Accountable Care Collaborative
Phase III

Draft Contract Engagement Summary

May 2024

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 in response to the Draft Contract for Phase III the Accountable Care Collaborative (ACC). 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. Additionally, stakeholders gave different types of feedback, with some providing feedback on specific contract language, whereas others provided feedback on the overall structure of the ACC itself. Furthermore, some of the information contained here may be out of date at the time of publication because some questions were posed as decisions were evolving. Comments included in this summary reflect individual stakeholders' perceptions 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. Some of the other feedback on the Draft Contract focused on federal or state requirements that HCPF cannot control. For instance, HCPF must include language on moral or religious objections for managed care organizations in these contracts due to Managed Care regulations developed by the Centers for Medicare & Medicaid Services.

Themes from Stakeholder Engagement

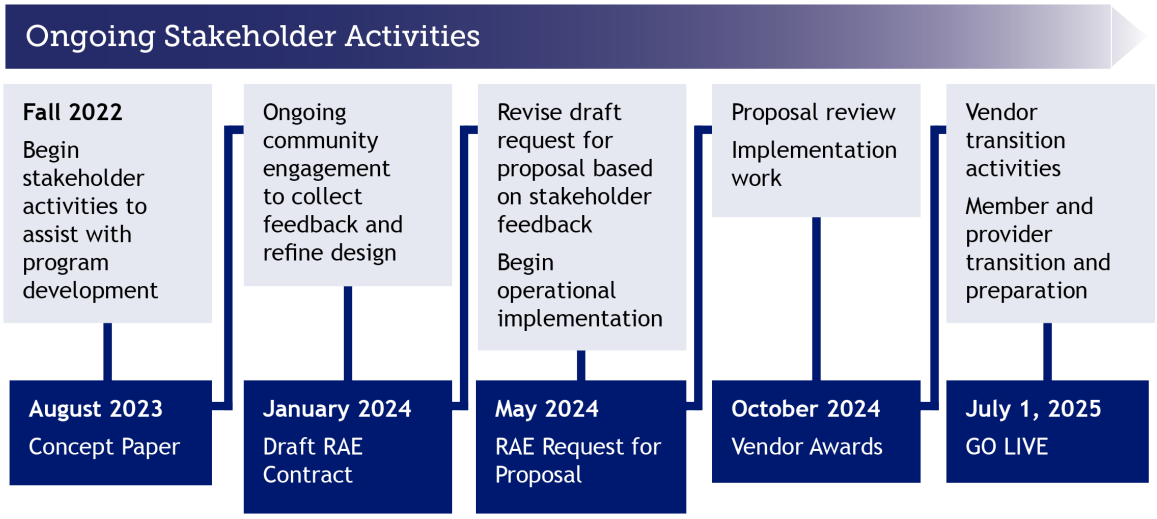
- Stakeholders believed many proposals outlined in the Draft Contract proposals held promise. Stakeholders also provided suggestions on the implementation of those proposals. For example:
  - Members, advocates, and other stakeholders liked the increased focus on cultural responsiveness.
  - Members and advocates also liked the focus on network adequacy and timely access to care, but they were concerned that RAEs would not be held accountable for meeting these requirements.
  - Members supported the increased requirements for Member Advisory Councils (MACs) and provided suggestions on how best to convene and facilitate these MACs.
  - Providers liked the proposal to remove geographic attribution, but they expressed concern about the possibility that this proposal may decrease their overall administrative payments.
  - Stakeholders liked the care coordination concepts, such as the tiers, but they were concerned about how those would be implemented.
- Some stakeholders felt that the Draft Contract was too prescriptive, while others disagreed, saying that the Draft Contract allowed for too much flexibility, which could lead to a lack of standardization across RAEs. For example:

  - Stakeholders disagreed about whether HCPF should require RAEs and providers to use specific tools. Potential bidders and providers worried that this may create duplication and unnecessary burden, while other stakeholders liked the idea of standardization to ensure RAEs are using evidence-based methods.
  - Some stakeholders were concerned that the Draft Contract is not prescriptive enough in how RAEs delegate or coordinate responsibilities with other entities, such as the Behavioral Health Administration and its Behavioral Health Administrative Services Organizations.
  - Some advocates were concerned that RAEs have too much discretion in the care coordination section, such as in creating a Care Coordination Policy Guide. Some members and advocates suggested that RAEs be more strongly directed to include members in the creation of these guides.
  - Many providers felt the provider support requirements are overly prescriptive and suggested providers be able to opt out of these requirements and instead directly receive a larger per member per month payment.
- Stakeholders had different visions for what RAEs' core functions and priorities should be. For example:
  - Many stakeholders expressed general concerns that RAEs are being asked to do too much in the new contract.
  - Several members suggested that the new contracts should focus on increased accountability for current care coordination responsibilities, as opposed to expanding care coordinators' responsibilities.
  - Many advocates wanted RAEs to be more involved in the renewal and eligibility processes.
  - Many members and advocates liked the focus on health-related social needs, but others were concerned that these new responsibilities would overextend RAEs.
  - Providers and advocates had a range of suggestions for specific measures that should be added to incentive programs. These suggestions differed based on stakeholders' vision for what RAEs should prioritize.

Introduction

In preparation for launching Phase III of the ACC on July 1, 2025, HCPF developed a multi-step process to engage 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 Draft Contract 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, community-based organizations, 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 Engagement Summary, available on HCPF's website. The Concept Stage of stakeholder engagement began in April 2023 with most engagement occurring between August 2023 and October 2023. Stakeholder feedback from the Concept Stage is summarized in the ACC Phase III Concept Stage Engagement Summary.

In January 2024, HCPF published a Draft Contract detailing specific requirements for RAEs in ACC Phase III. This Draft Contract was informed in part by stakeholder feedback from the Vision Stage and Concept Stage.

After the Draft Contract 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 15 meetings between January and March. This included six virtual public meetings; two were for all stakeholders, while others focused on specific audiences, including primary care medical providers and Health First Colorado members. A full list of meetings and presentations that CHI and HCPF conducted together between January and March 2024 is available in Table 1. Materials from these meetings are available on the ACC Phase III Stakeholder Engagement website. As a note, HCPF independently conducted other meetings that may not be reflected in this summary or on the website.

CHI and HCPF also sought written feedback about the Draft Contract through an online form that closed on March 10.

In addition to feedback about the Draft Contract, CHI and HCPF also asked for feedback about the questions that should be asked of offerors, or bidders, in the formal Request for Proposal (RFP). CHI

and HCPF received feedback both in meetings and through a separate feedback form, which also closed on March 10.

In total, through all three stages of stakeholder engagement, CHI and HCPF spoke with approximately 3,800 stakeholders across 86 meetings. Some of these stakeholders may have participated in multiple meetings. CHI and HCPF also received nearly 500 total written comments through surveys throughout this process.

HCPF has considered all stakeholder feedback as it has finalized the formal RFP for offerors to serve as RAEs in Phase III. The May 2024 release of the final RFP begins the formal procurement process.

