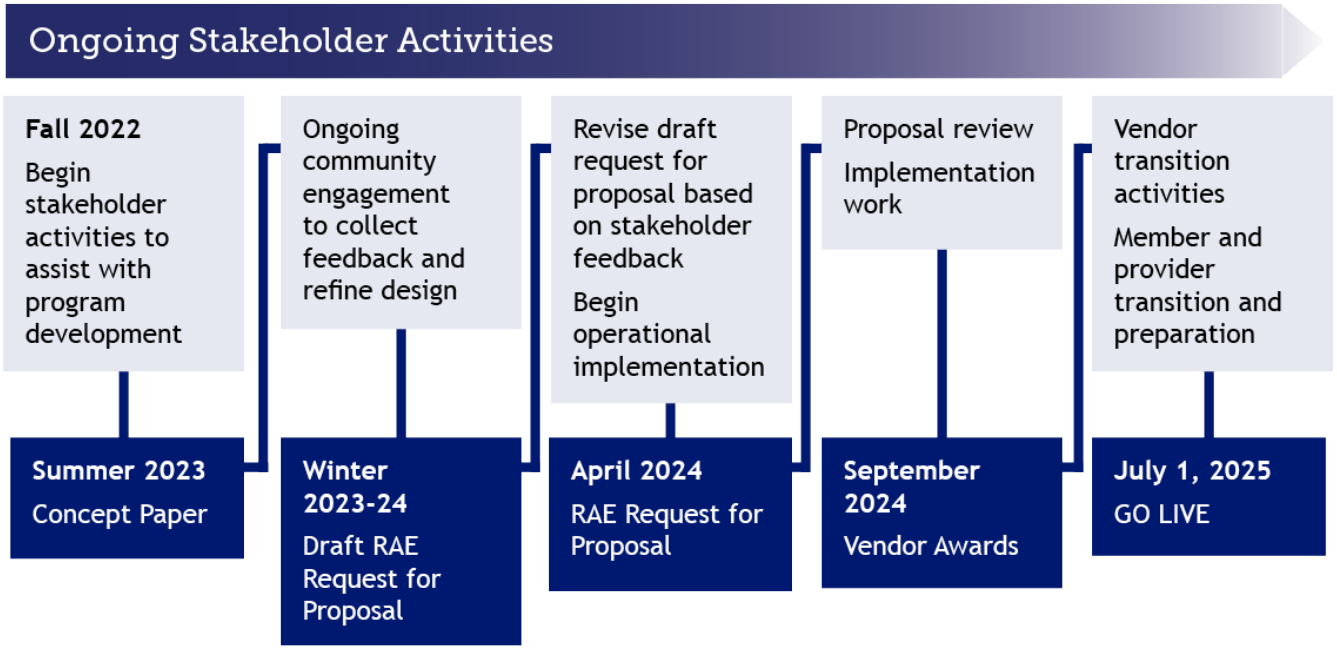
RAEs create regional requirements. As part of this health equity proposal, many advocates and members would also like to see a focus on hiring those with lived experience for different positions in Phase III.

5. Many members feel that there is not enough awareness among members of the role of the RAEs. They would like to see proposals to expand member awareness of RAEs and additional supports from RAEs, including by requiring member advisory councils. Stakeholders do not unanimously agree on what those proposals might include.
6. Members are concerned that RAE staff and providers do not always receive sufficient training and sometimes provide misinformation or out-of-date information to members. They would like to see training or processes for staff to have more up-to-date and accurate information and accountability for those who provide incorrect information.
7. Many stakeholders support the care coordination proposals, but providers and advocates have concerns about care coordination payments to providers and other organizations. Stakeholders have varied opinions on how HCPF should respond to those concerns.
8. Members support the care coordination proposals, but many have experienced that, in practice, they are not offered care coordination or do not know how to access it. They believe more education about care coordination resources, both for members and for RAE staff and providers, may be needed.
9. Stakeholders are excited about the concept of more focus on health-related social needs, but they disagree on what role RAEs should play. They would like to see more specific funding for health-related social needs if possible.
10. Providers and other stakeholders generally support the Standardized Child Benefit proposal, but they are confused about the implementation, particularly around the screening and referral process and about how this proposal relates to new care coordination proposals. They also have concerns about how this proposal incorporates health prevention and promotion.
11. Stakeholders disagree about whether HCPF should expand RAEs' responsibilities in Phase III. Specifically, some providers would like to be able to opt into or out of receiving RAE support depending on providers' capacity, and they would like administrative payments to providers to depend on the services providers choose to receive from RAEs.
12. Stakeholders, particularly providers, support the idea of allowing behavioral health providers to serve as primary care medical providers, but they disagree on what requirements behavioral health providers should have to meet to be in this role.

Introduction

In preparation for launching Phase III of the ACC in summer 2025, 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.

Figure 1: ACC Phase III Timeline



HCPF contracted with CHI to assess stakeholder needs and collect feedback from diverse perspectives, such as members, providers, policy leaders, consumer advocates, and RAE representatives. The Vision Stage of stakeholder engagement ran from November 2022 through March 2023. Stakeholder feedback from this stage is summarized in the ACC Phase III Vision Stage Summary, available on HCPF's website.

From April through August 2023, staff at HCPF, in collaboration with CHI, facilitated 26 discussions related to preliminary proposals for ACC Phase III. In August, HCPF released a Concept Paper detailing proposed policies and changes for Phase III that was informed by feedback from the Vision Stage and ongoing conversations during the summer.

After the Concept Paper was published, CHI and HCPF worked together to collect stakeholder feedback on the content. CHI and HCPF spoke with a range of stakeholders, including members and their families, providers, advocates, RAE and county staff, and others, through 18 meetings in August and September. This included six virtual public meetings focused on different audiences, from the general public to certain types of providers. A full list of meetings and presentations from April to October is available in Table

1. Materials from these meetings are available on the ACC Phase III Stakeholder Engagement website.

In addition to these meetings, HCPF staff also met with regional member and program advisory committees and other HCPF advisory committees and workgroups, with support from CHI staff when appropriate. Feedback from meetings that CHI did not attend is not reflected in this document but is being considered by HCPF.

CHI and HCPF also sought written feedback about the Concept Paper through an online form that closed on October 31. Stakeholders continued to have access to an open feedback form during this stage as well, which has been active since the Vision Stage and will stay open through RFP development.

HCPF staff are considering feedback on the Concept Paper as they work to create a draft RFP, which will be released in the coming months. Opportunities for stakeholder engagement and feedback will continue after the RFP is published.

Table 1: List of Stakeholder Engagement Meetings

Date	Meeting	Approximate Number of Attendees
4/5/2023	Behavioral Health Integration Strategies (BHIS) Subcommittee of the Program Improvement Advisory Committee (PIAC)	31
4/11/2023	ACC Regions Conversation: Larimer and Weld Counties	24
4/13/2023	ACC Regions Conversation: Elbert County	21
4/17/2023	ACC Regions Conversation: Statewide	89
4/19/2023	ACC Regions Conversation: Park and Lake Counties	29
4/19/2023	Statewide PIAC	50
4/20/2023	ACC Regions Conversation: Statewide	110
4/21/2023	Colorado Partnership for Thriving Families	15
4/25/2023	ACC Regions Conversation: Boulder County	28
4/27/2023	Performance Measurement and Member Experience (PMME) Subcommittee of PIAC	39
5/3/2023	BHIS Subcommittee	19

5/11/2023	Provider and Community Experience (P&CE) Subcommittee of PIAC	30
5/17/2023	Statewide PIAC	70
5/25/2023	PMME Subcommittee	30
6/7/2023	BHIS Subcommittee	30
6/8/2023	Primary Care Payment Reform Coalition	29
6/8/2023	P&CE Subcommittee	30
6/20/2023	Colorado Association of Family Physicians	6
6/21/2023	Statewide PIAC	84
6/22/2023	PMME Subcommittee	30
6/28/2023	American Academy of Pediatrics — Colorado Chapter	15
7/19/2023	ACC Regions Conversation: Pueblo County	38
7/20/2023	ACC Regions Conversation: San Luis Valley	41
7/25/2023	ACC Regions Conversation: Southeast Colorado	30
7/26/2023	ACC Regions Conversation: Statewide	105
8/3/2023	Colorado Health Policy Coalition	20
8/10/2023	Disability Competent Care Listening Session	44
8/16/2023	Statewide PIAC	75
8/21/2023	ACC Concept Paper Public Meeting: Introduction	86
8/31/2023	ACC Concept Paper Public Meeting: Primary Care Medical Providers	45
9/6/2023	ACC Concept Paper Public Meeting: Community-Based Organizations	68
9/6/2023	BHIS Subcommittee	62

