COLORADO
Department of Health Care Policy & Financing

Annual Network Management Strategic Plan

Instructions and Narrative Report

RAE Name	**Colorado Access**
RAE Region #	**Region 3**
Reporting Period	**[SFY23-24 07/01/2023 – 06/31/2024]**
Date Submitted	**8/29/23**
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Purpose: Regional Accountable Entities (RAEs) are responsible for managing and improving the health of their respective members. As part of that responsibility, RAEs are required: to develop, support and engage their provider networks and the broader health neighborhoods in these efforts; and to reward them financially respective to their efforts to improve member health outcomes and to increase value in their respective regions. This plan outlines each RAE's strategic approaches to accomplish these tasks and to meet the goals of ACC Phase II during the upcoming contract year.

Instructions: Please provide a narrative that outlines your strategic approach to leverage your regional resources to maximize the care delivery system and community to reduce costs and improve member health outcomes and the experience of care of members. Address how your strategic approach has or has not evolved since the previous year's submission with evidence to support these changes. The narrative must describe the RAE's planned strategies, including process and outcome goals, relative to: PCMP and behavioral health provider network development; practice support, transformation, and communication; health neighborhood and community engagement; and administrative payments and incentives.

1) **PCMP and behavioral health provider network** – Please describe your region's plan to develop your PCMP and behavioral health provider networks. Please be sure to address that which is required in the Network Adequacy Plan Deliverable Guidance.
2) **Practice support and transformation** - Please describe the types of information and administrative, data & technology support (including plans to promote the use of telehealth solutions and the Dept's eConsult platform [once adopted], trainings, and practice transformation, to advance the Whole-Person Framework and to implement the Population Management Strategy, that your region plans to provide network providers.
3) **Communication** – Please describe your region's plan to maintain necessary, both proactive and responsive, communication with network providers and other health neighborhood partners (and other oversight entities) as dictated by section 3.9.2 contract, as well as promoting communication among network providers. Please be sure to address communication with

behavioral health providers, including rate changes and internal processes for responding to provider questions and complaints. *(Specific member-level grievances are captured in the Grievances and Appeals deliverable*).

4) **Health neighborhood and community** - Please describe your region's plan to engage, support (including financial), leverage, and advance the health neighborhood and community to ensure members timely and appropriate access to necessary services. Please be sure to address your plans to establish relationships and improve processes, communication, and collaboration with the health neighborhood and community including coordinating with crisis services, MSOs, etc. Also address your plans to increase appropriate and efficient utilization of specialty care.
5) **Administrative payments and incentives** - Please describe your region's plan to distribute administrative payments and incentive payments. Be sure to provide descriptions of your arrangements for PMPM Administrative Payments, Key Performance Indicator (KPI) and/or Performance Pool incentive payments to contracted PCMPs and Health Neighborhood entities. These arrangements should involve varying payment models and payment amounts for varying types of service. Please include your approach to pay and monitor performance of entities that provide care management for members with complex care needs. *(Include any larger documents or policies as attachments.)*

Strategic Plan Narrative

Colorado Access (COA) continues to be creative and intentional in the ways in which it supports and grows its provider network. Health equity sits at the center of the network management strategy of COA and the Department of Health Care Policy and Financing (the Department). COA strives to maintain a network of providers and community partners who deliver culturally responsive care, address social determinants of health (SDoH) and drive positive member health outcomes. COA has an extensive network of partners across Regional Accountable Entity (RAE) Region 3 which enables the organization to meet members wherever they are at along their individual health journey. COA believes that prevention, education, and culturally responsive engagement is foundational to all that it does, and continuously works with its provider and partner networks to impact its various member populations in preventing disease occurrence and progression. COA is committed to continually evaluating its provider network to ensure the needs of its members are met. COA works hard to ensure that practices and providers are equipped with the tools they need to support members with varying care needs. Importantly, the partnerships of COA extend beyond practice and provider partners, and into the community. COA relies on its strong community partnerships and expertise as a local nonprofit to help drive community-based solutions that it could not achieve on its own.

Over the past three years, COA has necessarily been focused on addressing the needs of its members while reacting to the ever-changing COVID-19 pandemic. COA, like most health care organizations, had to quickly pivot and adapt its systems to address the countless impacts of COVID-19. During the pandemic, COA implemented a myriad of changes to its operations in order to best serve its members at the given time. Some of these changes were short-term solutions in reaction to the severity of the pandemic, and some changes remain as long-term systematic improvements. COA has learned an immense amount through this process, built strong partnerships within the community, and continuously iterates on its programming and network management strategy based on its learning from the past three years.

It is well known that the COVID-19 pandemic brought to light the many inequities that exist within America's health care system. COA is an equity-focused organization, and learnings from the pandemic have reiterated the need to put additional resources towards better understanding and addressing persisting health inequities among member populations. The pandemic caused large shifts in the way in which people access both physical and behavioral health care. With the end of the Public Health Emergency (PHE) and the state's Continuous Coverage Unwind, health care organizations must shift and adapt once more. After multiple phases of change over the past three years, COA is invested in re-evaluating the landscape of physical and behavioral health care—including the impact of social factors—to better understand how to engage its provider and partner networks to ultimately meet the needs of its members.

Through this work, COA will move forward with an intentional, data-driven approach to its network management. Each of the priorities of COA for the upcoming fiscal year and beyond are driven by the organization's commitment to maintaining and building

the trust of its members. COA remains committed to building a network of providers, partners and internal staff who have its members' best interests at heart and the skills needed to provide culturally responsive and compassionate care.