Table 1: List of Stakeholder Engagement Meetings in Draft Contract Stage

Date	Meeting	Approximate Number of Attendees
1/17/2024	Statewide Program Improvement Advisory Committee (PIAC)	95
1/25/2024	Performance Measurement and Member Experience (PMME) Subcommittee of PIAC	45
2/1/2024	ACC Draft Contract Public Meeting: Introduction	60
2/7/2024	Behavioral Health and Integration Strategies (BHIS) Subcommittee of PIAC	70
2/8/2024	Provider and Community Experience (P&CE) Subcommittee of PIAC	35
2/12/2024	ACC Draft Contract Public Meeting: Primary Care Medical Providers	35
2/13/2024	Member Experience Advisory Council	15
2/14/2024	ACC Draft Contract Public Meeting	50
2/15/2024	ACC Draft Contract Public Meeting: Behavioral Health Providers	60
2/21/2024	Statewide PIAC	80
2/21/2024	ACC Draft Contract Public Meeting: Community Based Organizations and Advocates	45

2/22/2024	PMME Subcommittee	35
2/27/2024	County Directors Meeting	80
2/29/2024	ACC Draft Contract Public Meeting: Health First Colorado Members	35
3/7/2024	Colorado Health Policy Coalition	15

General Draft Contract Comments

Some stakeholders chose to focus their feedback on the Draft Contract as a whole, rather than specific contract language.

Many stakeholders, particularly providers and members of community-based organizations, expressed their appreciation of the content and that the Draft Contract incorporated earlier stakeholder feedback. However, other stakeholders had the following concerns about the Draft Contract: that it is overly broad and confusing, that it potentially prioritizes providers' interests over Health First Colorado members' needs, that it delegates too many responsibilities to RAEs (which already struggle to meet all the requirements), and that it does not have sufficient accountability in place to ensure RAEs meet all of their responsibilities. One advocate said that, while the Draft Contract includes performance standards and deliverables, they were worried that HCPF would not have the staff to review these deliverables and hold RAEs accountable for any shortcomings.

Throughout the Draft Contract, many stakeholders also flagged specific sections and sub-sections that confused them and that needed clarification. They also indicated places where terminology was inconsistent or was not defined. This summary does not list all those points of confusion.

Some stakeholders, particularly providers, also appreciated the move toward increased standardization but asked that the final RFP include even more standardization and less variation across RAEs. On the other hand, some advocates and other stakeholders shared concerns that the Draft Contract is overly prescriptive of RAEs and asked for more flexibility for RAEs to modify some of the requirements based on local needs.

Beyond these overarching comments, some stakeholders also shared concerns and suggestions that relate to multiple sections of the Draft Contract. Many stakeholders noted that the Draft Contract regularly calls for RAEs to work with other entities, such as the Behavioral Health Administration (BHA) and the future Behavioral Health Administrative Services Organizations (BHASOs). While they appreciated the focus on collaboration, several were concerned that the division of responsibilities is not always clear, which may lead to confusion or delays in care.

Other stakeholder concerns included:

- Confusion between multiple tiering systems: one for providers, based on how advanced their primary care practice is, and one for members, based on their care coordination needs.
- Provisions for religious or moral objections to providing services. Advocates worried that these provisions could allow for discriminatory behavior from RAEs.
- Requirements that RAEs and providers use specific tools. Potential bidders and providers worried that this may create duplication and unnecessary burden, especially if RAEs and providers are already using alternative tools that serve the same function. However, other stakeholders, including member advocates, liked the idea of requiring standardized statewide tools to ensure RAEs are using evidence-based methods.
- The continued payments for physical health services and behavioral health services through different payment structures.
- The perception that RAE innovation is not incentivized in the Draft Contract.

Finally, a few stakeholders focused on the deliverable requirements, with one advocate suggesting that HCPF create a separate section just about deliverables and a provider suggesting that HCPF prioritize making deliverables publicly available.

Section 1: Regional Accountable Entities

The first section of the Draft Contract includes requirements for the overall governance of the RAE. Very few stakeholders shared feedback about this section, with those who did focusing on the RAE Governance Plan and the governing body.

A few stakeholders applauded the requirement that the RAE publicly post its Governance Plan. One advocate also suggested that HCPF write a stronger policy requiring the governing body to disclose and review all conflicts of interest.

Stakeholders had mixed suggestions on the makeup of the governing body. Some advocates suggested that members be explicitly named as governing body members. One member advocate suggested that, at most, 25% percent of the governing body be providers, with a preference that no providers be part of the governing body. A provider, on the other hand, suggested that 10-25% of the governing body be behavioral health providers alone and seemed to like the guideline that no more than 50% of the governing body be providers.

Section 2: Member Enrollment and Attribution

Section 2 of the Draft Contract focuses primarily on how members are assigned to a RAE and attributed to a primary care medical provider (PCMP). Although not detailed in the Draft Contract, HCPF plans to remove the process of geographic attribution, wherein members who have not previously engaged in care are linked to a provider who is geographically near them.

A few stakeholders said that they would like HCPF to further streamline the attribution process.

Attribution and Assignment Methodology

Many stakeholders, particularly providers, had feedback about HCPF's proposal to change how attribution occurs. Many providers supported the plan to end geographic attribution, but they also worried that this proposal would decrease the amount of administrative funding PCMPs receive through the per member per month (PMPM) payment. They said that, if administrative funding decreases because of this proposal, PCMPs may have difficulties continuing to fund services like care coordination.

HCPF also said it will continue to attribute new members by their claims history. Going forward, several stakeholders suggested that wellness visits and well-child visits be prioritized or more heavily weighted when attributing members to a provider. Another stakeholder suggested that attribution use a 24-month claims look back, which would better align with other efforts, such as Making Care Primary and Primary Care First.

The third component of the current attribution methodology is family attribution, wherein family members living at the same address are attributed to the same provider, as long as the provider serves their age group. One provider asked that family attribution continue for siblings, so they are attributed to the same pediatrician.

Other members and advocates suggested that the process should focus more on asking members who they consider to be their primary care provider on a regular basis and attributing members based on their response. These members noted that the current process for changing PCMPs, which requires calling the HCPF Enrollment Broker, is burdensome, so most members never change their attribution. They would like to be able to change their provider through the PEAK system, via website or the Health First Colorado mobile app.

Conversely, a few members and member advocates shared concerns about how RAE assignment occurs. Currently, if a member is attributed to a provider based on claims history, they are assigned to a RAE based on the provider's address. Stakeholders reported that this process can cause challenges, particularly for children discharged from residential care far from where they live.

A few member advocates also noted that the process for changing RAEs seems overly difficult.

Finally, many stakeholders had questions about the to-be-developed PCMP Fidelity Tool to ensure that members are properly attributed. Some stakeholders suggested that members and MACs help develop the tool, and a few others suggested that RAEs be held accountable for ensuring attribution is accurate.