9/7/2023	Colorado Health Policy Coalition	18
9/12/2023	Statewide Member Experience Advisory Council (MEAC)	34
9/14/2023	ACC Concept Paper Public Meeting: Behavioral Health Providers	63
9/14/2023	P&CE Subcommittee	50
9/21/2023	Disability Competent Care Listening Session	22
9/26/2023	ACC Concept Paper Public Meeting: Providers	75
9/26/2023	HCPF County Directors Meeting	81
9/28/2023	ACC Concept Paper Public Meeting: Members	21
9/29/2023	HRCC (HCPF, RAEs, Child Welfare, and Counties) Collaborative Forum	50
10/4/2023	BHIS Subcommittee	62
10/10/2023	Statewide MEAC	19
10/18/2023	Statewide PIAC	80
10/24/2023	Colorado Early Childhood Comprehensive Systems Working Group	60
10/26/2023	PMME Subcommittee	50

Clinical Quality Strategic Objectives

HCPF has proposed six clinical quality strategic objectives based on national standard metrics that will drive work during the entirety of Phase III, including shaping its metrics for success. The strategic objectives will be connected to incentive payments during Phase III. A financial strategic objective is still under construction, but the other five objectives are to:

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

CHI heard little feedback about specific strategic objectives, although a few advocates applauded the general focus on equity and offered feedback on where a more targeted racial/ethnic equity lens may be useful, based on existing metrics. Stakeholders had diverse opinions about metrics to consider adding. These included the number of members accessing primary care, oral health, and developmental screening and Early Intervention referrals. On the other hand, one organization suggested removing any specific metrics on contraceptive care use, noting that these metrics can lead to provider bias and reproductive coercion.

Generally, providers strongly supported the decision to keep these objectives consistent for the entirety of Phase III to support the ability to trend data, make measurable progress, and reduce administrative burden. One stakeholder, however, expressed concerns that the existence of these strategic objectives creates additional burden by creating another set of metrics for providers to manage.

Some advocates expressed concern that the strategic objectives had been decided without member input, and they suggested that members be involved in developing the fiscal strategic objective, which has not yet been proposed. Some members also expressed concerns that the existing metrics are overly focused on provider performance, rather than member experience.

Payment Structure

Section IV of the Concept Paper described HCPF's proposed payment strategies to best enable RAEs and providers to improve outcomes, reduce disparities and drive affordability in the Health First Colorado program. The paper discussed payment strategies including the capitated behavioral health benefit, administrative payments to RAEs, incentive payments, alternative payment models, shared savings, and leveraging other existing incentive payment efforts.

Many stakeholders had questions about specific changes to the payment structure in ACC Phase III and noted that they are looking forward to more information on payment proposals. The sections below include some of these questions as well as stakeholders' initial feedback on each payment structure detailed in the Concept Paper.

Additionally, several providers expressed concerns with the Making Care Primary model, a payment model developed by the Center for Medicare and Medicaid Innovation that is currently being tested in eight states. While some providers strongly support the model, others are concerned that a focus on this model may undervalue the unique perspectives of providers who are not eligible for Making Care Primary, particularly pediatricians and those engaged in Primary Care First.

Some stakeholders also shared questions or concerns about payments that are either partially or entirely outside the purview of ACC Phase III. Those are noted here because they remain important considerations for HCPF and others at the state level, though discussions about concerns and potential solutions may be more effective elsewhere:

- Reimbursement rates for applied behavior analysis (ABA). Several providers and advocates raised concerns that these reimbursements are too low, possibly causing many ABA providers to leave the state.
- Reimbursement rates for providers who reflect the patients they serve. Several advocates suggested that providers who look like their patients, who speak the same language as their patients (whether Spanish, American Sign Language (ASL), or another language), or who themselves have disabilities or experience as Health First Colorado members should receive higher reimbursement rates.
- Reimbursement rates for providers who serve members with disabilities. Advocates and members said that members with disabilities often need more time with their providers, and they would like to see providers receive higher reimbursements for episodes of care with patients who require this additional time.
- Reimbursements for health care visits involving law enforcement. Several advocates flagged a concern that too many visits, particularly mental health care visits, include representatives from law enforcement or protective services. One organization suggested that visits resulting in law enforcement involvement should not be reimbursed at all.
- Enhanced payments for school-based health centers who are meeting incentive metrics. Providers would like to see more alignment with school-based health centers.
- Reimbursements for community health workers and doulas. Given recent legislation requiring HCPF to request the ability to reimburse these professionals, many stakeholders had questions about how the payments would be built into Phase III.

Capitated Behavioral Health Benefit

HCPF has proposed retaining the current capitated benefit for behavioral health with some modifications to address concerns around consistency and transparency.

Many advocates and providers support HCPF's proposed steps toward greater transparency around RAE denials and payment rates for behavioral health services. They asked to see public data on denial rates for various behavioral health services for each RAE. One

stakeholder expressed concerns that this proposal may violate antitrust laws and could lead to price fixing by RAEs.

Most advocates and providers also supported the suggestion for a rate floor for behavioral health payments for consistency. A few stakeholders, however, disagreed, saying either that this approach could effectively create "rate ceilings," that is, could de-incentivize competition between behavioral health providers, or that having set rate floors would hamper RAEs' ability to respond to local behavioral health needs or to set rates based on the local cost of operation.

A few stakeholders had questions about HCPF's proposal for directed behavioral health payments, including who would be eligible for those payments. Providers signaled that they would like more specifics on these directed payments. One stakeholder shared concerns that directed payments could disincentivize provider participation in alternative payment models and increase administrative burden for RAEs.

Administrative Payments

Many providers and advocates shared a concern that administrative payments are not being appropriately distributed to primary care medical providers, particularly for care coordination. A range of providers suggested that HCPF require RAEs to offer providers a menu of options for administrative supports they would like to receive from RAEs, and that the amount of the administrative payment passed through to providers should be based on which services providers opt into. This suggestion is discussed in more detail in the care coordination section. Another organization suggested that, given the number of responsibilities, HCPF should create priorities for how administrative payments should be used.

Other advocates and stakeholders had questions about how administrative payments would be decided for other, non-provider entities in Phase III. Several stakeholders mentioned that requirements on administrative payments should take into account the work that community-based organizations and local public health agencies do and stated that RAEs should provide payments to these entities for their work with Health First Colorado members. They would like to see more concrete recommendations and requirements regarding these administrative payments.

While most stakeholders like the idea of requirements imposed by HCPF to regulate how RAEs pay providers and other organizations, some stated that any additional requirements would limit RAEs' abilities to flexibly respond to local community needs.

Incentive Payments

Many stakeholders, primarily providers, had questions and concerns about the specific metrics proposed for incentive payments in Phase III. Across many meetings, providers shared three major concerns about their experience in Phase II that they hope to see

change: that providers are being asked by various programs to make progress on too many metrics, that metrics change too frequently for providers to make meaningful progress, and that incentives and metrics are based on factors outside of providers' control.

Providers applauded HCPF's intention to align with alternative payment work happening through the Division of Insurance, but some were concerned that some of HCPF's proposed metrics do not align with the Division of Insurance's proposals. For instance, the proposed metrics for reducing disparities in maternal health do not align with any of the Division of Insurance's proposed metrics for HB22-1325. Other providers and advocates suggested that HCPF look at and try to align with metrics already tracked by the Uniform Data System and the Healthcare Effectiveness Data and Information Set. When asked about specific numbers of metrics, several providers suggested that HCPF choose three to four metrics that align with one or more of these other programs, plus a menu of options for any additional metrics to give providers some choice.