In the coming fiscal year, COA plans to assess its current state and build off learnings from recent years. COA plans to better utilize its data to inform programming and more deeply address present health disparities. Doing so will support COA in operationalizing comprehensive integrated care and will drive coordinated programming. COA recognizes that barriers to care persist for many members and thus plans to take additional steps towards better aligning its programming and funding priorities with SDoH needs. It is important that COA further its understanding of social, environmental, and systemic barriers within the communities it serves. In order to more effectively reach and engage its members, partners and providers, COA plans to assess its communications methods and messaging to identify areas for improvement. With its vast network of community partners, the organization plans continued leveraging of existing and new partnerships in order to extend the reach of health programming into the community, meeting more members where they are at. COA recognizes the persistent and growing need for culturally competent care within both the physical and behavioral health care space. In the coming fiscal year, COA plans to work with providers and care management teams to continue building cultural responsiveness. Over the past several years, COA has been able to identify gaps that exist within Colorado's behavioral health care system. In state fiscal year (SFY) 2023-2024 and beyond, COA plans to enhance behavioral health services available within the state, and through strategic partnerships will continue to build a culturally responsive behavioral health talent pipeline.

As a local nonprofit organization with extensive programmatic experience and data-driven expertise, COA recognizes the impact of its work on the broader Region 3 community. COA encourages a culture of quality improvement, giving staff across the organization the skills, tools, and resources necessary to assess what is working and what is not. In the coming year, COA plans to refine its existing data systems and structure to streamline and increase visibility of its many data sources. COA will work to further build the data literacy of teams across the organization, empowering staff to grow their understanding of various levels of data and enhancing the ability of COA to effectively utilize its data to drive decision-making. By remaining flexible, innovative, and responsive to the needs of its members and providers based on quality and varying types of data, COA has the ability to further improve the health and well-being of not only its members but the broader systems that exist within its members' communities. COA acknowledges its influence within the state and strives to enact larger systems-level change that will have greater long-term upstream impacts for the communities it serves.

For reference, SFY 2022-2023 network management goals are included in Appendix A, and details of goal outcomes are incorporated throughout this plan and previously submitted SFY 2022-2023 reports.

1. PCMP and Behavioral Health Provider Network Development

The expansive provider partnerships COA established during its tenure as a Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) laid the initial foundation for its current provider networks. Building on this foundation, COA continues to utilize various resources to outreach and recruit potential new providers and grow a diverse and culturally responsive provider network. COA continues to enhance its understanding of its members and communities at a more granular level in order to better target recruitment, payment, and support efforts for the providers who serve these communities. COA places a large focus upon health equity and continuously works to build a network that best reflects the needs, backgrounds and lived experiences of Heath First Colorado (Colorado's Medicaid program) members who access services within Region 3.

Recruiting to Meet Contractual Standards

COA has a dedicated provider contracting team that both initiates and responds to inquiries and requests to add providers to the network on a daily basis. These requests consistently arise from:

- Interested adult and pediatric physical health providers.
- Interested adult and pediatric behavioral health providers.
- Requests from contracted providers such as UC Health and other medical groups to add sites and providers.
- Inquiries from members, and referrals by the customer service team.
- Referrals from the COA care coordination team as they work to place members in the proper care setting.
- Partnership with the Department and Health First Colorado Enrollment to outreach and contract with providers that have been requested by members, but who are not yet participating in the network.
- Extensive outreach to providers in areas of need by the provider relations team.
- Referrals from the COA provider recruitment manager; cultural community navigator; behavioral health team; and diversity, equity and inclusion (DE&I) team.
- Referrals by community partners.

Provider-to-member ratios are regularly monitored to identify areas needing prioritized targeted provider outreach. COA is dedicated to contracting with qualified and appropriate providers to build a high-performing, high-quality network that helps the organization meet the needs of its members. Providers that join the COA primary care and behavioral health networks must meet established network participation criteria and credentialing standards.

To become part of the network, COA requires all providers to complete a comprehensive provider application and to sign a Professional Provider Agreement (PPA). The PPA's Appendix 1 (the provider application) is used to assess each provider's readiness to meet the general primary care and behavioral health needs of members and to accommodate members with special needs.

PPA Appendix 1 surveys providers for their readiness to render services to Health First Colorado enrollees with physical and behavioral health disabilities. Compliance with the Americans with Disabilities Act (ADA) is a section noted specifically in the Provider Application and every COA provider is required to complete it. COA follows National Committee for Quality Assurance (NCQA) credentialing standards and due to the credentialling team's extensive experience and expertise, COA is able to quickly and efficiently credential providers. The responsive systems of COA and its utilization of delegate credentialling allows the organization to consistently turn around provider credentials in under 30 days.

To monitor contractually required time and distance standards, COA populates provider data by county, using an in-network flag to identify the total number of providers per county, then crossing that with the number of members per county to get time and distance ratios. In-network providers include unique practitioners, practice sites, and entity locations. COA has de-duplicated practitioners that work in multiple locations by their Medicaid IDs.

Enhancing Network Adequacy

COA continually monitors its network adequacy. As part of ensuring an adequate network, COA has expanded its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Access to Care (formerly Secret Shopper) program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in practices' front office significantly contributed to challenges with adhering to the access to care standards. Any practice that experiences turnover in staff key to access to care compliance (front office, office manager, etc.) will have trainings scheduled for all new staff within two weeks of notification. The intent of this system is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers. This new program model consists of highly engaged and collaborative trainings for providers that focus on all aspects of access to care requirements, including a specific dedication to training front office staff on Medicaid rules. Examples of training areas include appointment scheduling requirements developed for front office staff, or voicemail scripts to ensure appropriate referral messaging. Providers are randomly selected to participate in this COA-led training. All trainings are made available on the COA Learning Management System (LMS) and are accessible to all providers at any time. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs. The ultimate goal through this work is to reduce the number of no-shows, reduce members' time in provider offices, and reduce administrative burden.