Outreach to Unattributed Members

HCPF has proposed removing geographic attribution to the nearest PCMP for members who are not engaged in health care. Many stakeholders supported this approach. Some said providers do not have capacity to reach out to unengaged members, and others said that trying to engage members in care does not seem to be a good use of money, based on available data. Other providers and advocates, however, were concerned that RAEs would not spend enough time and money reaching out to

unengaged members, with some pediatricians saying that RAEs should focus on engaging children in preventive care.

If members have engaged in urgent or emergency care but are unattributed, RAEs will be expected to try to connect those members to PCMPs. Some providers were concerned about how this connection would occur. Some suggested that RAEs preferentially connect members to Federally Qualified Health Centers (FQHCs), while others suggested that RAEs be required to connect members to all PCMPs in a fair manner. A few behavioral health providers said safety net behavioral health providers should be able serve as the PCMP for unattributed patients who regularly engage in behavioral health care.

Eligibility and Renewal

Many member advocates also suggested that RAEs be required to take a more active role in helping members through the eligibility and renewal processes. Some specific suggestions included:

- RAE staff should help members fill out renewal packets.
- RAEs should incentivize hospitals in their regions to enroll eligible newborns.
- RAEs should work with community-based organizations (CBOs) and local public health agencies (LPHAs) to offer enrollment and renewal assistance.
- RAEs should be held to a performance standard to initiate an enrollment, eligibility, or renewal program in their region.

Section 3: Member Engagement

The bulk of the feedback on Section 3 of the Draft Contract, which focuses on how RAEs engage with members, came from members and advocates. At a high level, several members voiced concerns that this section seems to be more focused on engagement at the individual level without enough focus on incorporating member change into all aspects of RAEs' work, including systemic and policy change. Other members shared high level concerns that this section does not include enough trust-building between RAEs and members, which is important to member engagement. Finally, a few members shared a general concern that RAEs do not have enough staff to do all this member engagement work and that RAE staff, such as call center staff, are not trained to respond to members in a trauma-informed, person-centered way.

Beyond these general concerns, members and advocates provided suggestions in specific categories.

RAE Communications

Several members said they do not know their RAE or know how to find information about their RAEs. They suggested that HCPF include RAE information both on members' cards and on the main page of the Health First Colorado app. They also suggested that HCPF use the same term to describe RAEs to both members and other stakeholders to reduce confusion, with some stakeholders suggesting that HCPF keep the term RAEs, because more members are now used to that term. Some members also

suggested that all members be re-onboarded at the beginning of Phase III and be provided information about their RAE and its role.

Regarding communication, several members said they would be more likely to respond to RAEs if they received communication about upcoming outreach from either RAE staff or care coordinators. One member suggested that RAEs be required to make repeated outreach attempts, because members may not always respond to an initial outreach. Others mentioned that it can be hard to reach RAEs and said they would like a range of options to communicate with RAEs, including flexibility regarding format of communication and day and time of communication.

In terms of member feedback loops with RAEs, several members flagged that it is essential that members have a safe way to communicate with RAEs, with one specifying that members should be able to submit information anonymously and in the language and format of their choosing. A different member focused on the fact that RAEs are required to make materials accessible and easy to understand and suggested that there be a specific form for members to submit when materials are confusing or inaccessible.

Call Center

Several members also shared their thoughts about the additional call center requirements. While some members thought these were unnecessary, others appreciated the goal of these increased requirements. However, a few members flagged that call centers would only be accessible if staff received training about being trauma-informed and if they were penalized for giving members inaccurate information.

A few members also suggested HCPF require RAEs to publicly report call center data, and some of these members suggested that HCPF create a standardized way to categorize call types and subtypes to help identify when there are systemic issues.

Cultural Responsiveness

Many members and advocates supported the increased focus on cultural responsiveness. However, advocates suggested that these requirements could be strengthened by requiring RAEs to have a more specific strategy about ensuring language access for members and by developing projects to increase access to linguistically and culturally appropriate services.

Providers suggested ways to clarify these requirements, including providing a definition of prevalent languages and clarifying whether trainings can be delegated to providers who already have resources in place to increase cultural responsiveness.

Health Needs Survey

Several members, providers, and advocates were confused about the existing health needs survey. Specifically, some stakeholders did not understand how this would be administered, and others were concerned it may duplicate existing provider work.

Beyond this confusion, one group of advocates was concerned that very few members would fill out this survey, which would decrease its usefulness, while another group was concerned that this may not focus enough on connecting members to primary, dental, and behavioral health care.

Provider Directories

A few stakeholders expressed concerns that provider directories can be inaccurate. Specifically, a few members and member advocates complained that many providers do not report when they are not accepting new Medicaid patients. An advocate suggested that providers be required to regularly report whether they are accepting members as patients. More generally, one member suggested that members and providers have an easy way to report inaccurate information online, while an advocate suggested that provider directories be updated within five days when provider information changes. Additionally, a couple advocates suggested that RAEs should be required to help members find another provider if their provider's agreement with the RAE ends.

Member Incentives

The Draft Contract includes a new section requiring RAEs to co-create a member incentive program with HCPF. This suggestion was met with a range of concerns. A couple advocates felt that RAEs should not be creating their own incentive programs, pointing out that many member incentive programs have had underwhelming results and that creating successful incentive programs would require in-house experience. These advocates suggested HCPF instead create a statewide incentive program that uses national best practices. A few potential bidders were concerned that these programs could threaten members' eligibility for Health First Colorado.

Other stakeholders, while they appreciated the concept, asked that MACs, PIACs, and Regional Health Equity Committees help design these incentive programs. Providers wanted these incentive programs to align with other work, such as the existing quality metrics for providers, the Key Performance Indicators (KPIs), the design of Pediatric Alternatives for Colorado Kids (PACK), and LPHAs' existing prevention work.

Section 4: Grievances and Appeals

The fourth section of the Draft Contract focuses primarily on the process for members and others to submit grievances and appeals.

A few members commented that, because these are two separate processes, they should be separated in the final contract.

Grievance Process

Many members did not know about the grievance process, and they suggested that RAEs be required to educate members about it, as well as about less formal ways to share feedback about both RAEs and providers.

One member who had used the grievance process said the current grievance process is lengthy and suggested that RAEs be required to allow grievances to be submitted through email or through an online system, as opposed to just by letter or phone.

An advocate mentioned that quality of care grievances can also affect people who are not Health First Colorado members and suggested that the grievance be shared with appropriate agencies, such as BHA, with the member's permission.

Finally, a couple of advocates expressed concerns that the Ombudsman may be used in grievance processes without a member's consent and suggested that RAEs not be able to share member information with the Ombudsman, or with anyone else, without explicit member consent.

Appeals Process

A few member advocates also shared feedback about the appeals process.

First, they noted several ways that members can become confused during the appeals process. They suggested that any adverse benefit determinations, information on timeliness of appeals, and information on continuation of benefits be member-tested, fact-checked, and standardized across RAEs, and should be provided in a member's preferred language. A couple suggested that members also have a phone number to call to receive more information about alternate services listed in adverse benefit determinations. They also suggested that RAEs be required to inform members about their opportunities for representation and support in appeals cases, such as through Colorado Legal Services. Finally, so members can better prepare for appeals, advocates suggested that members have access to their case files at least one week before the appeals process.