Several providers previously expressed frustration that metrics for incentive payments change yearly, which makes it difficult for practices to make progress and creates administrative burden for providers. These providers strongly supported the proposal to keep any incentive metrics consistent for the entirety of Phase III, or in 5-year intervals. One practice also highlighted that some RAEs have set frequently changing metrics in Phase II, and they would like to see this method end in Phase III.

Providers were concerned that some of the metrics suggested may be out of primary care medical providers' control. For instance, providers said that metrics about timeliness of behavioral health referrals are difficult to meet in areas that do not have behavioral health services. This was specifically called out for rural areas. Similarly, current metrics around dental screenings are difficult to meet in rural areas where no dental providers accept Health First Colorado patients. Other providers shared concerns that some metrics about behavioral health are hard to meet in non-integrated clinics or that these metrics may penalize providers with more patients with higher social risk factors. Pediatricians shared that immunization measures can be very difficult to address because of nationwide vaccine hesitancy. Finally, some stakeholders shared concerns about the proposed metric about follow up for substance use disorder, noting that this metric does not account for the treatment and recovery timeline that many people follow. Providers encouraged HCPF to consider these concerns when choosing final metrics for incentive payments.

Beyond these more common suggestions about incentive payments, other provider feedback included a wide range of suggestions, including more focus on maintenance metrics, parity in number of metrics for pediatric practice and adult providers, consistent statewide metrics, and longer timelines for providers to implement improvements before incentive payments begin.

Alternative Payment Models for Providers

Many stakeholders expressed support for HCPF's focus on alternative payment models (APMs), and pediatricians, in particular, appreciated the development of a separate APM for pediatric services. Other stakeholders also strongly supported HCPF's plans to include member voice in any APM design.

However, several providers expressed concerns about being unable to access data timely enough to work toward improving outcomes and about RAEs providing technical assistance and practice support for APMs. Both are important components of APMs, and several providers suggested that RAEs, with HCPF's support, should be more accountable for helping practices.

Other providers and advocates, while they agreed about the need for timelier data and technical assistance, shared concerns about RAEs being involved with APMs. They felt that RAEs have not succeeded in their Phase II roles, and these stakeholders were concerned about giving RAEs more responsibilities, particularly when those responsibilities would affect providers' payments. Some providers and advocates suggested that RAEs be one option for technical assistance but that providers also should be able to choose help from other sources, such as assistance through the University of Colorado School of Medicine's Practice Innovation Program. One advocacy organization said that they did not think RAEs should be involved in APMs at all, aside from the behavioral health APM, because they wanted RAEs to instead focus on improving their current functions. They suggested that HCPF be responsible for all data, trainings, and technical assistance for APMs.

While many providers and advocates were concerned about RAE participation in APMs generally, they were less opinionated about RAEs paying out APMs to providers, as long as RAEs' payments are delivered efficiently.

Additionally, many advocates applauded the particular focus on member incentives. Several of these advocates had questions about whether member incentives would be set by HCPF or individually by RAE, but, regardless of the approach, advocates agreed that these incentives should be available to all members, regardless of RAE. Other questions focused on the monetary cap for member incentives. Aside from these more general comments and concerns, stakeholders had many questions about HCPF's APM proposals. Several providers wanted to know more about the timeline for APM payments, because they would like to see timelines better aligned in ACC Phase III. A few providers had questions specifically about the behavioral health APM, including how HCPF would choose metrics and whether or how the Behavioral Health Administration (BHA) would be involved in the administration of this APM. Others applauded the decision to include a medical acuity adjustment in administrative payments to providers to account for these APMs but wondered whether HCPF had considered a similar adjustment based on social risk. They encouraged HCPF to do so. A few advocates asked whether any APMs would provide funding for health-related social needs.

Finally, several providers had questions about the proposal for prospective payments and whether HCPF may pay providers to expand or implement new services.

Shared Savings

Very few stakeholders gave feedback about shared savings beyond general requests for more information and questions about the metrics on which RAEs would be measured. One stakeholder stated that, while they support shared savings, they would like HCPF to ensure that shared savings reflect providers' and RAEs' burden of work and performance and that HCPF does not substitute shared savings payments for upfront provider investments. They shared that upfront investments are essential to building provider capacity, particularly for new APMs.

Several other stakeholders who did have specific feedback were skeptical that RAEs should receive a percentage of shared savings payments. These providers and advocates expressed that RAEs' care coordination work should be paid through the administrative payment as a central function of the RAEs, and it therefore should not also be incentivized through shared savings. Another stakeholder disagreed, pointing out that RAEs do play a role in shared savings.

Accountable Care Collaborative Structure and Tools

Section V of the Concept Paper discusses various elements of the proposed ACC Phase III structure and tools, including the geographic regions, managed care organizations, member enrollment and attribution, and supports and tools for providers. Feedback related to those four proposals is detailed here.

More generally, several providers mentioned that contracting with multiple RAEs is difficult. They proposed having one preferred RAE per practice, even if their patients span multiple RAEs.

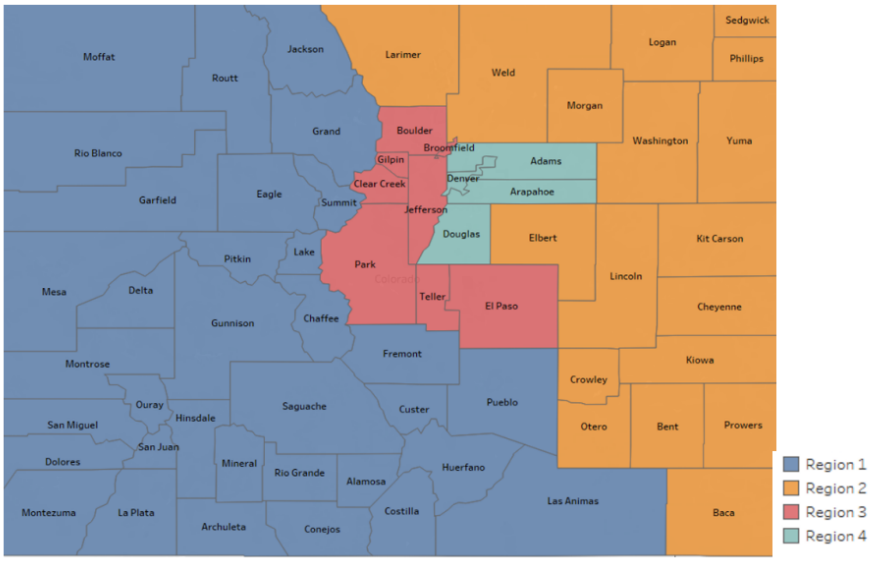
Providers also spoke generally about difficulties they have had with RAEs. For instance, some providers stated that they have struggled to negotiate with RAEs and said they would like a clear and transparent arbitration process in these cases. Others shared concerns about some RAEs' ability to meet their current responsibilities regarding care coordination and technical assistance for providers.

Given these perceived difficulties, many members and advocates would like to see stronger oversight and accountability requirements for RAEs in Phase III.

Geographic Regions

Instead of the current seven RAE regions, HCPF has proposed a four-region model for Phase III, shown in the map below.

Figure 2: Proposed Regional Map as of June 2023



Providers and other stakeholders have largely been supportive of the decision to decrease the number of RAE regions because they find contracting with seven regions to be administratively burdensome. A few stakeholders have expressed concerns that four regions may be too few, but this was not the majority opinion.

However, some providers and advocates have pushed for eliminating the regional model altogether in the name of administrative simplicity. Other advocates have suggested an alternate model that allows members more choice in selecting their RAE. They suggested either allowing multiple RAEs to exist in each region or eliminating regions in favor of competing statewide entities.

Regarding the proposed geographic regions themselves, some stakeholders have expressed concerns that HCPF is not working to align with existing provider networks and patterns of care, particularly in southeastern Colorado. Stakeholders in the southern part of the state, including those affiliated with the RAE currently representing that region, have asked HCPF to consider changing its proposed regions and have provided an alternate map for consideration.