Provider Recruitment and Expansion of the Behavioral Health Network

Provider partners have a significant impact on member care outcomes and experience, given they influence members at the point of care. COA has the opportunity to align behavioral health priorities with the Department's health equity frameworks in order to build capacity in the COA provider network to reduce health disparities, increase all forms of accessibility to health care services and coverage, and advance language access, health literacy, and the provision of culturally tailored services. COA continues to enhance DE&I provider data within its databases to identify new areas of focus in provider recruitment, going beyond the current network adequacy standards. The goal of COA is to build and maintain a network of providers that its members feel comfortable with. In doing so, COA believes that members will feel more empowered and encouraged to utilize primary care and subsequently less inclined to utilize emergency department (ED) services. The organization works collaboratively to identify needs through community engagement, practice support and provider affairs in order to create an engaged and responsive network that members feel comfortable seeking care from. The COA provider recruitment program manager continues to develop, implement, and direct a data driven strategy to recruit and maintain a network of culturally responsive providers based on the needs of COA members in their communities. DE&I information will be made available to members in the provider directory to give members a better understanding of who they are seeking care from and help them find a provider that best fits their specific medical, social, and cultural needs.

COA has a long-standing statewide behavioral health network, which serves as the foundation of efforts to ensure adequate access to behavioral health services for members in Region 3. This network includes contracted relationships with every community mental health center in the state, hospital systems, institutes for mental disease (IMDs), SUD providers, behavioral health providers who are integrated with PCMPs, and independent behavioral health providers. COA continues to collaborate with internal and external partners to broaden its network of behavioral health and SUD providers. The COA SUD program manager oversees the clinical application process for providers, collaborates on new value-based initiatives, and works to support provider recruitment. COA also deploys two behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. These practice facilitators meet individually with providers who have an application in progress to develop or improve administrative practices and procedures, workflows to improve authorization procedures and/or transitions of care, training plans and requirements, and clinical oversight processes. As an additional support, the organization offers training videos focused on SUD clinical quality measures. These videos provide an overview of each measure, explain the specific documentation needed, and share tips as well as common pitfalls. COA is contracted with all SUD providers who are validated by the state to render SUD treatment and anyone not contracted is still eligible to render services and receive out-of-network rates.

Supporting Crisis Services

COA maintains strong partnerships with Community Mental Health Centers (CMHCs) that render services to Region 3 members, engaging in regular reporting and data sharing related to capacity and safety net functions in the network expansion plan. COA hosts monthly meetings with the CMHCs to review data, increase accountability and to help tell the story of community behavioral health. CMHC partners are focused on screening for suicidal ideation and creating pathways for care. COA also maintains strong partnerships with community organizations providing crisis services. COA works to support complex members who have had three or

more behavioral health visits to a CMHC or crisis service center by facilitating communication between the members' physical health and behavioral health providers.

Internally, the COA care management team continues to utilize a suicide prevention script, which incorporates the Ask Suicide Questions (ASQ) screening tool to quickly identify members in crisis. The ASQ tool is now part of every care management workflow and is used based on the specific needs and appropriateness of each population served in the program. COA recognizes that any transition period poses risks for adverse outcomes or disengagement, but this is particularly true for the transition from inpatient to outpatient behavioral health care.

Plans for the upcoming fiscal year:

In SFY 2023-2024, COA plans to continue building its provider recruitment strategy and expanding behavioral health services and workforce within the state of Colorado. The organization will continue to direct a data driven strategy to recruit and maintain a provider network of culturally and ability aligned providers based on the needs of COA members and their communities. The COA provider recruitment manager plans to implement an integrated recruitment strategy in collaboration with all provider-facing teams, recognizing the need for more alignment and collaboration in efficiently identifying and addressing network gaps. In support of this effort, the COA behavioral health team will more intentionally partner with community cultural navigator(s) to recruit and build relationships with bilingual providers. This organization-wide approach will empower various staff and teams to prioritize and support recruitment, with an intentional focus on growing a network of trusted culturally responsive providers from diverse backgrounds. In order to better understand gaps in the provider network, COA will also utilize heat maps to look at the geographic overlay of members to providers, and will utilize claims data the better understand the provider network and determine active versus inactive participating (PAR) providers. In an effort to increase provider diversity and linguistic competency, COA will also implement an initiative to enhance reimbursement to providers for providing services in languages other than English. In support of this effort, the COA behavioral health team will more intentionally partner with community cultural navigator(s) to recruit and build relationships with bilingual providers.

In SFY 2023-2024, COA specifically plans to focus its recruitment efforts on culturally responsive and diverse providers, respite providers, substance use disorder - American Society of Addiction Medicine (SUD-ASAM) providers, eating disorder providers, long-term residential mental health and SUD treatment for adolescents. The organization's recruitment strategies focus on short-term and long-term solutions to building both the physical and behavioral health provider networks. However, COA recognizes the increased need for behavioral health providers with varying specialties in recent years and plans to utilize many of its resources in order to maintain and grow its behavioral health provider network. In order to enhance incentives for behavioral health providers, COA plans to implement rate increases and fee structure increases. Innovative value-based agreements represent an important step toward a health care system centered on improved patient outcomes and reduced medical spending. Value-based agreements drive this shift from transactional care to a system where payers, health systems and doctors are incentivized by value of care and patient outcomes, not volume of care provided.

