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How the Draft Contract Stage Informed the Phase III Request for Proposal

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The Accountable Care Collaborative (ACC) is the primary delivery system for Health First Colorado (Colorado's Medicaid program). The ACC was created in 2011 to improve health care access and outcomes for Health First Colorado members. In preparation for launching ACC Phase III, the Department of Health Care Policy and Financing (HCPF) contracted with the Colorado Health Institute (CHI) to gather stakeholder feedback about the design of the next iteration of this program.

In January 2024, HCPF published a Draft Contract that outlined the contractual responsibilities for the Regional Accountable Entities (RAEs) in ACC Phase III. We heard from nearly 1,000 attendees at 20 different sessions and received over 70 written comments from January to March 2024; that feedback was described in the Draft Contract Stage Engagement Summary. Subject matter experts at HCPF carefully reviewed the feedback we received by each section of the Draft Contract and recommended changes for inclusion in the final request for proposal (RFP) released in May 2024.

Where past stakeholder engagement summaries had clear themes for specific proposals, feedback during the Draft Contract stage ranged from detailed suggestions on specific clauses within the contract to broader feedback on the scope or role of the RAEs. At a high level, we heard the following themes:

- Stakeholders believed many proposals outlined in the Draft Contract held promise. Stakeholders also provided suggestions on the implementation of those proposals.
- Some stakeholders felt that the Draft Contract was too prescriptive. Others disagreed, saying that the Draft Contract allowed for too much flexibility, which could lead to a lack of standardization across RAEs.
- Stakeholders had different visions about RAEs' core functions and priorities.

This fact sheet discusses the ways that feedback during the Draft Contract stage helped us to further refine the ACC Phase III RFP. However, given that much of the feedback we received centered around how we implement this work, that feedback is not reflected in the RFP; instead, we will continue to engage with stakeholders around ongoing operations as we evolve and begin implementation of ACC Phase III.

Member Engagement

Key takeaways from Draft Contract Summary

- Members, advocates, and other stakeholders liked the increased focus on cultural responsiveness.

- Members supported the increased requirements for Member Advisory Councils (MACs) and provided suggestions on how best to convene and facilitate these MACs.
- Many advocates wanted RAEs to be more involved in the renewal and eligibility processes.

How this Informed the RFP

- RAEs will be held to two performance standards aimed at increasing accountability for RAE staff to complete cultural and disability competence training and to ensure network providers make those trainings available to their staff.
- HCPF added further requirements for transparency for the MACs, including posting agendas and de-identified minutes on RAE websites.
- There are federal guidelines that limit how the RAEs can currently be involved in the renewal and eligibility process. However, we further refined contract requirements for RAEs to have a role in this process by providing outreach and assistance for renewals, at HCPF's guidance.

Attribution

Key takeaways from Draft Contract Summary

- Providers liked the proposal to remove geographic attribution, but they expressed concern about the possibility that this proposal may decrease their overall administrative payments.

How this Informed the RFP

- The RFP defines that RAEs must payout, at minimum, 33% of their administrative per-member-per-month payment to their Primary Care Medical Provider (PCMP) Network. We appreciate the concerns raised by providers and will continue to engage stakeholders as we work to align PCMP payment through the RAEs with HCPF Alternative Payment Model (APMs).

Accountability

Key takeaways from Draft Contract Summary

- Many stakeholders expressed general concerns that RAEs are being asked to do too much in the new contract.
- 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.
- Several members suggested that the new contracts should focus on increased accountability for current care coordination responsibilities, as opposed to expanding care coordinators' responsibilities.

How this informed the RFP

- To reduce confusion and streamline areas of the contract, specific sections, like Care Coordination, Standardized Child and Youth Benefit, and Provider Support, were reorganized and simplified from the draft contract, where possible.

- New performance standards were added to monitor network requirements. We will also be following federal guidance on how to best monitor these requirements.
- We share stakeholders' focus on balancing increasing accountability without creating new responsibilities or administrative burdens. In Phase III, we've introduced the Commitment to Quality program which creates financial accountability for RAEs' achieving defined performance standards that are clearly linked to requirements within the contract.
- Additionally, a key focus for ACC Phase III has been around refining the foundation that has been built in the previous two iterations of this program. Where there are areas that may seem like significant additional responsibilities, the intent has been to better define in contract what RAEs have already been doing. To effectively hold RAEs accountable and create a more standardized experience for members, we've spelled out best practices in care coordination.

Care Coordination

Key takeaways from Draft Contract Summary

- Stakeholders liked the care coordination concepts, such as the tiers, but they were concerned about how those would be implemented.
- 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 members and advocates liked the focus on health-related social needs, but others were concerned that these new responsibilities would overextend RAEs.

How this Informed the RFP

- Many of the concerns we heard around implementation of the standardized tiers centered around a member's ability to move between tiers as their needs change. While our goal has been to create a more standardized care coordination experience for members, this is ultimately a flexible model that is intended to reflect the unique needs between children and adults and be responsive to changes in a member's situation. The standardization of populations and activities within these tiers helps us to monitor and hold RAEs accountable for providing the minimum appropriate services based on a member's level of need. Members will be able to move through these tiers based on their preference and providers' clinical judgement.
- We further clarified contract sections around RAE responsibilities to delegate care coordination activities to provider practices and to collaborate with other agencies that may also serve Health First Colorado members. The RAEs are responsible for making sure that care coordination is available to Health First Colorado members either through a member's provider or through the RAE. Since BHASOs will be responsible for individuals without Health First Colorado coverage, RAEs will collaborate with BHASOs for those members that move on or off Medicaid.

- HCPF continues to encourage RAEs to use evidence-based models and programs that best address the unique needs of the members in their regions. RAEs are also required to engage their regional Program Improvement Advisory Committees (PIACs) and MACs to review their deliverables, such as the Care Coordination Policy Guide, and provide input on program policy changes.
- Work around supporting health-related social needs is continuing to evolve based on state legislation and other work happening at HCPF, like the pursuit of amendments to the 1115 Waiver. Contract requirements for the RAEs are intended to complement this ongoing work and create a foundation for further collaboration as this work evolves.

Provider Support

Key takeaways from Draft Contract Summary

- 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.
- 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.
- 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.

How this Informed the RFP

- RAEs are encouraged to promote the use of HCPF and state-developed tools that are aimed at leveraging existing systems and consolidating duplicative systems.
- RAEs are tasked with supporting practices of all sizes to ensure they have the tools and resources to support the coordination, communication and care of Health First Colorado members. Providers always have the option to choose which systems and tools they use, as well as the level of support they receive from a RAE during individual negotiations.
- HCPF is committed to creating a quality program that is consistent and aligned with other standards and programs that providers are already held to, such as the Centers for Medicare and Medicaid Services (CMS) Core Metrics and the Division of Insurance's Alternative Payment Models for Primary Care. There are also pieces of the quality program for ACC Phase III that will require further engagement with stakeholders for implementation.

For more information

ACC Phase III webpage
Draft Contract Stage Summary
ACC Phase III RFP