Many stakeholders from northern and northeastern Colorado stated that HCPF's proposed map does a good job of preserving patterns of care in their region. They were satisfied with the placement of Larimer and Weld counties in the same region, a change from Phase II. Stakeholders from western Colorado generally supported the current map.

For the larger geographic regions, a few members mentioned that regional "hubs" would be important to ensure that members can receive in-person services near where they live without having to travel great distances.

Managed Care Organizations

The ACC currently includes two managed care organizations (MCOs), Denver Health Medicaid Choice and Rocky Mountain Health Plans (RMHP) PRIME. For both MCOs, physical health services are paid through a capitation plan. HCPF intends to offer the managed care organization operated by or under the control of Denver Health and Hospital Authority, created pursuant to Article 29 of Title 25as part of ACC Phase III. The ACC Phase III RFP process will allow offerors for the Region 1 contract to propose a limited managed care capitation initiative for the current RMHP PRIME counties.

A couple of providers have expressed their dissatisfaction with the RMHP PRIME plan. Some specifically shared that providers face additional administrative barriers, particularly difficulties billing services, when working with RMHP PRIME. They would like to see this MCO eliminated in Phase III. However, most stakeholders, including members, have voiced their support of this MCO. They would like to see this MCO continue to exist and potentially to expand to other counties in Phase III.

A few other providers seemed to be interested in increasing the number of managed care organizations in Phase III.

Enrollment and Attribution

HCPF has proposed eliminating geographic attribution to a primary care medical provider for members with no claims history. In Phase II, members with no claims history are being geographically attributed to a proximate provider in their region. In ACC Phase III, members without claims history would be assigned to a RAE based on the county in which they live with no primary care medical provider attributed. The process for those with claims history would be unchanged; the member would be attributed to the primary care medical provider based on utilization and then assigned to the RAE covering the county in which that primary care medical provider is located.

Most providers seem to support this proposal. According to providers, geographic attribution tends to be inaccurate, and this can be a problem because attribution is tied to value-based payments for providers. Others pointed out that geographic attribution is particularly problematic for practices that serve certain populations, such as people experiencing homelessness.

A few members and advocates suggested basing attribution solely on geography, which would be a departure from the current practice of only attributing members based on geography if they do not have a claims history. Specifically, these stakeholders would like to see members assigned to the RAE serving their county of residence, instead of attributing members to a provider based on claims history and then assigning members to a RAE based on that provider's location. According to these stakeholders, the RAE assignment process in Phase II has created difficulties for some members, because claims history does not always reflect current usage, as experienced by providers.

Several other providers worried that eliminating geographic attribution would lead to a decrease in their caseload, and thus their per member per month (PMPM) payment. These stakeholders said that they would then have to spend more effort and money recruiting new patients in order to receive adequate administrative funding, when that time and money could be better spent on providing care.

Additionally, despite their general support, some providers said they end up treating members who are not attributed to them because members switch providers and attribution data is not up to date. According to these providers, in the current system, the PMPM payment providers receive for all members attributed to them provides enough of a buffer to allow them to continue seeing patients not attributed to them. Therefore, providers stressed the importance of ensuring that attribution is up to date and easy to adjust to ensure that providers are receiving an adequate total PMPM. Some would like to be able to escalate inaccurate attribution concerns to HCPF or even to a third party if they cannot resolve these concerns with the RAE, and other providers mentioned a need for an accuracy threshold for attribution. They noted that these changes are particularly important if HCPF eliminates geographic attribution in Phase III.

Several providers were also concerned that RAEs would not be objective in helping connect patients to a primary care medical provider. They would like to see a plan to ensure RAE objectivity when helping connect members without a claims history to providers, expressing concern that a RAE could attribute a member to a provider that is a member of RAE leadership, to boost their PMPM. One provider suggested that the fairest approach would be to have HCPF offer this support to members, not the RAEs. Others suggested that HCPF set extremely clear guidelines in how RAEs connect members to primary care medical providers.

A range of members, advocates, and providers all said it can be difficult for members to choose a new primary care medical provider, so many members never change their official provider even when their care patterns shift. This contributes to outdated attribution data. Several stakeholders have asked HCPF to consider ways to streamline the process for changing providers and to increase the frequency of re-attribution, perhaps by allowing providers to make this change on behalf of their patients, allowing members to easily see and change their attributed provider on the PEAK app, or sending members mail that allows them to confirm who their primary care medical provider is. Currently, members must contact a broker to help make this change, which providers note puts the burden on members, especially those who do not speak English.

Pediatricians pointed out that the issue of inaccurate attribution can be especially pressing for newborns, who often have enhanced needs. A few suggested that newborns be attributed to the first provider they see, which would allow the provider to serve as a medical home and receive the appropriate value-based payments.

Finally, providers, advocates, and members wanted more information about what the re-attribution process will look like at the beginning of Phase III and how re-attribution will occur if a patient's claims history changes beginning in ACC Phase III.

Provider Tools and Resources

Many providers expressed excitement about some of the new tools mentioned in the Concept Paper, specifically the Social Health Information Exchange, and mentioned that it is necessary to invest resources in expanding these tools. A few providers specifically mentioned it as potentially helping with current care coordination challenges by streamlining the collection of health care information about members. Other providers, while supportive of the tools mentioned in the Concept Paper, were concerned that HCPF or the RAEs may force providers to adopt new methods, even if they are duplicative of existing ones that providers already use. Some providers have also shared that some of HCPF's proposed tools may be incompatible with existing electronic health records, so these providers would like to be involved in the development of future tools.

Other stakeholders had questions about these tools: they wanted more information on how the Prescriber Tool and the Social Health Information Exchange connect to each other, how expensive these tools would be, and who would have access to these tools.

Additionally, some advocates and providers were hesitant about the proposal for RAEs to be involved in the rollout of some provider tools and resources, particularly the Prescriber Tool. A few organizations expressed confusion over the role RAEs play in prescription costs and hesitation regarding RAE engagement with the Prescriber Tool.

Finally, a few members and advocates expressed concerns that these tools would not center member experiences and equity-related goals and suggested that members be involved in an advisory committee overseeing the implementation of these tools to ensure that they are person-centered.

Health Equity

At the RAE level, HCPF has proposed health equity plans along with equity-focused trainings, task forces, and personnel for Phase III. As mentioned in the ACC Concept Paper, health equity is an overarching goal of Phase III, so many proposals in other sections of the Concept Paper also incorporate health equity. The feedback in this section ties directly to proposals from the Health Equity section of the Concept Paper.

Stakeholders universally praised HCPF's focus on health equity for the next phase of the ACC. They also supported an increased emphasis on health equity for RAEs.

However, many stakeholders wanted more details on HCPF's specific health equity proposals. For instance, stakeholders, particularly members and advocates, wanted to know how the health equity personnel and task force members would be chosen, and they were curious

about the content of health equity trainings. Others were curious about how HCPF and RAEs would intentionally plan out this process, and whether RAEs would be required to use needs assessments. A few stakeholders asked how this work would be aligned with other existing work, such as required community health assessments. They were also interested in how these trainings would occur. Several advocates suggested that members with lived experience should lead or co-lead different health equity trainings.

Stakeholders disagreed about how prescriptive HCPF should be regarding health equity requirements at the RAE level. Some stakeholders felt that HCPF should institute specific requirements about hiring processes and the work of the task forces. They suggested that RAEs be required to hire personnel with lived experience who are reflective of the community they serve and that members should be involved in hiring and task force processes. Many advocates suggested incentive payments for RAEs who hire more staff who are bilingual or bicultural or have other lived experience.

Some other stakeholders felt that RAEs should decide their own hiring processes and plans for task force formation. As their rationale, these stakeholders stated that RAEs understand local needs and health equity priorities better than HCPF does. In particular, a few stakeholders stressed that health equity work needs to happen at the local level, and even having one health equity process per RAE may not be granular enough to meet a region's diverse needs. Others pointed out that having set deliverables could limit RAEs' ability to respond nimbly to community needs and could take away resources from actually doing health equity work.

