July 26, 2023 Meeting Chat and Questions/Answers – Statewide Update

Meeting Chat

Suman Mathur (she/her) - CHI:	Slides (in English and Spanish) are available here -
Kendra Neumann:	For captioning in a separate window with a little less lag, click on this link https://www.streamtext.net/player?event=HCPF
Kendra Neumann:	Health First Colorado Member, please complete this form to sign-up to receive compensation for your participation today: https://forms.gle/kuNsMiAhL4tTrmZv9
Attendee:	Hooray, alignment is good
Attendee:	I agree with {Attendee}
Attendee:	But most primary care providers also get some RAE supplemental payments - the RAEs seldom negotiate these payments; they mostly declare them. Providers have little ability to negotiate. And they do vary RAE to RAE.
Attendee:	Agree with {Attendee} on this. RAE care coordination is difficult for providers to value when the providers are doing the work. And if HCPF leaves care coordination with RAEs, it needs to be standardized, at least to some baseline, so that patients and providers aren't getting different answers for their care and their authorizations.
Attendee:	{Attendee} with the Colorado Hospital Association- we agree with the need for localized care coordination.
Attendee:	It's interesting that it was specified in this meeting that many factors outside of population size went into choosing the four RAE lines. However, when looking at a three RAE model, it was only population size that was the determining factor for adding another region. It is pretty clear population distribution was the driving force for this map.
Attendee:	I have said this comment at each stakeholder meeting that I have attended (2 previously). I don't think it is a great idea to split the SLV and Pueblo/Fremont/Custer from the Southeast corner of Colorado. As those counties have collaborated well in the past and it would be a shame to lose that gained collaboration. As well as the SLV, Pueblo/Fremont/Custer are more similar in issues regarding the regions, so it seems it would just behoove the State to move forward with a Southern Colorado Region.
Attendee:	we'll have to reinvent collaborations and relationships. lots of history, time and energy lost to the wind blowing.

Attendee:	The San Luis valley has so much potential to get lost in this large coverage area. It also may not lend to a more simplified process for providers, as we will now have to go through a larger RAE to advocate for and access resources. I fear this doesn't simplify much for us in this region.
Attendee:	Especially when it is already hard enough to advocate for and access to resources.
Attendee:	Is there any coordination with DORA/DOI for similar care coverage with commercial insurance?
Attendee:	I strongly agree with the comments {Attendees} made. I also have heard these repeated several times
Allie Morgan (she/her) | CHI:	[Paraphrasing Matt's answer] This is probably outside of the map conversation. There are lots of conversations and alignment opportunities with other state agencies, including DOI/DORA, to ensure consistency for serving Coloradans. But don't have many details to share on this today.
Attendee:	I am very concerned that Carelon will acquire Region 1 and you're right Audrey, we will get lost in the shuffle. These RAE entities are massive corporations and the rural towns of Colorado simply will not be their concern. While we may have less RAE's the administrative burden will only become heavier
Attendee:	I hold the same concerns mentioned regarding communities being lost in the larger regions and losing local voice and the ability to keep healthcare local.
Kendra Neumann:	If you would like to share your thoughts on this map, please complete this survey by July 31: https://www.surveymonkey.com/r/RAERegions_July23
Kendra Neumann:	Si desea compartir sus opiniones sobre este mapa, llene esta encuesta antes del 31 de julio de 2023: https://es.surveymonkey.com/r/RAERegions_July23_Esp
Kendra Neumann:	The survey link, a summary fact sheet, past meeting materials, and information on upcoming meetings is available on the Department's ACC III webpage: https://hcpf.colorado.gov/acc-phase-iii-stakeholder-engagement
Suman Mathur (she/her) - CHI:	Health First Colorado Member, please complete this form to sign-up to receive compensation for your participation today: https://forms.gle/kuNsMiAhL4tTrmZv9
Attendee:	Thanks!

Q & A

Question	**Answer**
I haven't heard about the BHASO RFI process - is that out, or is it something we're still anticipating?	We don't have any BHA representatives on tonight to provide the most current information, but I think this page is the best resource for the rulemaking process for the BHASOs:

	https://bha.colorado.gov/resources/laws-rules. We can pass a request for additional information on the RFI process to staff at the BHA. Thanks for your question.
How does this affect fee per service. Each RAE reimburses at a different rate. What happens if a county falls into a different RAE but were getting reimbursed higher by the previous RAE	[Paraphrasing Matt's answer here!] There are 2 sides of the ACC: FFS side for primary care/medical services, and capitation side for BH services. On the FFS side, primary care providers contract with RAEs but they bill directly to the state. This isn't changing in Phase III. On the capitation/BH side, these providers contract with RAEs and the hope is that there will be less variability in rates for Phase III. If RAEs aren't providing high enough rates for providers, they will not be meeting network requirements in their contracts with HCPF.
Could a single organization bid for all four regions? If you want to simply…	[Paraphrasing Matt's answer] In Phase II we had restrictions on how many regions an organization could bid on. Expect restrictions again in Phase III but this is still under consideration. Will be looking for feedback when the draft RFP comes out.
Why is 3 too few RAE regions? That seemed to be a reaction to the BHA stakeholder input. Is the goal still to have RAE and BHASO regions congruent?	[Paraphrasing Matt's answer] In drawing the map, HCPF heard some concerns over having too many members in each new RAE region if limited to 3. HCPF was also considering other maps and context around efforts to align with case management work and reprocurement.
How close are we to the concept paper being released?	[Paraphrasing Matt's answer] We're going through final clearance now on the concept paper – so HCPF has a draft that's fairly close, but no specific date for release yet.
Could there be more than one RAE in a region to foster enrollee choice?	[Paraphrasing Matt's answer] HCPF has discussed this concept but there are some implementation challenges. HCPF values choice but also values attribution and member assignment. Attribution depends on where people are receiving services (currently, primary care). Currently isn't something HCPF anticipates being included for Phase III.
After CCU, what are the population estimates for each region?	[Paraphrasing Matt's answer] Still assessing the impact of the unwind. HCPF needs more data

	before they can respond to this question about estimates.
One of the purported values of RAEs was connecting patients with non-medical services. Again, providers that serve Medicaid patients do this AND according to legislation this year for 2025, providers will be paid for community health workers' activities. How will this change the roles of RAEs and providers in the new contracts?	[Paraphrasing Matt's answer] It feels premature to comment on CHW activities – others at HCPF are working more closely on this. Considering many other activities and needs around community supports and services. HCPF wants to build on Phase II successes and expand on them in Phase III through RAE contracts.
In the proposed large rural regions, how would a PCMP that is hours and hours away from the RAE headquarters be assured that they would receive the same level of support, engagement, opportunities as closer PCMPs?	[Paraphrasing Matt's answer] This has been a concern in Phase II also as we currently have some large rural regions. HCPF is thinking through how best to accomplish/improve this. This could include standards in contracts around the level of supports RAEs must provide to PCMPs. Critical for them to feel supported by RAEs, HCPF/state, others. Members should receive the same level of service and support regardless of where they live.
Are you considering direct funding for local public health agencies that do this work as well? Without community reinvestment grant application processes which we have appreciated.	[Paraphrasing Matt's answer] This is probably outside tonight's conversation focused on the map. All RAEs have community reinvestment grant application processes. RAEs have been given a lot of discretion in how funds are distributed to support efforts in their region. Will continue to look at how we are supporting local public health agencies.
What benefits accrue to members from having multiple RAE regions and how does that "balance" with the potential cost savings (simplification of contracting, care coordination, etc.) for fewer RAE organizations ?	[Paraphrasing Matt's answer] HCPF is juggling a few different things. We see the regional flexibility in Phase II as a success. We have seen RAEs responding to local emergencies or needs, from the pandemic to natural disasters, and they have been well positioned to do so. Want this to continue in Phase III. Part of simplification efforts is reducing the burden on providers, which saves costs for them, and also simplifies the process for HCPF.
Might want to check with NASHP as they held a webinar today about mental health support for providers and patients in rural areas that may be helpful.	Thank you for flagging this webinar!

R3 and R4 have the most infrastructure and resources AND the most clients while R1 and R2 are huge geographical areas with less resources and infrastructure AND the least clients which is to say less reveune to do the same work. That seems out of balance.	[Paraphrasing Matt's answer] This is part of why HCPF is proposing changing to fewer regions. There are some regions in the current map that are large geographically but have smaller populations. Region 2 (eastern) is the smallest. When you get into these smaller numbers, it's more difficult to operate as margins are slimmer. The 2 largest regions here each only have 2 large population centers within them. That was not the only factor considered by HCPF but was one of them in an effort to right-size regions and services.
You are absolutely correct regarding the infrastructure and resources, it's concerning that R1 and R2 cover so much area!	Thank you for the comment.
This is the name of the NASHP webinar for reference. NASHP Webinar: Improving Behavioral Health Services in Rural Communities through Medicaid.	Wonderful, thank you! We will share this out with the chat/slides from today.