More specifically within behavioral health care, COA continues to recognize the significant gap in eating disorder care and services available within the state of Colorado. COA is eager to address this issue at a systems level, and plans to work with local practices and providers to develop and enhance services for individuals seeking eating disorder treatment. In SFY 2023-2024, COA plans to fund EDCare to develop and expand a new residential program for adults with eating disorders. COA also plans to work at a systems level to add capacity for partial hospitalization (PHP) and intensive outpatient (IOP) programming. The goal is to provide both short and long-term solutions to addressing the existing gap of treatment options within the state of Colorado. COA believes that individuals struggling with an eating disorder should not have to travel outside of their state of residence for the care that they need. COA is looking forward to driving this work both at the regional level and at the state level, to create accessibility to services for Health First Colorado members across the state.

In addition to the recruitment strategies mentioned above that aim to strengthen the COA provider network and recruit additional providers with cultural and linguistic diversity, COA is currently working with the Department of Social Work at Metro State University (MSU) in Denver to fund behavioral health workforce development programs. COA has agreed to fund a scholarship program for social work students at MSU who reflect the member population of COA and who have an interest in pursuing a career in culturally responsive behavioral health care. The goal of the program is to provide viable career paths for students from historically marginalized backgrounds and create systems of support for students and young professionals entering their careers. COA believes that investing in students early on is important in building the talent pipeline of qualified, representative and culturally responsive behavioral health providers. The first MSU Social Work scholars' cohort is anticipated to begin in the fall of 2023. COA has partnered with local organizations such as Maria Droste Counseling Center and Centus Counseling to provide internship and mentoring opportunities for scholarship students. COA plans to expand upon this work and build similar partnerships with other higher education institutions and local health care providers within Region 3.

COA acknowledges that there may be existing and perceived barriers to becoming a network provider and is actively assessing and identifying barriers to contracting. The COA practice support, provider affairs, and contracting teams will work together to help new and existing providers understand the requirements of validating with the Department and how to engage more fully within Colorado's behavioral health system. COA is closely following the developments of the state's Behavioral Health Administration (BHA) and stands ready to engage in future discussions on streamline the overall system and enhance access to whole-person care for Health First Colorado members.

GOAL 1: Direct a data driven strategy to recruit and maintain a provider network of culturally and ability aligned providers based on the needs of COA members in their communities.

Tactic A: Implement an integrated recruitment strategy in collaboration with all provider-facing teams.

Tactic B: Utilize heat maps to look at geographic overlay of members to providers.

Tactic C: Utilize claims data to better understand the provider network and determine provider gaps (determine active versus inactive PAR providers).

Tactic D: Implement an initiative to enhance reimbursement to providers for providing services in Spanish.

GOAL 2: Expand and diversify the behavioral health workforce.

Tactic A: Focus recruitment efforts on DE&I, respite providers, SUD-ASAM providers, long-term residential mental health and SUD treatment for adolescents, and eating disorder treatment providers. Partner with community cultural navigator(s) to recruit and build relationships with bilingual providers.

Tactic B: Work with MSU Denver to fund school of social work scholarship program, enhancing/diversifying the behavioral health career pipeline. Begin first cohort of scholars in August/September 2023.

GOAL 3: Increase access to eating disorder services to help keep members affected by eating disorders in the state.

Tactic A: By June 2024, fund EDCare to develop and expand a new residential program for adults with eating disorders.

Tactic B: By June 2024, add capacity for partial hospitalization (PHP) and intensive outpatient (IOP) programming.

2. Practice Support & Transformation

COA supports providers in building and maintaining a consistent presence of Health First Colorado members on their panels. The practice support team addresses the demands of today's health care system by offering meaningful support intended to improve patient outcomes. The team offers physical and behavioral health providers the assistance necessary to drive change and enhance member experience, improve health outcomes, decrease costs, and increase provider satisfaction. COA supports providers of all sizes and continues to utilize a team-based approach to supporting medium and small provider groups. The goal of COA is to support PCMPs in engaging fully with their members, and work with practices to develop and maintain systems that support well-care screenings, care coordination and SDoH or specialty care referrals. The practice support team works with providers with the goal of moving them towards becoming an engaged PCMP+ and/or Enhanced Clinical Partner (ECP) that is recognized for its distinction within the system.

Advancing the Whole-Person Framework

COA recognizes the importance of looking holistically at behavioral health, physical health and SDoH to improve member health outcomes. Leaning into the organization's commitment to enhancing health equity, a behavioral health facilitation team has been

formed to increase support for providers. In collaboration with the COA DE&I team, a pilot program was created to ease the burden of supervision for behavioral health providers in primary care clinics that only employ one behavioral health provider and in some SUD facilities that employ a licensed clinician to supervise peers and non-licensed staff. COA requires that all SUD facilities employ at least one licensed clinician on staff who supervises unlicensed providers and is listed as the rendering provider on claims. The assistance provided by these supervision strategies increases access and ensures quality of care for members.

As part of the ongoing Innovation Support Project in collaboration with the University of Colorado School of Medicine, practice support staff offer support on several initiatives including behavioral health integration, risk stratification, expansion of community resources, SUD services and telehealth in primary care. Health equity milestones have been incorporated to better support the diverse member population. ECP contracts now require that PCMPs have an integrated care clinician and practice facilitators are skilled in supporting behavioral health workflow implementation and optimization.

COA also continues to carry forward the Department's potentially avoidable costs work (PAC) via "Access Health Connection" to continuously improve cross-system care and communication between hospitals and primary care providers—a decision that was encouraged and fully supported by the participating providers. Through this work, convened and supported financially by COA, major hospital systems are paired with high-volume PCMPs that share many of the same members. A major goal is to reduce rapid hospital readmissions by fostering better care coordination between the systems. The program enhances care coordination of members with chronic diseases (specifically asthma, diabetes, and COPD), improves condition management and outcomes, and reduces PAC across the inpatient/outpatient continuum of care. Provider partners collaborate to design, develop, and implement system-level interventions such as enhancing data sharing and transitions of care workflows with the goal of reducing high-PAC services such as ER visits and readmissions.