Beyond these comments about information for members, the same advocates also provided suggestions on several other parts of the appeals process. First, a couple providers were concerned about RAEs being able to cut off behavioral health benefits during appeals in certain cases, noting that delays in requesting continued benefits could be out of a member's control. Second, while these advocates appreciated the provision that RAEs cannot take punitive action against providers for requesting expedited resolutions, they asked that this provision also be extended to members.

Section 5: Network Development and Access Standards

Section 5 of the Draft Contract focuses on the networks of providers RAEs are required to work with, as well as on standards for members being able to access care. Generally, stakeholders seemed to appreciate the intention behind many of the requirements in this section, but they shared concerns that these requirements may be hard to enforce. Additionally, several stakeholders, particularly members and member advocates, noted that network adequacy and access to care can be difficult in rural areas, especially when members need transportation assistance to access any providers.

Finding and Retaining Providers

A range of providers, members, and member advocates shared their insights on the requirements for RAEs to find and contract with providers, specifically PCMPs.

Specific to PCMP selection and recruitment, one member expressed concern about the requirement that PCMPs offer evening or weekend hours. While they appreciated the sentiment, they were concerned that this may lead to increased provider shortages in rural areas.

The requirements for building a provider network include specific provisions that RAEs work to build a diverse and culturally responsive provider network. Many stakeholders applauded this requirement. However, they also shared a few suggestions for these requirements. One advocate noted that telehealth is not appropriate for all populations and suggested that certain safety net providers be required to offer in-person options across their service regions. Another advocate felt that the requirements around language access are not specific enough. They asked that HCPF more specifically require RAEs to maintain a network to provide access to all covered services for all members, including those who do not speak English. Similarly, a provider suggested that HCPF specifically require networks to have linguistic expertise that is based on identified community need. Finally, a couple advocates and members suggested that RAEs focus more on recruiting and contracting with providers who have competency in disabilities and chronic illnesses, because these are gaps many members experience.

Network Adequacy

Regarding behavioral health access, many members and a few advocates expressed concerns that the network adequacy requirements may not solve existing problems. Several members noted that, in their experience, it is very difficult to find behavioral health providers who are accepting new Health First Colorado patients, particularly for regular, supportive therapy.

They noted that behavioral health networks should not be considered “adequate” if RAEs contract with many providers but none of those providers are accepting new patients. An advocacy organization suggested that it may be helpful to reconfigure network adequacy standards using ratios of providers to members, to include considerations for whether providers are accepting new patients, and to look at different sub-types of behavioral health providers to ensure there is network adequacy across all types of behavioral health providers.

Timely Access to Care

The Draft Contract provides a list of standards about how quickly members should be able to access different types of care. Generally, while many members and member advocates appreciate these standards, they worry that the current standards are not enforced and would like to see more accountability in Phase III.

Several stakeholders appreciated that medication-assisted treatment had been added to this list in the Draft Contract, although one potential bidder suggested that the time limit be changed from 72 hours to seven days to align with timelines for other types of behavioral health care.

For other types of recurring behavioral health care, such as regular therapy, one advocate suggested that there not only be standards for starting care but that there should also be standards for how regularly providers are able to offer care to members.

Single Case Agreements

Finally, a few members noted that, currently, single case agreements for providers can be confusing. They appreciated the attempts to clarify this process in the Draft Contract. One member suggested that this section could be further improved by requiring RAEs to offer more member and provider education on single case agreements. Another member suggested adding to this section to expedite single case agreements for limited cases, such as when members need a provider who speaks a specific language.

Section 6: Health Neighborhoods

Section 6 focuses on a range of topics, but the sections that received the most attention were those on health-related social needs and on health equity. Stakeholders had divergent perspectives on this section. Some members and CBO representatives applauded the focus on health-related social needs, particularly food security. Others were concerned that this section is duplicative of existing work, particularly the screenings that many partners already conduct, or that it would require RAEs to take on too many new requirements, instead of focusing on their core functions.

Additionally, even though many CBO representatives and members generally supported this section, they were concerned that RAEs would not work closely enough with existing partners, including CBOs, LPHAs, and PCMPs that are already focused on health-related social needs. Many stakeholders suggested that RAEs be required to compensate partner organizations who are already focused on addressing health-related social needs, such as food insecurity. Specifically, some LPHA representatives suggested that RAEs create a per-member per-month (PMPM) payment plan for LPHAs and county human services.

Finally, several stakeholders said it would be helpful to call out other partners, such as Regional Health Connectors, community health workers, and immigration and farmworker support services throughout this section.

Beyond these general comments, stakeholders provided specific feedback about both health-related social needs and health equity.

Health-Related Social Needs

As mentioned, a range of advocates, members, and CBO representatives appreciated the focus on health-related social needs. Specifically, they applauded the call-outs for food security and Non-Emergent Medical Transport.

Stakeholders were also supportive of the requirements related to housing stability, although several provided the caveat that these requirements may be too difficult to meet. Other stakeholders were confused about many of the specific requirements within the housing stability section.

One member noted that this section mandates certain priorities, such as housing stability and food security, and asks RAEs to seek member feedback on health-related social needs. This member said that these requirements may be at odds with each other.

Many other stakeholders shared their concerns that the workforce is not sufficient to complete referrals for health-related social needs. Several members suggested that RAEs be required to track whether referrals for health-related social needs are completed to ensure requirements are being met. However, one provider noted that following up on all referrals for health-related social needs is too administratively burdensome to be feasible.

Finally, a wide range of stakeholders, primarily member advocates, also suggested other health-related social needs that RAEs should be required to prioritize. These suggestions included:

- Transportation.
- Nutrition support, in addition to food security.
- Support to help people be less isolated.
- Interpersonal violence.
- Legal support.
- Job readiness and employment.

Health Equity

Most stakeholders supported the focus on health equity, but a few had some specific concerns. First, a group of stakeholders, primarily advocates, mentioned that they found this section to be too broad. Two advocacy organizations suggested that RAEs focus instead on trying to address two or three specific inequities, with one of these organizations commenting that RAEs should need to use evidence-based strategies to address inequities.

Other advocates and members said they did not feel there was enough RAE accountability in this section, and they would like to see additional ways to hold RAEs accountable for meeting their health equity requirements.

Section 7: Care Coordination and Population Management

Section 7 of the Draft Contract, which provides RAE requirements for care coordination, received the largest amount of stakeholder feedback, as well as the most clarifying questions. Many stakeholders were confused about specific proposals in this section, includingthe care coordination tiers, care coordination payments, and collaboration for care coordination.