Many stakeholders, including members, also wanted trainings, plans, and task forces to consider health equity expansively. Many members and advocates specifically called out a need for disability competent care trainings as part of these health equity sessions, and several named a specific need for more training about providing care to members with intellectual and developmental disabilities. Members and providers shared that, in their experience, many providers are not qualified or appropriately supported to treat members with disabilities. Some members and providers also would like RAEs to develop health equity trainings for administrators and other non-provider staff.

Some stakeholders had questions about how HCPF plans to hold RAEs accountable for these health equity issues, including if HCPF identifies concerns with any RAE health equity plans. A few stakeholders specifically asked about which equity metrics HCPF would use and how HCPF would use them to ensure that both RAEs and providers meet health equity requirements. Others asked about how providers would be held accountable for taking health equity trainings and for providing more equitable care. Some members suggested that RAEs be responsible for holding providers accountable for providing culturally responsive care to members.

Regardless of their specific suggestions, many stakeholders noted that HCPF and RAEs need to be required to commit monetary resources to health equity in order to actually make progress.

Finally, a few stakeholders had questions about how HCPF is planning to address health equity at the state level. They noted that the Concept Paper focused on RAE requirements for health equity, not requirements that would apply to HCPF and Health First Colorado as a whole.

Member Experience

While conducting stakeholder engagement on the Concept Paper, CHI and HCPF staff spoke with many members about ways to improve their experience in ACC Phase III.

The Concept Paper discussed improving the experience for members who receive Long-Term Services and Supports (LTSS) and for members enrolled in Dual Eligible Special Needs Plans (D-SNPs). There was general support for HCPF's goals of improving communication and experience for these members, including through training RAEs on members' unique eligibility and needs, but stakeholders shared little other feedback around these proposals. One specific suggestion was to use an APM to try to coordinate efforts and improve outcomes for these populations. Others mentioned that technology innovations and shared systems may allow for better information sharing about those who either receive LTSS or are enrolled in D-SNPs. Finally, a few stakeholders mentioned that better care coordination and team-based care is particularly necessary for children and youth who receive LTSS. One stakeholder suggested that HCPF rely on the National Academy for State Health Policy's National Care Coordination Standards for Children and Youth with Special Health Care Needs to create clearer guidelines.

Generally, members said there should be more training for RAE staff so they can assist members with complex health needs, share accurate information with members who have questions, and more clearly communicate the RAEs' roles and responsibilities to members. Several members would also like to see accountability for RAE staff who provide incorrect information to members.

Most feedback focused on the following areas: member awareness and education about the RAEs, member advisory councils, the centralized member call line, and supports for members with disabilities. These four areas are discussed in detail below.

Beyond these major conversations, members also brought up the following concerns:

- Members would like increased transparency around what data is shared about them with providers and others who have access to their health records.
- Members have seen a rise in "ghost providers," who claim to be taking Health First Colorado patients but will not actually see new patients. They would like to see these providers held accountable for misleading members about their availability.

- Members have experienced challenges applying for behavioral health benefits in the PEAK app because these benefits may be interpreted as separate, optional benefits based on how they are presented. Members would like to see this updated in the PEAK app to make it clearer that behavioral health services are core benefits.

Member Awareness of RAEs

Many members reported that they did not have much knowledge of their RAEs, with some saying they had never even heard of RAEs until they joined a member advisory council. They said it would be helpful for HCPF to share information about RAEs to new members at the time of enrollment in a format that is accessible and easy to understand. Others suggested that RAEs should invest more resources into member outreach. Several members also shared that, when their RAEs reached out to them with information, they did not realize the RAEs were affiliated with Health First Colorado. These members suggested that any RAE communication include the Health First Colorado logo so members do not wrongly assume these communications are either marketing from unaffiliated organizations or a scam.

Members also emphasized that it is important that providers who see high volumes of Health First Colorado patients use consistent and accurate messaging when referring to the name and role of RAEs. Some suggested that providers have materials and information about RAEs available within their offices to improve accessibility.

Many members also shared that the term "RAE" feels confusing and overly technical, and they agreed that a simpler and clearer term would be better to describe these entities. The fact that each RAE has its own name also makes it counterintuitive that they are all affiliated with HCPF. Some members suggested more straightforward terms like "Care Coordination Entity" or "Medicaid District," and others suggested that each individual RAE have a standardized title like "Care Coordination Agency for Region #_." However, members did not coalesce around one name that they would prefer to see used in Phase III.

Member Advisory Councils

Members affiliated with member advisory councils praised these councils and supported the proposal to make them mandatory for each RAE. They also said more members should have the opportunity to be involved in these advisory councils.

Other members shared that, while they liked the idea of member advisory councils, they were concerned that HCPF could be requiring the existence of these councils without any additional requirements to ensure RAEs actually implement member suggestions or dedicate funding for these councils to operate successfully. Members disagreed about what requirements HCPF should have for these councils. For example, some thought HCPF should require RAEs to convene a certain number of times, while others thought that this was a decision better left to RAEs. However, many members agreed that RAEs should be required to dedicate funding to a regional member advisory council.

Additionally, while many members liked the idea of member advisory councils vetting RAE communication materials, they said members would need to be compensated for time spent reviewing and testing communication materials, and that HCPF would need to allow RAEs and members sufficient time to actually test communications for accessibility.

Beyond these required member advisory councils, some members and advocacy organizations suggested holding an occasional meeting across various HCPF and BHA member councils to allow those seeking care to communicate with each other. Others suggested that HCPF implement member-only policy subcommittees that would be more focused on discussing proposed policy changes than is the case for the current member advisory councils.

Centralized Member Call Line

Most members liked the idea of having one centralized call line, as long as the call center staff were adequately trained and could get members appropriately connected to the right places. Some members suggested that having peers staff the call center would be helpful. One non-member stakeholder expressed concerns that a centralized member call line could create a barrier for members who are used to calling their RAEs.

However, a few members also indicated that there should be an alternative way to reach out via email or text for those who prefer not to talk on the phone. Others said HCPF would need to ensure that any centralized communication system has an accessible alternative for all members, including those without access to technology.

Supports for Members with Disabilities

Many members with disabilities shared that, in their experience, few providers offer disability competent care. They suggested that providers working with patients with disabilities should receive extra training and resources, such as accessible equipment and higher reimbursement rates to be able to spend more time with members with disabilities. Others said appropriate translation and interpretation services, including ASL, need to be more easily accessible for all members in Phase III. One member suggested that a centralized state resource could help members efficiently access needed translation services.

Several stakeholders suggested that, for providers who do not meet requirements for trainings or other mandates, there should be stronger oversight and a process for accountability through either the RAEs or HCPF. One advocate specifically called out a need for increased funding for protective oversight and asked HCPF to think about ways to incorporate this into ACC Phase III.

Behavioral Health Transformation

Behavioral health transformation is a major priority in ACC Phase III. It intersects with many of the other proposals discussed in the Concept Paper, such as those related to care coordination, the integrated care benefit, and increased services for children and youth.

The feedback discussed in this section focuses on four topics that are not discussed elsewhere: HCPF's collaboration with the BHA, proposals to lessen the administrative burden on members and providers in the behavioral health space, HCPF's proposals to fill historical service gaps and ensure members can receive needed care, and accountability measures for providers and RAEs who do not meet their obligations.

Generally, across each behavioral health discussion, stakeholders had questions about the implementation of many Concept Paper proposals, including the pre-release coverage for incarcerated individuals and the coverage of residential services for young people.

Increasing Collaboration with the Behavioral Health Administration

Much of HCPF's proposed behavioral health transformation work is being designed in partnership with staff at the BHA, a decision which most stakeholders have praised. Across sectors, stakeholders have stressed that they would like to see as much collaboration between the BHA and HCPF as possible, with some members suggesting close coordination and collaboration in the future between HCPF's and the BHA's member advisory councils.

Some advocates and providers specifically highlighted the need for HCPF and the BHA to cover the whole spectrum of care and to implement a no-wrong-door approach for those seeking services, while others highlighted the need for clear procedures to transition those who churn on and off Medicaid. A few stakeholders suggested a shared grievance process that encompasses both RAEs and the Behavioral Health Administrative Service Organizations overseen by the BHA.