COA is invested in encouraging and increasing usage of primary health care to promote disease prevention and decrease costs. PCMPs are engaged in providing acute care, well care and chronic condition management. COA recognizes that many providers have been and continue to be overwhelmed by acute care needs and thus is invested in utilizing its data to understand existing and potential gaps within primary care. The COA practice support and care management teams can then address these gaps through training, resource development and dissemination of well-care information. Additionally, COA has piloted the Connected Care Collaborative (C3) whose primary purpose is to support "high-risk" child and adult members who are utilizing services but do not have a health home. The goal of the C3 is to connect these members to a PCMP, reduce utilization of high-cost services and ultimately improve health outcomes by establishing a health home. COA plans to utilize this collaborative framework to also support other priority populations within the region.

Information and Administrative Support

COA continues collaboration with leaders throughout the health care system to share regional strategies. COA regularly engages its provider partners through the governing council, multiple provider workgroups and topic-specific forums. Current and upcoming governing council priorities include topics such as the continuous coverage unwind, ECP workforce challenges, health equity strategy and the BHA. Additionally, provider forums allow for organic processes to form between PCMPs, specialty providers, and hospitals. These processes tend to focus on timely communication and care coordination to ensure smooth transitions of care and wraparound support for members while reducing unnecessary care utilization. COA holds many opportunities for physical health and behavioral health providers to build stronger connections and better support members within the health neighborhood. Monthly provider resource groups offer a space for providers to share current trends and gain information on relevant topics. COA also continues to convene the bi-monthly Behavioral Health Key Performance Indicator (KPI) workgroup which brings providers together based on their depression screening scores. COA has worked with providers to prepare them for the new depression screen measure, which is included in all of the COA value-based payment models. PCMPs are expected to use standardized screening tools, such as the Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and Patient Health Questionnaire (PHQ-9). The intent of these convenings is to address screening, billing, coding and process challenges impacting this measure, as well as scale best practices that positively impact performance improvement. All provider resource group meetings are recorded and made accessible to all providers on the provider LMS. Embedded within the LMS are surveys that enable COA to assess learning and comprehension of providers as they utilize these trainings.

Additionally, COA continues to utilize behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. Practice facilitators meet individually with providers who have an application in progress to create or improve administrative practices and procedures, develop new workflows to improve authorization procedures and/or transitions of care, develop and organize training plans and requirements, and develop clinical oversight processes. At this time, COA continues to permit all SUD providers who are validated by the state, and not yet contracted with COA, to render SUD treatment and receive out-of-network rates.

The new complex member definition for COA was implemented at the start of the reporting period on July 1, 2022. In SFY 2022-2023, the COA practice support team focused on providing technical assistance to ECPs in order to support the shift of data and care coordination activities to the new complex member population. ECPs give ongoing feedback related to the implementation of the new definition. COA continues to learn from its partners about potential limitations of the new complex member definition and works to better align definitions across the continuum of care. COA also relies on its biannual complex member audits to understand the effectiveness of its current systems and areas in which processes could be improved.

Data & technology support

The new portal and platform COA is using for provider data, PowerBI, incorporates self-service data visualization tools that aid primary care providers in comparing site level KPI trends to regional and cohort performance trends. COA has worked on translating

site-level trends to member-level reporting that show providers how their attributed members are counted for a given measure. COA has developed dashboards showing member-level performance on the organization's value-based administrative payment model metrics as well as site-level payment history across incentive programs. COA also utilizes a dashboard to support ECPs in outreaching members related to the Continuous Coverage Unwind. The dashboard helps COA and ECPs assess provider capacity and better understand the volume of member outreach required.

Practice facilitators provide regular messaging to PCMPs regarding the state's Prescriber Tool initiative which includes guidance on the purpose of the tool, and inquiries into the experience of practices with active tools on their EMR platforms including SureScripts. The Prescriber Tool initiative and the practice facilitators assessment of the tool's success in provider practices is an ongoing effort and partnership with the Department. COA makes continuous efforts to align provider priorities and standardize tools for measure improvement. In addition, practice support staff aided providers by maximizing funding potential in the value-based payment program. On a monthly basis, COA staff share with providers the Provider Enhanced Payment Report (PEPR) to focus on engaged members and coordinate the services they need. As a result of sharing lists of engaged members monthly, providers' value-based payments increased, which has improved staff satisfaction in the practices.

To further support value-based payment implementation, the Provider Metric Summary Tool (PMET) was developed to show cohort performance, regional comparison for multiple performance measures, and trendlines per metric. The tool has been expanded to show every performance measure and show how providers are attributing. COA plans to add member-level details per metric to better support providers' quality improvement efforts. Additionally, a standardized value-based payment implementation toolkit has been developed and shared across the provider network and continues to be updated based on provider feedback.

Telehealth support

The COA Virtual Care Collaboration and Integration (VCCI) Program continues to provide increased access to health care for its participating network providers. In a recent analysis, COA found that individuals who utilize VCCI have decreased costs of care. The VCCI program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the member's home. The VCCI Program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member's medical home. The VCCI Program includes an eConsult component that allows its participating PCMPs to directly query a VCCI psychiatrist via asynchronous HIPAA-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care and works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care. The VCCI Program incorporated further updates to its online scheduling provider portal, based on feedback from its PCMP partners, to increase efficiency for patient referrals and the sharing of clinical information through the

HIPAA-secure web-based platform. Within this provider portal, scheduling, progress notes, consent forms, and demographic information can be shared to optimize the coordination of member care with VCCI's participating PCMPs.