Additionally, many stakeholders had overarching suggestions for this section. Many providers were concerned that this section does not discuss RAEs' incentives to subcontract care coordination to PCMPs or behavioral health providers. These providers suggested that they should be paid directly for care coordination, because care coordination works best at the point of care. Several member advocates felt that too much within this section is left up to each RAE to decide and suggested stricter requirements that RAEs adhere to national best practices for care coordination. Other stakeholders disagreed, with providers and potential bidders expressing concerns that the requirements in this section are overly prescriptive. Many members shared their frustration that, in practice, they already struggle to access care coordination. They suggested that HCPF should focus on making sure the RAEs are held accountable for providing the services and supports they are

expected to provide. One member said adding new requirements will further strain care coordinators and weaken their ability to provide adequate support to members.

Beyond these comments, stakeholders also provided feedback on many requirements in this section, including the care coordination tiers, the requirements on transitions of care, collaboration requirements, the Care Coordination Policy Guide for Children and Adults, and accountability for care coordination.

Care Coordination Tiers

Most stakeholders appreciated the general concept of three tiers for care coordination, with several members saying that they thought this would improve care coordination if well implemented. These stakeholders also had many questions about the specifics of this proposal and how it will be implemented. For example, providers were confused about how rigid the tiers are and about whether people in each tier need to receive each of the listed services. Members were unsure whether member choice plays a role in the tiering system. A couple stakeholders were concerned that the implementation may lead to delays in care coordination.

Several members and providers also shared their confusion about how other conditions fit into the tiers, with a few stakeholders suggesting that specific conditions be added or removed. For instance, one member mentioned that rare diseases and neurological conditions such as multiple sclerosis and Parkinson's disease be specifically added to these tiers. Public health staff suggested adding hypertension to Tier 2, while a provider suggested removing situational anxiety from Tier 2. A few members also shared concerns that, because these tiers focus primarily on diagnosed conditions, members who do not receive diagnoses for long periods of time may not receive adequate care coordination.

A CBO representative noted that the tiers, while they may work for adults and older children, may not work well for younger children. A different CBO representative suggested that newborns should automatically be eligible for Tier 3 care coordination.

Other stakeholder reactions primarily focused on the specifics of Tier 3 care coordination. A few providers said monthly care coordination is too frequent for Tier 3 care coordination, while several members said that, for those at Tier 3, monthly care coordination is not frequent enough. Other members and advocates suggested that there should be a mandated caseload limit for Tier 3 care coordination to ensure care coordinators have enough time for their patients. Finally, one member noted that, in their experience, Tier 3 care coordinators do not always have the most relevant knowledge. This member suggested that Tier 3 care coordinators focus either on patients with primarily medical needs or patients with primarily social needs and that they only take trainings relevant to their caseloads. This member also noted that care coordinators should have knowledge about the medical conditions of members on their caseloads.

Transitions of Care

Stakeholders uniformly supported the additional focus on care coordination during transitions of care in the Draft Contract, although a few had questions about the implementation of these requirements and whether RAEs would have the power to complete these requirements.

Beyond this concern, a couple providers also suggested adding two more transitions of care to this section: the transition from the neonatal intensive care unit to home, as well as the transition from childhood to adulthood that requires health care changes.

Care Coordination Collaboration

Many members and member advocates were excited about the greater focus on collaboration between RAE care coordinators and other entities, particularly dual eligible special needs plans (D-SNPs) and case management agencies (CMAs). However, other stakeholders, especially providers and potential bidders, were concerned that, particularly with D-SNPs, CMAs, and BHASOs, the Draft Contract does not provide enough clarity about how care coordination roles will be shared. These stakeholders noted that communication and lack of role clarity is often a barrier currently.

Members and other stakeholders also expressed support for the required collaboration with CBOs and others, with some members noting that CBOs are often best positioned to contact members. Member advocates and CBO representatives also supported this collaboration, but they noted that they would like to see RAEs be required to compensate CBOs that help with care coordination. Finally, LPHA representatives also applauded this requirement and suggested that RAEs also be required to collaborate with LPHAs and county human services.

One member advocate noted that, to make sure collaborations are occurring as planned, it may be helpful to require RAEs to hire dedicated staff to liaise with care coordination partners.

Care Coordination Policy Guide for Children and Adults

Many stakeholders supported the idea of a policy guide for care coordination. Beyond their general support, one CBO representative suggested that this policy guide be made public, and a couple members expressed concerns that members may not be involved enough in helping create the Care Coordination Policy Guide for Children and Adults. One member suggested that MACs be involved in the co-creation of this policy guide.

Care Coordination Accountability

Many members and member advocates discussed their concerns that RAEs are not held accountable for care coordination. Some of these members were hopeful that performance standards may help increase accountability in the future, while others were concerned that performance standards would simply be a box-checking exercise for RAEs. A couple of members suggested that care coordination accountability may be improved if members had the opportunity to provide feedback after all care coordination interactions.

Providers and member advocates suggested alternative performance standards for care coordination. A few providers suggested the Draft Contract focus on access to care coordination and health outcome metrics, instead of number and frequency of communications. A member advocate suggested that performance standards should focus on things like how quickly a care coordinator initiates contact and develops a care plan.

Other Care Coordination Feedback

Some of the suggestions that stakeholders provided were not specific to these proposals but did focus on care coordination. One member suggested that it may be helpful to have a single third party run care coordination across all the RAEs to decrease variation. A different member commented that many members need care coordination for pain management and suggested that requirements regarding pain management be included in this section.

Finally, a few stakeholders discussed the focus on prevention in this section. Some advocates felt that there was not enough focus on prevention services and stated that they would like to see more requirements to support prevention. A member, on the other hand, was concerned that too much focus on prevention would leave out the members with complex or unpreventable health conditions.

Section 8: Provider Support Practice Transformation

Providers primarily shared feedback on Section 8, which deals with how RAEs are expected to support practices, including with value-based payment programs and those working to become more advanced primary care practices.

At a high level, many providers, particularly pediatricians, expressed frustrations about the required supports from RAEs and the associated payments. Many of these providers felt that they are better able to complete things like care coordination and practice transformation internally or through other provider networks, and they did not want to be mandated to work with RAEs on these functions. Specifically, HCPF pays RAEs a PMPM to support some of these functions. RAEs are expected to pass along at least 33% of that PMPM to providers, but many providers felt that they should be able to opt out of RAE supports and that RAEs should instead pass along a greater share, between 50 and 75%, of the PMPM to providers, with the specific amount differing based on how much RAEs are supporting providers with practice transformation.

Beyond this suggestion, a few providers expressed support for the idea of a provider satisfaction survey and hoped the results of this survey would be made public. Providers and other stakeholders also provided the following specific feedback about the different supports RAEs are expected to provide.

Value-Based Payment Programs

According to the Draft Contract, RAEs are expected to coach providers to succeed in value-based payment programs. Many stakeholders had concerns about this approach. Some advocates felt that RAEs should not be taking on additional responsibilities, such as coaching providers about value-

based payment programs. FQHC representatives expressed concerns that RAEs would not be able to coach FQHCs, who have different experiences when it comes to value-based payment programs. Some other providers were concerned that having both HCPF and RAEs involved in the same value-based payment programs could create inefficiencies and confusion.