However, many stakeholders continued to ask questions about the relationship between HCPF and the BHA. Many asked how the two state agencies will effectively divide up roles, responsibilities, and authority. Some advocates suggested HCPF should have more decision-making authority because it serves many more Coloradans than the BHA will.

Reducing Administrative Burden

Many stakeholders, particularly behavioral health providers, praised HCPF's commitment to reducing administrative burden, saying that contracting with seven RAEs currently creates a heavy administrative burden. While HCPF's proposal to reduce from seven to four regions in Phase III would make progress toward system simplification, stakeholders feel additional proposals are needed.

Specifically, many providers were excited about the possibility that universal contracting and centralized credentialing would reduce providers' burden in working with RAEs. One provider

suggested that credentialing would be most successful if the state contracted with a third party to complete this work. However, many providers did not feel that these proposals alone were enough — they shared that they would like to see universal rates for behavioral health services across RAEs, as well as more consistency in how quickly RAEs submit claims and pay providers for behavioral health services. While generally supportive of these comments, representatives from one advocacy organization expressed some concerns that the proposals to reduce administrative burden, such as universal contracting, would merely create a minimum standard for RAEs to meet instead of encouraging them to continue to improve member and provider experiences.

Stakeholders also disagreed about the value of standardized utilization management tools. Some advocates who generally supported standardization were concerned that increased utilization management would actually increase burdens on providers instead of decreasing them. A few stakeholders disagreed, saying that standardization of utilization management using agreed upon standards is important to reducing variability and providing oversight. One supporter of standardized utilization management specifically highlighted the need to allow the use of tools that are valid for young children.

RAE staff and a few other stakeholders disagreed with the majority of stakeholders, sharing some concerns that, generally, these proposed changes may be overly prescriptive instead of allowing RAEs necessary flexibility to respond to unique needs in their regions.

Finally, according to some providers, HCPF's Concept Paper proposals on this topic do not consider administrative burden as comprehensively as should be the case. They suggested an Administrative Burden Review Task Force made up of providers and members to work on reducing administrative burden in Phase III.

Filling Historical Gaps in the Care Continuum

During these discussions, members and providers described what services they have had the most difficulty accessing or paying for.

Most notably, a few members shared that even though they are theoretically able to go outside their RAE for behavioral health care, they have not been able to do so in practice. Advocates working with members with intellectual and developmental disabilities also shared that they have extreme difficulties finding behavioral health care for these members. Advocates would like similar attention paid to behavioral health services for members with dementia or traumatic brain injuries.

Generally, advocates agreed with HCPF's decision to highlight discharge planning in the Concept Paper and said they hope to see more work in this area. They also highlighted a need for more attention on crisis services and on residential programs for members who cannot stay in their homes due to behavioral health challenges. A few advocates also highlighted a need for high intensity outpatient services that address trauma at all ages, particularly for young children.

On the payment side, providers and advocates hope HCPF is thinking about payment for behavioral health screening tools and for community health workers in community mental health centers. According to providers, reimbursement for these services is currently extremely difficult. One provider said this sometimes occurs because RAEs and HCPF disagree on which entity should reimburse providers for screenings. Other providers also shared that a major gap exists in paying for upstream prevention and promotion services for children and youth, and they would like to see Phase III address this gap.

RAE and Provider Accountability

Several advocates felt that RAEs and providers are not consistently meeting their behavioral health requirements in Phase II, and they would like to see more accountability.

At the RAE level, advocates said some RAEs do not pay behavioral health providers enough to have an adequate network, which is crucial for ensuring patients can receive needed care. At the provider level, some advocates named community mental health centers as not consistently meeting their requirements, and these advocates suggested that community mental health centers that do not meet their enhanced requirements should not receive higher payments. Others suggested that HCPF should provide more practice support to community mental health centers and other comprehensive and essential providers.

Behavioral Health Integrated Care Benefit

Section IX of the Concept Paper proposes a behavioral health integrated care benefit, which would help support reimbursement for providers and practices who work toward integrating physical and behavioral health care.

Most stakeholders, particularly providers, strongly supported the proposal to design and implement an integrated care benefit that is more holistic than the current Six-Visit Short-Term Behavioral Health benefit. Providers were also interested in learning more about the specific billing codes that may be involved in this new benefit, with several providers specifically calling out the utility of health and behavior codes and collaborative care codes. They would like providers across many sectors to be able to use these codes, with one provider suggesting practices be able to use these codes even if they are not contracted with a RAE. One advocate also called for reimbursement for protective oversight through a billing code, which is an approach used in other states.

Given that several pilot programs on integrated care are underway, HCPF has decided to wait to fully implement this integrated care benefit until there is a chance to learn from the pilot programs. Stakeholders also supported this decision, with some saying it indicates that HCPF is being thoughtful in its implementation of this new benefit.

A few advocates, while supportive of the integrated care concept, also expressed concern that ACC Phase III may overemphasize integrated care to the detriment of patient experience. They shared that some members prefer to seek physical and behavioral health

care from different providers, and these advocates would like to see safeguards to ensure members are not pressured to seek both behavioral and physical health care at the same clinic if it is not their preference.

Care Coordination and Case Management Standardization

In the ACC Phase III Concept Paper, HCPF shared two major proposals related to care coordination: a tiered model and a requirement for RAEs to create a network of community-based organizations. Feedback about both of those proposals is below, along with some member-specific feedback about care coordination experiences in Phase II.

A great deal of the stakeholder feedback on care coordination did not deal with these proposals and instead focused on providers who coordinate care for members. Many providers and advocates shared that, in their experience, care coordination works best at the point of care (i.e., at a doctor's office). Providers from many larger practices, who already provide care coordination, shared that they would like HCPF to ensure that practices that provide this coordination are paid for it. According to providers and advocates, this model differs by RAE, which means many larger practices are not necessarily reimbursed for their time and efforts on care coordination.

Practices shared that they would like to be able to opt into or out of RAE care coordination based on their own care coordination capacity. Members and advocates primarily felt that, if members are offered multiple care coordinators, they should be able to choose their own coordinator, and these stakeholders said the RAEs or HCPF should pay for care coordination based on members' choice.

In addition, many advocates and members provided high-level feedback that care coordinators should be better trained to be culturally responsive to the communities they serve. When possible, advocates and members would like to see RAEs and practices hire care coordinators who have lived experience and are reflective of the communities in which they work. Some of these advocates also shared that care coordinators should serve more strongly as client advocates within the medical system.

Tiered Model of Care Coordination

Generally, members, providers, and other stakeholders were supportive of a tiered model for care coordination; they liked that this model would provide clearer standards for RAEs and patients. A few shared that, while they liked the model at a high level, they wanted to ensure the definitions would be flexible enough to account for unforeseen circumstances. Others suggested more specific definitions than currently exist.

All of these stakeholders wanted to know more about the specific implementation plan for the tiered model. Many stakeholders shared that they hope the model will be implemented in such a way that it gives more structure for providers and members, and provides more

support for members who would fall into Tier 2 or Tier 3 (i.e., those who have more intense care coordination needs).

Despite their general support for this model, stakeholders shared that they hope HCPF will take various considerations into account. Those included:

- Ensuring that the tiered model is flexible enough that members can move to a different tier of care coordination when necessary.
- Aligning this tiered model with other care coordination services, including the care coordination and case management offered through case management agencies and the BHA.
- Training care coordinators so they share accurate and consistent information with members and know how to work with multisystem-involved members.
- Ensuring that these tiers of care coordination do not silo members by requiring them to change care coordinators and re-share all information if their tier changes.
- Updating resources regularly so care coordinators are not providing out-of-date information to patients.
- Incorporating robust care coordination technology that crosses systems for communication, referrals, medical guidance, and external data sharing.
- Incorporating social risk factors into the care coordination tiers, in addition to medical complexity.
- Incorporating additional conditions into care coordination tiers, such as high-risk medication use and history of emergency department use.
- Implementing a systematic, timely, and clearly documented screening process.
- Providing public demographic data on those who are offered and are receiving care coordination.
- Building in accountability measures to make sure RAEs are actually providing members with the care coordination services for which they are eligible.