Plans for the upcoming fiscal year:

COA believes that practices, providers and all member facing positions should be equipped with the tools needed in order to provide high quality culturally responsive care that honors members' lived experiences and takes into account cultural influences on one's health and health care. In SFY 2023-2024, COA plans to provide culturally responsive trainings for providers and all COA member facing teams, including care management and customer service, to help better serve members with diverse backgrounds. The COA DE&I team will work to develop and provide trainings that focus on building the skills, knowledge and understanding needed to serve the priority populations of COA and improve the member experience. To better understand existing disparities and needs within the provider network, COA also plans to consistently evaluate encounter rates by race and ethnicity. COA will look at access to and quality of care by race and ethnicity to better understand areas of cost savings and existing gaps in care.

Additionally, as part of its broader evaluation efforts, COA plans to more deeply engage providers in the program development and implementation process. The organization will do this through the use of provider surveys and environmental scans, and based on findings will provide proactive trainings to providers in advance of program implementation in order to encourage program success and understanding of associated metrics. The health programs team at COA has a variety of digital engagement programs and initiatives that advance the organization's health strategy and target condition management and prevention & wellness priority areas. Simultaneously, the practice support team addresses the demands of today's health care system by offering meaningful support to provider practices intended to improve patient health outcomes. While the two teams share a common goal of improving member health outcomes, the health programs team focuses on member-facing interventions and the practice support team focuses on provider-facing interventions. To create more robust and comprehensive population health programming, COA recognizes the need for more integration between provider and member programming. This would support a strategy where both interventions benefit from one another and work towards the same goal.

COA recognizes that the telehealth landscape has gone through several evolutions over the last three years. As society enters into a new era following the PHE, COA plans to evaluate the telehealth landscape to better adapt and meet the changing needs of providers and members. It is vital that the organization understand population and provider trends within the telehealth space in order to best use its telehealth resources and programming to meet the needs of its members. COA plans to use the findings from recent provider needs assessments to identify opportunities for change and growth within the VCCI model, and how to better integrate the VCCI program into practices and community organizations. In the coming fiscal year, the COA telehealth team will also continue to work with Colorado Health Institute (CHI) to conduct an environmental scan of e-health options in Colorado to better understand the landscape of telehealth and where gaps may exist. In order to increase access and engagement within the VCCI

program, COA plans to increase DE&I representation of providers and accessibility of language services within the VCCI program. This is part of the larger ongoing provider recruitment and DE&I strategy of COA.

Also, in an effort to improve member engagement and increase access to care, COA plans to utilize DE&I data collected during the credentialing process to enhance its provider directory. COA will ensure that all credentialed providers are listed in its internal directory with information related to cultural competency, race/ethnicity, gender, ADA and languages spoken. Available DE&I information will be made accessible to members in the provider directory to give members a better understanding of who they are seeking care from and help them find a provider that best fits their specific medical, social, and cultural needs. COA will also continue to ensure that the directory shows all providers accepting patients at the practitioner level, rather than solely at the practice level. This will enable members and care managers to better access available providers with preferred backgrounds and cultural competency, and will improve the overall member experience.

GOAL 1: Ensure providers have the training and the resources needed to provide culturally competent care.

Tactic A: Provide culturally responsive trainings for member-facing staff (including care management and customer service) and providers to better serve members with diverse backgrounds.

Tactic B: Reduce disparities through consistent evaluation of encounter rates by race and ethnicity. Look at access and quality of care by race/ethnicity to understand areas of cost savings and gaps in care.

GOAL 2: Evaluate the telehealth landscape to better adapt and meet the changing needs of providers and members.

Tactic A: Using findings from provider needs assessments, identify opportunities for change/growth within the VCCI model.

Tactic B: Increase DEI representation of providers and accessibility of language services of the VCCI program.

Tactic C: Work with CHI to conduct an environmental scan of e-health options in Colorado.

GOAL 3: Utilize DEI data collected in credentialing process to enhance and increase the accessibility of the provider directory, and improve member engagement.

Tactic A: Ensure credentialed providers are listed in the COA internal directory with information related to cultural competency, race/ethnicity, gender, ADA and languages spoken, and that members can easily access this information when searching for a provider.

Tactic B: Ensure that the provider directory shows all providers accepting patients at the practitioner level, rather than at the practice level to improve access and timeliness of services.

GOAL 4: Evaluate population health data to understand gaps in programming and drive population health strategy.

Tactic A: Engage providers in the program development/implementation process through provider surveys and environmental scans.

Tactic A1: Based on findings, provide proactive trainings to providers to encourage program success.

3. Communication

COA provides ongoing communication with its provider network through several channels. When a provider contract is executed, a provider relations representative conducts a phone introduction to initiate onboarding, provide an electronic orientation package, and check in periodically as necessary. Provider Network Services (PNS) representatives conduct new provider training to all new practices within 60 days and offer ongoing training to those providers who need updates. Webinars are scheduled periodically throughout the year and providers may register for education on the COA website. Providers can access all provider-related training through the LMS. In SFY 2022-2023, COA implemented its new Access to Care training program and Cultural Responsiveness completion incentives. The resources, communication, and training given by the PNS team provide the provider network with the tools, resources, and knowledge to be administratively successful in their care for members, leading to improved outcomes and experience of care for their patients. Training, issues, and communication with providers are logged in the contact database to track and monitor progress and issue trends. Documenting these activities allows COA to make ongoing improvements to the onboarding program. PNS representatives are available to assist both internal and external staff through in-person meetings, phone, mail, and email with questions and concerns.