A few other providers, while they did not object to RAE participation in state value-based payment programs, were concerned about the idea of RAEs creating their own value-based payment programs, because it would create additional burden on providers. A few providers noted that there are already several value-based payment programs requiring alignment, with one provider specifically calling out a desire for clearer alignment between these value-based payment programs and the existing Hospital Transformation Program.

Finally, a few advocates expressed more basic concerns about the use of value-based payment programs. They were concerned that these programs prioritize profits instead of prioritizing access to health care and health equity. They suggested centering health equity in any value-based payment program.

Other Practice Transformation Support

While some providers, as noted above, did not like the idea of RAEs uniformly being paid for practice transformation support, other providers were more appreciative of the practice transformation activities outlined in the Draft Contract. In fact, a few providers said they would like to see RAEs support small practices who need more help connecting to electronic health records and to new tools like the social health information exchange.

Providers were more uniformly supportive of RAEs helping support providers in connecting to community-based resources and inventories, especially for health-related social needs. They noted that they would like RAEs to be aware of local community organizations and to help facilitate some of these connections. One public health representative suggested that RAEs may also be able to play a role in helping connect providers to resources for disease prevention and management.

PCMP Tiered Payment Framework

The Draft Contract includes a requirement that RAEs create a tiered payment framework to help support practice transformation and participation in value-based payment programs. Generally, providers had many questions about this tiered framework.

More specifically, a few pediatricians said they would like to see these tiers include pediatric-specific criteria. These same pediatricians would like to be involved in helping develop the tool that would place practices into different tiers.

Section 9: Capitated Behavioral Health Benefit

Stakeholders — including providers, member advocates, and potential bidders — had extensive feedback about Section 9 of the Draft Contract, which details the Capitated Behavioral Health Benefit that RAEs administer.

Stakeholders did not provide much overarching feedback on this section, but the majority of their comments split into five categories: feedback about prior authorization requests, transitions from hospitals and emergency departments, Measurement Based Care, integrated care, and specific funding strategies for behavioral health providers.

Prior Authorization Requests

A few members were excited about the changes to this section because they hoped these changes would make it easier to receive care. One member appreciated that the Draft Contract specifically states that members with co-occurring disabilities need access to behavioral health care. That member suggested that all members with co-occurring disabilities should begin receiving care while awaiting a determination on a prior authorization request.

Many stakeholders also supported the idea of peer consultations for prior authorization requests, although one member noted that these would only be successful if the peers had cultural competence in relevant areas. A potential bidder suggested that peer consultations not be available for administrative denials.

Member advocates and providers had many suggestions for how to change this section. Member advocates largely focused on changes that would improve members' access to care. Notably, these advocates were concerned that RAEs could request 14 days for expedited authorizations, noting that members' lives or health could be in immediate danger within that time frame. They were also concerned that RAEs develop the criteria around when to admit and discharge patients and when patients are stabilized in emergency situations. These advocates said that, in their experience, RAEs do not always pay for necessary services, and they suggested that providers have the final say in when members should be admitted, considered stabilized, and discharged from care.

Providers' concerns largely focused on variation across RAEs regarding prior authorization requests. A few providers felt that there is too much flexibility from RAE to RAE. One suggested that a third party manage all prior authorization requests statewide to provide more consistency. Others suggested that RAEs:

- Automatically approve services that are almost always approved.
- Automatically approve services required at intake appointments.
- Process all prior authorization requests within 72 hours for inpatient or residential services.
- Provide more specificity when they respond to prior authorization requests.

Transitions from Hospitals and Emergency Departments

The Draft Contract provides some specific requirements for RAEs when members are discharged from inpatient or emergency behavioral health care, including around timelines for follow-up. Many stakeholders applauded the focus on transition planning and follow-up for behavioral health care and noted specific changes that they would like to see.

First, several providers noted that communication between inpatient facilities, outpatient behavioral health providers, and RAEs is not always timely, which can make it very difficult for behavioral

health providers to establish new patients leaving residential care and for providers to follow up with their existing patients to reduce hospital readmissions and repeated emergency department use. Other providers noted that the roles are not clear for who reaches out to patients when they transition from inpatient or emergency care.

Second, several advocates were concerned that a follow-up within seven days of a behavioral health discharge is too long to wait. They suggested that RAEs be required to follow up within one day of a behavioral health discharge.

Finally, one advocate shared a concern that too many people with disabilities are being discharged into nursing facilities, particularly from Colorado Mental Health Hospitals. They suggested that there should be stronger requirements for hospitals and RAEs to connect these members with community-based services and that discharges to nursing facilities should be a last resort.

Measurement Based Care

A few providers shared their feedback on the requirement that RAEs help safety net providers adopt Measurement Based Care. Some of these providers supported the idea of using Measurement Based Care, while others liked the concept but were concerned that the implementation would lead to high administrative burden for safety net providers.

One provider suggested that, if this requirement is implemented, RAEs should ensure that there is a clear methodology for defining system improvement and that RAEs be required to use age appropriate and interoperable tools.

Integrated Care

Many providers shared their excitement that HCPF is focused on integrated care. They understood that the Draft Contract does not contain specifics on integrated care and provided the following suggestions for HCPF to consider in the future:

- Allow providers to use integrated care billing codes to bill for visits that include both physical health and behavioral health components.
- Allow providers to specifically bill HCPF using Health and Behavior Codes and Collaborative Care Management Codes.
- Ensure that providers can be reimbursed for the full continuum of behavioral health services.
- Provide incentive payments to cover the increased costs of staffing, technology, and the administrative burden that accompanies transitions to integrated care.
- Do not include reimbursements for integrated care as part of the Capitated Behavioral Health Benefit.

These suggestions came from various providers who did not necessarily agree with each other's recommendations.

Funding Strategies

Part of Section 9 of the Draft Contract refers to specific reimbursement mechanisms. For instance, the Draft Contract requires a minimum reimbursement rate for FQHCs and Rural Health Centers, which FQHC staff appreciated.

The Draft Contract also includes specific payment strategies for Essential Safety Net Providers and Comprehensive Safety Net Providers. Providers requested more clarity on both payment strategies. Additionally, providers were supportive of the reimbursement structure for Essential Safety Net Providers but concerned about the funding model for Comprehensive Safety Net Providers, noting that it moves away from braided funding opportunities.

Beyond these specialized types of providers, other providers shared their support for a directed fee schedule for certain critical behavioral health services.

Other Feedback

A few stakeholders shared comments that do not fit neatly into one of the above categories but that related to the Capitated Behavioral Health Benefit. One member noted their concern that there are very few metrics on substance use disorder. Another member asked that RAEs be required to help members access alternative care, such as social skills training and equine therapy.

A provider noted that they would like clearer guidance about billing for behavioral respite services and asked that RAEs be required to reimburse suicide prevention and intervention services. A second provider had concerns about how HCPF will ensure transparency and accountability for the future consolidated credentialing process. A third provider applauded the required use of Certified Community Behavioral Health Clinic metrics in RAE-designed value-based payment programs.