Stakeholders also had concrete suggestions for ensuring members at Tier 2 and Tier 3 receive adequate care coordination. Stakeholders stressed that coordinators working at Tiers 2 and 3 need smaller caseloads, with members sharing that a 65:1 ratio is much too high for Tier 3 care coordinators. One organization suggested that for the most complex cases, the ideal caseload would be 20:1, while for Tier 1, the maximum caseload should be 75:1. Members and advocates also stressed that, particularly at Tiers 2 and 3, care coordinators should be doing more than providing referrals or lists of resources. Members shared that they would like these coordinators to be providing warm handoffs, helping members navigate payments, and similar services. Some stakeholders, including providers, also liked the idea of having a third-party coordinator to provide Tier 3 care coordination, but they would like more information about the proposal to fully understand it.

Beyond these suggestions, many stakeholders asked for more clarification about the different services that would be offered at each tier of care coordination. Several advocates

shared that they would like to see high-fidelity wraparound services offered for all Tier 3 members and that care coordination should happen more frequently than monthly for these members. Stakeholders shared that for higher-tier members with more than one care coordinator, it would be useful to have a "super coordinator" to orchestrate care between various care coordinators and case managers. They shared that getting various providers and care coordinators to communicate is difficult and emphasized that it should not be a member's responsibility.

Network of Community-Based Organizations

Members and advocates were particularly supportive of the proposal to require RAEs to create a network of community-based organizations for care coordination. Stakeholders shared that these organizations can be extremely helpful in reaching members who are otherwise difficult to engage, such as members experiencing homelessness. Stakeholders shared that members are more likely to trust community-based organizations because staff members at these organizations often have similar lived experiences to members. Some advocates shared that they believe local, community-based care coordination is more successful than care coordination offered either by RAEs or by providers who are not integrated into the community. Several members reported that some of their most positive care coordination experiences, including coordination on health-related social needs, have come from working with community-based organizations.

A couple of stakeholders shared that local public health agencies also provide community-based care coordination support and suggested that any care coordination model also include coordinating with local public health and reimbursing these agencies for their services.

Most stakeholders' largest concern was around how community-based organizations would be paid to help with care coordination in Phase III. They shared that, in their experience, not all RAEs share care coordination dollars according to the work being done, and they want to ensure that these organizations will be compensated for any increased responsibilities.

Other questions about this proposal included those around:

- How RAEs would identify organizations to work with.
- How community-based organizations would be trained to support care coordination.
- What specific responsibilities community-based organizations would be required to meet.
- How this proposal would interact with the care coordination tiers.
- How RAEs would track data on the referrals and services provided by community-based organizations.

Other Member Feedback

CHI and HCPF staff spoke with many members, including those who sit on the statewide MEAC or on several RAEs' member advisory councils, about their experiences with care coordination and their reactions to HCPF's proposals. Members were generally supportive of these proposals, but many members shared that they currently do not receive care coordination, even though many should be eligible for it. Some did not know that RAEs are required to coordinate care for certain members, while others reported that they knew about care coordination but had difficulties accessing it in practice. Some of these members said they had never been contacted by their RAE. Others had heard from a care coordinator once but had either never received follow-up information or had felt uncomfortable engaging because they did not understand why these care coordinators were reaching out to them. Additionally, some members who did receive care coordination shared that they felt as though their care coordinators were often "checking a box" instead of actually providing comprehensive care coordination, which made them feel less useful and genuine in their efforts.

Given these difficulties, many members shared that they would like to see increased accountability for RAEs who do not provide the required care coordination. These members were excited about some of HCPF's proposed accountability measures, including holding RAEs accountable using a policy guide and metrics around hospital readmission.

Members also suggested that HCPF should more explicitly explain care coordination benefits to new members when they enroll and that HCPF should provide reminders about care coordination to members every year when they renew their coverage. These members also shared that they would like care coordinators who reach out to more clearly explain their connection to HCPF and their reasons for reaching out to members. Others suggested HCPF add an explainer about care coordination to the PEAK app and allow members to connect with and see their care coordinators through this app. This would allow members to seek out care coordination even if those services were not offered to them.

Health-Related Social Needs

Providers, members, and advocates were enthusiastic about HCPF's proposal to focus on health-related social needs, especially housing and food security, in ACC Phase III. However, many stakeholders had questions about the specifics of HCPF's health-related social needs proposals that limited their ability to provide feedback in the Concept Stage.

Some questions and suggestions focused on staffing and funding for these proposals. Stakeholders wanted to know more about who would provide services for health-related social needs and whether they would be reimbursed for those services. Specifically, some stakeholders wanted to see community health workers more involved in this work, while others suggested paying community navigators to dedicate all of their time to health-related social resource navigation. Several members mentioned that they would like to see members

work with local staff who are more likely to know local community-based organizations and be able to provide localized services. A few members suggested that clinical care coordinators should also help with health-related social needs, but others disagreed, saying this would be too much work for one individual and would lead to lower-quality care coordination. Regardless of who is providing this assistance, many stakeholders stressed that they do not believe any assistance will be successful if HCPF does not dedicate appropriate levels of funding to addressing health-related social needs. Some shared that, currently, many providers must spend administrative dollars earmarked for other purposes on responding to patients' health-related social needs.

Many stakeholder questions focused on what services would be provided to Health First Colorado members and would like to receive more information. While some like the idea of RAE-produced community resource guides, many members and advocates would like to see more support than a simple list of resources given by providers, RAEs, or care coordinators. Some members suggested that RAE employees or providers should be required to help members apply for other programs, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Supplemental Nutrition Assistance Program (SNAP).

Some stakeholders preferred an approach that would require RAEs to contract directly with community-based organizations who help address health-related social needs. They felt that a more collaborative approach would better support members' needs, because it would not overextend RAEs and would allow providers, organizations, and other entities to continue improving on their current work, instead of trying to take on additional responsibilities.

Still other stakeholders suggested that HCPF think about ways to provide direct reimbursement for health-related social needs, including food, housing, transportation, and social isolation, perhaps through a flexible pool of funds for providers or by pursuing an 1115 waiver. However, some stakeholders cautioned that HCPF and RAEs should not limit existing functions, which are essential, to provide health-related social needs. If HCPF cannot receive additional funding to do this work, stakeholders would like to see thoughtful conversations about prioritization of various RAE and HCPF responsibilities.

Finally, a few stakeholders focused on provider screening and connections to services. While providers said they tend to be supportive of health-related social needs screeners, they would like flexibility to choose their own screening tools. Some providers do not support required screeners because they lack resources to offer members who are identified as having health-related social needs, particularly in rural areas. Providers also shared that there is often no follow up from members after providers offer them referrals. They suggested HCPF think about ways to ensure that members are actually receiving health-related social services when they are referred to those services.

Supports for Children and Youth

Many stakeholders, particularly providers and advocates who work with children, were excited about the Concept Paper's focus on additional supports for children. Several stakeholders pointed out that adults and children have different needs, which means children need specialized services and supports in the ACC to receive appropriate care.

In addition to this more general feedback, stakeholders provided insight on two specific proposals to support children and youth: the Standardized Child Benefit and the sub-proposal regarding conflict-free intensive care coordination. Stakeholders had questions about how these two proposals would intersect with the proposal for tiered care coordination for all members, which is discussed earlier in this summary report. Many stakeholders also had questions about how the Standardized Child Benefit proposal would intersect with the BHA's work on behavioral health services for children.

Beyond these proposals, many stakeholders shared their perspectives about health prevention and promotion for children and young people. These perspectives are included in the final subsection under Supports for Children and Youth.

Standardized Child Benefit

Stakeholders, particularly providers and advocates, generally supported the Standardized Child Benefit as a concept because they believed it could help create consistency statewide. However, they had many questions and concerns regarding its implementation. For instance, many providers said any Standardized Child Benefit would need to feature standardization across the RAEs while also allowing flexibility for providers and members, which they felt may be a difficult balance to strike.