The COA practice facilitators and the PNS team are regularly engaged with providers and quickly respond to barriers providers could face which may impact access to care. Through this high touch team-based care model, practice facilitators and network managers are quickly able to see turnover in provider offices and help support onboarding of specific new hires with training focused on Medicaid rules and regulations, such as the access to care standards. Using Net Promoter Scores (NPS), COA conducts annual and quarterly provider satisfaction surveys. The practice support team utilizes feedback through the NPS survey to continuously improve team processes and maintain high levels of support. The practice support team also plans to supplement provider surveys with quarterly check-ins to address any issues or barriers to engagement. The team will assess practices around their frequency of engagement, their utilization of data and their overall experience.

Electronic Communications
COA distributes a variety of electronic newsletters to its provider network. The quarterly "Navigator" delivers relevant information on topics such as provider partnerships, DE&I, health equity, industry trends, SDoH and telehealth. The online "Navigator" has been redesigned in a magazine format that providers can digitally interact with each quarter. At the beginning of the pandemic, a bi-monthly newsletter, "COVID-19 Provider Update" was developed to distribute pertinent information regarding COVID-19, community

resources, vaccines, and updates from the Department. In SFY 2022-2023, a new monthly newsletter was developed, "Provider Update." This newsletter communicates essential information about COA Medicaid and Child Health Plan *Plus* (CHP+) plans, provider networks, notifications from the Department, and COVID-19 updates. Providers are automatically enrolled to receive the "Provider Update" and "Navigator" but may choose to opt out.

Disseminating Urgent Communications

COA has a system in place for disseminating urgent communications as needed. When an urgent situation or crisis has been identified, information is conveyed to providers immediately through a prominent website location, splash page messaging on the provider portal, and message on social media channels as appropriate. Further, the customer service team is also given a list of talking points to prepare for calls from providers as another way to convey urgent communication. An email blast is also sent to all providers directly, conveying the urgent communication. To accelerate internal approval of urgent messaging, key staff members are notified by email noted by high urgency, as well as a phone call to the person's office and cell phone. To address any communication deficiencies, the marketing and communications team works with provider relations and customer service as appropriate to increase hours and staff, as well as have a communications person on standby to address any immediate needs for communication to providers. Written notices of material changes, including fee schedules and contracting provisions, are sent by mail and provider contracts are amended as needed. Unless the change is retroactive, notices are communicated at least 30 days in advance of changes. Retroactive changes are also communicated within 30 days from the date they are received.

Receiving Provider Feedback

COA offers several opportunities to gather feedback from network providers and regularly incorporates provider feedback into programming and operations. Such opportunities include stakeholder meetings to discuss any changes being made to payment model structures. These meetings encourage feedback from providers and offer the space for providers to receive guidance and clarification about any upcoming changes. Additionally, COA hosted several meetings with providers to discuss changes to the complex pediatric member definition and incorporated provider feedback into the updated definition.

Beyond provider meetings previously mentioned, COA has several standard mechanisms in place to receive regular provider suggestions and guidance:

- PNS managers routinely conduct virtual site visits with network providers (hospitals, ancillary, specialty, behavioral health, and primary care).
- Providers may leave feedback through the COA website. Comments are directed to providernetworkservices@coaccess.com. This inbox is checked multiple times per day by provider network services and representatives who follow up with the provider by phone or email.
- PNS initiates face-to-face meetings as needed. Network providers participate in both formal and informal committees: Credentials Committee, Quality Performance Improvement Committee, and Joint Operations Committees.

- Provider Forums are held throughout the year to provide important information relevant to the network and gather feedback from providers.

Plans for the upcoming fiscal year:

In SFY 2022-2023, COA recognized the need for a more comprehensive and collaborative approach to its provider communication methods. Because many teams across the organization interact and communicate with the COA provider network, providers may receive disparate communications and messaging from various teams. Teams within the organization may also have access to differing provider contact lists, making it challenging to ensure communications are reaching providers through their accurate and up-to-date contact information.

In the upcoming fiscal year, COA plans to take a deeper look at provider communications across the organization to address gaps and areas for improvement. COA continues its participation in the department-initiated Communication Action Team. This team which includes representation from the department, RAEs and key providers convened in SFY 2022-2023 to better understand the root causes of provider communications challenges across all involved partners. COA plans to utilize the learnings from this workgroup to inform future communications improvements. The COA provider affairs team will also engage with provider workgroups to collect feedback from providers in order to develop a more effective communication strategy. Internally, COA plans to lead a strategy level initiative to assess all current provider distribution lists and the means in which information is collected and used, and to create a single source of truth for internal and external provider distribution lists. This includes data from various departments including marketing, IT, operations, finance, health strategy and health system integration. This will better enable COA to appropriately target communication based on provider type, for example tailoring messaging for clinic front office staff, PCMPs, specialists, etc. This will also allow the organization to identify the areas in which provider communications and messaging needs to be updated based on audience. Additionally, COA plans to establish metrics to better track communications successes and areas for improvement. The project will not include the development of new software but is meant to identify the processes and bottle necks that exist currently. This organization-wide strategy is an effort to better understand provider feedback, communicate more effectively with providers and make information more easily accessible across the network.

As part of its DE&I strategy, COA is invested in working with providers to help bolster available linguistic interventions. The organization plans to assess non-English language services and work with provider focus groups to understand where additional support is needed in engaging and communicating with members in languages other than English. As necessary, COA will work with practices and providers to develop informative and culturally relevant materials and communications to be shared with members. This will support non-English speaking members in having better access to health information and will support providers in supplying information in languages other than English.