Section 10: Children and EPSDT

Section 10 of the Draft Contract focuses on the health needs of children and youth, particularly the Early and Periodic Screening Diagnostic and Treatment benefit (EPSDT) and the future Standardized Child and Youth Benefit. This section is entirely new to ACC Phase III, and many pediatricians and advocates applauded the increased focus on children and youth, as well as on prevention and health promotion for children and youth. However, several stakeholders mentioned that they would like to see more focus on children and youth with special health care needs throughout the proposals in this section. For instance, one member advocate suggested including language around disability-focused EPSDT outreach.

EPSDT

Stakeholders appreciated the overall EPSDT requirements in law that are reflected in the Draft Contract, with many specifically applauding the goal of expanding screenings and the inclusion of an EPSDT Accountability Strategy. However, advocates noted that they would like this Accountability Strategy to be reviewed by the EPSDT Advisory Committee, as well as by MACs, PIACs, and relevant CBOs. Other advocates also suggested that this Accountability Strategy be publicly available.

Providers also shared a range of suggestions specific to EPSDT screenings. Many pediatricians noted that, in their experience, it can be difficult to know when to bill EPSDT screenings to RAEs as part of the Capitated Behavioral Health Benefit and when to bill screenings to HCPF as a fee-for-service payment. These pediatricians also said that EPSDT screenings are often not reimbursed at sustainable rates. They suggested a minimum reimbursement rate for EPSDT screenings. One CBO representative also asked about how CBOs and LPHAs could be compensated for completing screenings in ACC Phase III.

Standardized Child and Youth Benefit

The Standardized Child and Youth Benefit is currently under development by HCPF.

Many stakeholders, including providers, county staff, and member advocates, had questions about how this benefit would be implemented. One advocate was concerned that many specifics of this benefit have not yet been identified. They suggested requiring RAEs to use standardized tools and not leaving the creation of the benefit up to the RAEs.

A range of providers and county staff members worried that, depending on how this benefit is implemented, it could duplicate or disrupt existing work and that it could unintentionally be overly burdensome and create delays in access to care.

In addition to these questions, stakeholders disagreed on whether this benefit may be too standardized. Some stakeholders felt the benefit is too prescriptive to meet the needs of children and youth with complex needs. One advocate specifically suggested a more flexible continuum of care instead of set levels of care. One the other hand, some providers supported the clearly standardized levels of care, and some providers wanted a more standardized referral process for children and youth based on their level of care. These providers also wanted more clarity regarding who will manage specific services for the Standardized Child and Youth Benefit.

Regardless of their questions and concerns, many stakeholders suggested that members, providers, and CBOs all be involved in developing the details of the Standardized Child and Youth Benefit. In the more detailed development of this benefit, they suggested that HCPF and RAEs take the following considerations into account:

- Ensure that this benefit includes children younger than five and uses a screening tool valid for young children.
- Ensure that this benefit includes trauma-informed treatment at all levels of care.
- Ensure that this benefit includes medication-assisted treatment, withdrawal management, and peer support services.
- Ensure that there is accountability if families cannot access appropriate services.

The Standardized Child and Youth Benefit also calls out home visiting programs as a specific partnership for RAEs. Many CBO and LPHA representatives were excited to see this call-out within the Standardized Child and Youth Benefit. These representatives suggested building home visiting services into value-based payment programs and creating clearer reimbursements for Child First and

other home visiting models outside of the Standardized Child and Youth Benefit. However, a couple potential bidders were confused about why home visiting is included in the Draft Contract.

Section 11: Data Analytics and Claims Processing System

Section 11 of the Draft Contract primarily outlines different tools and systems that RAEs or providers are expected to use. This section received minimal feedback, but several RAEs and providers expressed concern that limiting RAEs to specific tools may create additional burden. They instead suggested that RAEs and providers be able to adopt any tools or solutions that help them manage and exchange data easily. On the other hand, a few providers said it would be helpful to ensure there is standardization in the tools each RAE is using, as well as standardization across RAEs and BHASOs, to make it easier for providers to work with different organizations.

Beyond this feedback, a few providers suggested that RAEs be required to partner with and leverage existing performance networks when possible, such as the Colorado Community Managed Care Network and the Community Health Provider Alliance, to avoid unnecessary changes or administrative burden. An advocate said they would like to see more focus on qualitative data and other mixed methods.

Finally, many providers noted that timely data sharing is important and that current data delays have caused significant problems, with a few applauding the expanded data sharing requirements.

Section 12: Outcomes, Quality Assessment, and Performance Improvement

Section 12 of the Draft Contract includes multiple topics. Most stakeholder feedback focused on two topics: the regional councils that each RAE is required to convene, and the various incentive programs designed to increase RAE accountability.

Member Advisory Committees, Program Improvement Advisory Committees, and Regional Health Equity Committees

The Draft Contract requires RAEs to convene regional MACs, PIACs, and Regional Health Equity Committees. The majority of stakeholders, including many members, supported the requirement that RAEs convene these committees, particularly the new requirements for two required MACs per RAE and for Regional Health Equity Committees. However, many of these stakeholders also suggested additional requirements for these various committees.

First, several stakeholders were confused about the requirement for two MACs and PIACs per RAE. Some suggested that these should be geographically divided, while others suggested they should be divided by primary focus on physical health versus behavioral health, or that one PIAC and MAC should focus on adults, while the other should focus on children. An advocate commented that, if the MACs and PIACs are geographically divided, it may not make sense to have two of each committee in the geographically smaller RAEs.

Members and member advocates shared a range of specific suggestions to allow members to participate in these committees more fully. Many members said that all members should be offered compensation for participating in any of these regional committees. A few advocates and members suggested that MACs offer interpretation in prevalent local languages and that they be chaired by a Health First Colorado member. One member suggested that RAEs be required to partner with local organizations like libraries to make it easier for all members to participate in virtual meetings, and another member suggested that RAE and HCPF leadership be required to meet directly with MACs.

Other suggestions focused on the makeup and role of these committees. For instance, a CBO representative said that PIACs and Regional Health Equity Committees should have a designated seat for an LPHA representative, while a provider suggested that all three of these committees should have broader responsibilities around reviewing programs, policies, and deliverables.

A few advocates and providers shared suggestions about transparency. For instance, a few stakeholders said it is unclear whether or how RAEs will use feedback from MACs and PIACs, and a provider suggested that RAEs be required to publicly report on how many suggestions they incorporate from each of these committees. An advocate suggested that RAEs be required to post an agenda and meeting information at least a week prior to each MAC or Regional Health Equity Committee meeting, although one potential bidder noted that MAC information may need to be more limited due to concerns about member confidentiality.

Finally, two stakeholders shared suggestions about statewide committees. A member advocate suggested that it may make more sense to have a statewide committee focused on health equity, instead of Regional Health Equity Committees, while a CBO representative suggested a joint regional advisory committee for both RAEs and BHASOs.

Incentive Programs

The Draft Contract discusses three programs that received stakeholder feedback: the Commitment to Quality Program, the KPI Incentive Program, and the Behavioral Health Incentive Program.