Many providers' and advocates' concerns focused on the specific screeners or assessments that would be used to identify children's acuity level for the Standardized Child Benefit. Some providers said certain screeners may be too narrow or that different screeners may be appropriate for different children or practices. Several suggested that their support of this proposal may be contingent on how HCPF decides screenings will be conducted. Other advocates had questions about how frequently children would be reassessed or how easily children would be able to be re-screened if their needs changed. These advocates also asked whether a third party would be contracted to conduct screenings; some supported this approach, while others were concerned that a third-party assessment could lead to a delay in services. Some stakeholders wondered whether children would be able to access services designed for those at a higher acuity level if a provider deemed those additional services necessary.

Finally, some providers had questions about how this model would define medical complexity. They liked the idea of standardizing the definition and encouraged HCPF to keep

looking into existing research on this topic. Others specifically suggested that HCPF include unmet social needs in defining criteria for complexity.

Within the Standardized Child Benefit, many advocates applauded the inclusion of high-fidelity wraparound services. Others were excited about the proposal to include dyadic services, with one stakeholder specifically suggesting the addition of a code for Family Connects dyadic assessments. Stakeholders wanted to hear more information on the details of these two proposals.

Other stakeholder questions about the Standardized Child Benefit included how both preventive care and private duty nursing would fit into this benefit (and why HCPF called out private duty nursing specifically).

Finally, many stakeholders questioned whether HCPF had any proposals for children and youth focused on the physical health side, given that this benefit seemed to be primarily focused on children with behavioral health needs. A few providers and advocates shared that separating out services for physical and behavioral health needs could create additional silos and barriers for families seeking services.

Intensive Care Coordination

The intensive care coordination proposal would be part of the Standardized Child Benefit for children with more complex health needs. Many stakeholders had a positive view on this sub-proposal, although a few were disappointed that HCPF did not discuss a medical home model in the Concept Paper.

Several providers suggested that they would prefer a third party provide this intensive care coordination instead of the RAEs or HCPF. Others disagreed, saying that they would prefer to be able to provide intensive care coordination internally if they had the resources. Still others worried that a third-party care coordinator could create additional siloing, so they shared that any third-party care coordination would require deliberate, multisystem implementation.

Other providers and advocates supported the idea of a care team with one lead care coordinator, and several stakeholders pointed out that children are often involved in multiple systems, which means they can have several care coordinators or case managers who do not communicate effectively.

Health Prevention and Promotion

Several stakeholders shared concerns that these proposals do not account for many children who do not have complex health care needs. Stakeholders, including advocates and providers, would like to see more focus on health prevention and promotion in ACC Phase III. Specifically, they called out a need to reimburse for health prevention and promotion activities and design value-based payment programs that incentivize these activities.

Specific recommendations from providers and advocates included:

- Reimbursing for dyadic services for both children and their caregivers, particularly for children ages 0-3. One stakeholder suggested Colorado adopt a version of the dyadic service reimbursement that California's Medicaid program recently implemented.
- Requiring RAEs to partner with and reimburse home visiting programs, particularly those eligible under the Maternal, Infant, and Early Childhood Home Visiting program, and include reimbursement for travel costs. Some stakeholders specifically called out the need to reimburse the Child First program.
- Requiring HCPF to reimburse the Healthy Steps program and all similar programs.
- Incorporating all of these health prevention and promotion programs into the Standardized Child Benefit.
- Offering reimbursement for all of these services through the same method, whether that be fee-for-service, as part of the behavioral health capitated payment, or through an alternative payment model.
- Restoring the Healthy Communities program as a separate program from the RAEs.

Primary Care Medical Providers

Stakeholder feedback regarding PCMPs that has not already been described in this report generally falls into one of two categories: feedback on RAEs' support for primary care medical providers, or feedback on the proposal to expand the types of practices that can serve as primary care medical providers.

RAE Support for Providers

Some providers, provider associations, and advocates shared concerns about the increased requirements on RAEs that are proposed in the Concept Paper. These providers said they have not felt adequately supported by the RAEs in Phase II and they feared that increased requirements may further strain RAEs' capacity. One practice suggested that RAEs should primarily support providers in Phase III and that some member-focused RAE functions, such as care coordination, should evolve to be primarily a provider responsibility. Some advocates who agreed that RAEs have not met their functions suggested that HCPF require RAEs to improve their current roles and responsibilities during Phase III instead of requiring them to perform additional services.

Other advocates, county representatives, and stakeholders disagreed, saying that RAEs have met their core functions. However, these stakeholders also questioned the increased responsibilities for RAEs in Phase III. They were concerned that RAEs would not have adequate capacity or funding to fill new roles. They would only support the expansion of RAE responsibilities if there were sufficient reimbursement for RAEs.

More specifically, providers stressed that RAEs should be responsible for helping them access more timely data, particularly data on how providers are performing on Phase III metrics.

Providers acknowledged that larger practices can often gather these data internally, but small practices need support from RAEs or HCPF to access it. Providers also called out a need for more accurate and more timely attribution data.

Because every provider has different internal capacity and resources and because RAEs can sometimes duplicate providers' work, many providers and advocates said they would like to see RAEs offer a menu of options of support for providers. According to providers, this would allow them to request different levels of data assistance, care coordination support, patient engagement, and other services based on their needs. These providers recommend that payments go to either RAEs directly or providers based on the supports that providers opt into or out of.

A few stakeholders also discussed the tiering model presented in the Concept Paper for RAE payments to providers. While many stakeholders like the increased specificity, some shared that they did not think tiers should be based on geography or experience with value-based payments but instead on general practice capabilities and practices' previous outcome measures. Some also suggested that providers' tiers should be publicly available data.

Although not mentioned in the Concept Paper, members with disabilities also discussed the need for better accessibility infrastructure and resources, such as wheelchair scales, accessible exam tables, and interpretation services for Deaf members. They would like to see either HCPF or the RAEs support practices in paying for accessible medical equipment and services to improve members' care experience.

Expanding Types of Primary Care Medical Providers

HCPF has proposed allowing behavioral health providers to be among those who can serve as primary care medical providers. HCPF's rationale is that this may be a good option for members with complex behavioral health needs, who primarily access behavioral health services, as opposed to physical health services.

Behavioral health providers were largely supportive of this proposal. Many providers pointed out that behavioral health providers often provide care coordination services in Phase II. They said these providers would benefit from an administrative payment to help them coordinate patients' care. A few providers, however, questioned why HCPF did not include other types of specialists in this proposal in Phase III.

Providers and other stakeholders were more divided on the question of whether behavioral health providers should be required to provide on-site primary care services if they wished to serve as primary care medical providers. Some felt that, when behavioral health providers do not have on-site physical health services, they have trouble providing whole-person care and thus should not receive administrative payments for acting as a primary care medical provider. Others disagreed, stating that behavioral health providers who can effectively provide high-quality care should receive administrative payments, regardless of whether

they refer patients to another provider for physical health services or provide those services in their office.

One provider suggested that HCPF consider allowing two providers to split the administrative payment for serving as a primary care medical provider, if one provides physical health services and another provides regular behavioral health services and care coordination to a given member.

Additional Comments

In addition to responses to specific proposals, several stakeholders shared more overarching feedback that impacts several of the proposals in the Concept Paper. Much of that feedback focused either on the health care workforce or on the concept of increasing standardization in Phase III.

Workforce Considerations

Many stakeholders shared concerns about workforce shortages and wanted to know whether HCPF could implement other initiatives to try to grow the health care workforce, particularly in rural areas. While these initiatives may not directly be part of ACC Phase III, workforce improvements are an important consideration in the implementation of any health care initiative, including the rollout of this next iteration of the ACC.

Standardization

Across many of the topics discussed above, stakeholders disagreed on the topic of standardization across RAEs and providers in Phase III. Many stakeholders felt that more standardization is needed to ensure uniform quality of and access to services across RAEs and to reduce disparities. However, a few stakeholders disagreed. They said that in their experience, the reason Colorado's regional model works is because there is flexibility at the RAE level. Many stakeholders have expressed a desire to find balance between these two ideas, but there is no consensus on what the ideal balance is.

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. The proposals discussed in the Concept Paper will be further detailed in the forthcoming Draft RFP. Stakeholders can continue to access written comments from stakeholders on this spreadsheet.

At that point, CHI and HCPF will continue to capture feedback about those detailed proposals to evolve and inform the final RFP.