Many stakeholders, including providers and members, supported the creation of the Commitment to Quality Program, although a few stakeholders shared concern that this program may not be realistic for RAEs, and one provider was concerned that RAEs may report overly positive numbers, given that their profits would be at risk.

A few providers and CBO representatives proposed modifications to the Commitment to Quality Program. A provider suggested that a higher percentage of RAEs' profits should be put at risk in this program, while a CBO representative suggested that PIACs, MACs, and Regional Health Equity Committees help decide where profits should be reinvested in this program. Additionally, a provider suggested that the following topics be incorporated into the performance standards for the Commitment to Quality Program: EPSDT (particularly well-child visits), health equity, health neighborhoods, delegated care coordination and provider supports, barriers to safe hospital discharge, attribution, RAE responsiveness to MACs and PIACs, and RAE eligibility and renewal support.

The KPI Incentive Program received kudos from some stakeholders, especially advocates and CBOs. However, other stakeholders, such as providers, disliked that KPIs are judged at a regional level, instead of a practice level. Regardless of their views, many stakeholders suggested the inclusion of other focus areas in the KPIs. Suggested focus areas included:

- Health equity
- Food security
- Housing stability
- Maternal and infant mortality rates
- Behavioral health

Beyond these specifics, some advocates and CBO representatives suggested HCPF work with stakeholders to finalize the KPIs for Phase III. Other stakeholders suggested that HCPF disaggregate the KPIs by demographic group and set the benchmarks for KPIs in alignment with HEDIS (Healthcare Effectiveness Data and Information Set) benchmarks. A couple providers suggested that RAEs be required to reward individual high performers, even if the region as a whole does not meet the set KPIs. Finally, regarding the flexible funding pool of money that is not earned through KPIs, a few advocates suggested that RAEs not directly receive any of this funding and that members and other stakeholders help decide where this funding is directed.

Finally, a few providers offered some feedback on the Behavioral Health Incentive Program, with one provider noting that these incentives have historically been very difficult for providers to achieve. A different provider suggested that this incentive program would benefit from timelier data sharing and more data availability for providers. A third provider liked this program but was concerned that it is subject to available funding and suggested it be offered with certainty.

Other Accountability Initiatives

Beyond these incentive programs, the Draft Contract includes a range of other accountability mechanisms on which stakeholders provided feedback.

Stakeholders had mixed feedback on the Member Experience of Care strategy. Some members were confused about whether and how this strategy would actually lead to changes for members, and other members shared some support for this idea but suggested that MACs may be a better way to gauge members' experiences of care than surveys. Other members liked the idea of surveys, with one specifically suggesting that RAE-developed surveys for this strategy ask about both overall member satisfaction and members' quality of life. A potential bidder expressed concern that more member surveys could lead to survey overload and that it might lead to members ignoring all RAE outreach.

Beyond this strategy, stakeholders suggested HCPF include other accountability measures. For instance, LPHA and CBO representatives suggested that RAEs be held accountable for collaborating with local organizations, such as LPHAs and CBOs, and further suggested that RAEs have financial incentives or penalties depending on how closely they collaborate with local organizations. On a different topic, a few members and member advocates suggested that the Quality Improvement

Program should specifically include RAE staff using case studies of when members have had poor experiences to improve their future performance.

Other Comments

Stakeholders also shared the following comments about Section 12 of the Draft Contract.

A couple advocates shared concerns about the Client Over-Utilization Program, particularly the idea of RAEs using a provider lock-in policy. They felt this was not in members' best interests. One of these advocates further commented that there should be more focus on under-utilization, not just over-utilization.

A few other stakeholders commented on the number of meetings between RAE staff and HCPF. They said this seems to be a lot of meetings and hoped that HCPF would coordinate and streamline these meetings to make them easier to attend.

Section 13: Compliance and Integrity

Section 13 of the Draft Contract, which focuses on compliance with ACC rules, primarily received targeted feedback. The only overarching feedback came from a couple advocates, who suggested adding specific language around the consequences of contract violations or deficiencies.

Beyond these overarching comments, one member was concerned that the requirement to monitor prescriptions for controlled substances would increase mistrust between providers and members. This same member also said that inappropriate emergency department use should not be investigated as member fraud, rather is indicative of barriers to accessing primary care services. They also suggested that members should be able to see the services billed in their names. Finally, they suggested that the provider fraud section include protections for whistleblowers.

Section 14: Compensation and Invoicing

Stakeholders provided very little feedback regarding the final section, which focused on compensation and invoicing. An advocate suggested that this section included a clearer explanation of administrative PMPM payments, including the total available funding and the specific purposes of this funding, and a potential bidder asked for more clarification about the requirement to submit monthly invoices.

Exhibit E: Personnel Requirements

Exhibit E of the Draft Contract lists required RAE personnel. Many stakeholders were excited to see new required behavioral health and health equity personnel. However, a couple providers and LPHA representatives suggested that many more RAE key personnel should be required to be based in Colorado to ensure they understand local needs. Providers also suggested that the behavioral health lead for each RAE be required to have professional experience with community-based mental health and with serious mental illness and substance use disorder.

Feedback on the Procurement Process

In addition to providing thoughts about the Draft Contract, stakeholders also shared suggestions and feedback on the procurement process, or the process of deciding which bidders should serve as RAEs. This included suggestions on the questions that bidders should be required to answer, suggestions on other pieces of their bids, and suggestions on how HCPF should evaluate bidders.

Several stakeholders suggested that HCPF ask bidders about their plans to center health equity, with one specifically suggesting HCPF ask about RAEs' plans for recruiting diverse providers and another suggesting RAEs submit community-specific plans to focus on disparities. Other stakeholders also suggested HCPF ask bidders about the following topics:

- Plans to support value-based payment programs
- Prior experience in Colorado
- Planned partnerships with CBOs
- Plans to ensure access to primary care and preventive services
- Ability to provide care coordination and appropriate member engagement
- Plans to support the renewal and eligibility processes
- Plans to increase access to Non-Emergency Medical Transportation
- Ability to adapt to unexpected changes
- Proven investments in pediatric care
- Plans to tailor PCMP contracts, based on PCMPs' capacity and needs

Beyond these suggested questions, several CBO and LPHA representatives, as well as providers, suggested that RAEs be required to submit letters of support from both local organizations and providers in their regions to demonstrate local commitment.

Finally, regarding the evaluation process, several stakeholders suggested that non-HCPF staff help evaluate proposals to choose the RAEs. One advocate also said they hoped bidders would be scored higher if they committed to employing Health First Colorado members and members of historically underserved communities.

Next Steps

CHI and HCPF have appreciated the thoughtful and robust feedback that stakeholders have provided throughout the preparation for ACC Phase III. HCPF received and carefully reviewed this feedback to finalize the RFP for bidders.

The RFP was published on May 10, 2024. The procurement process has begun, which means HCPF cannot continue to receive stakeholder feedback on the RFP and will be restricted from discussing the RFP until contract awards are formally announced and all protests and appeals are settled.