GOAL 1: Enhance and align the COA provider communication strategy across the organization.

Tactic A: Assess non-English language services through provider focus groups to bolster available linguistic interventions.

Tactic B: By June 2024, engage with provider workgroups to collect feedback and develop an effective provider communication strategy.

4. Health Neighborhood & Community Engagement

Health Neighborhood

To ensure that COA members receive the whole-person care that they need and deserve, the organization continues to strengthen the health neighborhood by maintaining a comprehensive network of PCMPs and continues to build relationships with specialty care providers and hospitals. COA staff members also have strong and ongoing relationships with local public health agencies and health alliances. Diverse partnerships within the health neighborhood help to increase system collaboration and promote collaborative care for members. COA works to ensure that providers have the tools necessary to deliver high quality care to members, which includes utilizing its data systems to identify gaps in care and areas for additional support. The COA practice support and care management teams are able to support small and mid-sized practices and streamline patient visits by proactively identifying well care and prevention needs. Beyond contracting directly with providers, COA has continued collaboration with leaders throughout the health care system to share regional strategies through the governing council and multiple provider workgroups and topic-specific forums.

To maintain a robust, high-quality provider network, forums have been created to allow for organic processes to form between PCMPs, specialty providers, and hospitals. These processes tend to focus on timely communication and care coordination to ensure smooth transitions of care and wraparound support for members while reducing unnecessary care utilization. COA holds many opportunities for physical health and behavioral health providers to build stronger connections and better support members within the health neighborhood. Monthly provider resource groups offer a space for providers to share current trends and gain information on relevant topics.

As noted in previous reports, the COA team works consistently to connect members with specialty care providers when needed. A sophisticated risk stratification data tool is used to identify members in need of outreach. COA utilizes an admission, discharge, and transfer (ADT) registry (high risk maternity, diabetes, behavioral health) and complex member data to create prioritized outreach tiers based on need. The COA strategies for ensuring appropriate utilization of specialty care continue to include: 1) promoting eConsult usage; 2) indirectly and directly linking providers to appropriate specialty and community resources; 3) directly linking members to these resources; 4) risk stratifying to determine members in need of intensive clinical care management and 5) adopting novel approaches to manage chronic conditions and promote healthier lifestyles. These strategies ensure that before any programmatic or outreach efforts are implemented, priority populations and their needs are identified so that members are connected to the right care at the right time and receive the right level of intervention.

Community

COA maintains several key community partnerships that support an interdisciplinary approach to member care. These partnerships are key to cultivating communication pathways through which member needs are identified and barriers to access removed. The strong partnerships with and between COA and providers and community organizations have bolstered clinical data exchange, promoted use of eConsult services, and created an internal repository to act as a source for community resources. COA also supports innovation and growth in initiatives promoting wellness, specialty access, and health equity through two large programs: the Community Innovation Pool (CIP) and the Provider and Community Investment Program. COA acts as a convener within the region and helps community partners connect with one another, allowing for increased communication and collaboration on priority projects.

COA maintains a strong partnership with Community Mental Health Centers (CMHCs) that render services to members, engaging in regular reporting and data sharing related to capacity and safety net functions in the network expansion plan. COA hosts monthly meetings with the CMHCs to review data, increase accountability and help to better tell the story of community behavioral health. CMHC partners are focused on screening for suicidal ideation and creating pathways for care. COA maintains strong partnerships with community organizations providing crisis services. COA works to support complex members who have had three or more behavioral health visits to a regional CMHC, by facilitating communication between the members' physical health and behavioral health providers.

COA is committed to strengthening the reach of supportive services by supporting community-based organizations (CBOs) that help its members achieve lasting physical, behavioral and social health. COA understands the key role that CBOs play in the lives of members and the health of the community and works consistently to cultivate relationships across this spectrum. Through programmatic partnership, consultation, and funding support, COA actively pursues opportunities to help better the community, positively impact the lives of members, and advance health equity. All funding requests are vetted through processes that include input from multiple COA subject matter experts, while also garnering input from members and engaged community partners. Data collection and evaluation are key components throughout the life of each funded proposal, in order to drive accountability and better inform future funding strategies, priorities, and mechanisms. COA continues to fund several community-led projects that focus on increasing vaccination programming, improving food security and other SDoH, and ensuring support for those impacted by the Continuous Coverage Unwind. COA has also invested in an internal complex care coordination team with registered nurses and a medical director that ensure medically complex members receive necessary specialty care and supports needed to address SDoH, like housing or transportation needs.

<u>Plans for the upcoming fiscal year:</u>

In SFY 2023-2024, COA plans to utilize an organization-wide strategic data-driven approach to better understand SDoH priorities and inform community funding initiatives. COA will achieve this through exploration of innovative sources of SDoH data, and will analyze all available SDoH data to understand the trends and priorities that exist within member sub-populations. Based on its findings, COA plans to prioritize its funding partnerships to focus on addressing SDoH trends and needs. The goal with all funded projects is to invest in and amplify the voice of the communities that COA serves. Community-based funding initiatives will continue to extend the reach of programming into the community and meet members where they are at through trusted organizations and partners.

COA also plans to leverage its community partnerships in order to extend the reach of member facing programming and identify further opportunities for collaboration toward enhancing member engagement and reducing disparities. In the coming fiscal year, the COA population health team plans to establish two new community partnerships and will develop collaborative strategies for engaging members in health programming. The COA telehealth team also plans to establish relationships with additional community partners in order to better reach member populations that are medically underserved who may benefit from access to services through telehealth.

Additionally, the COA care management and community engagement teams plan to develop a collaborative framework that will enhance care management's presence and reach within the community. COA plans to continue working with its community partners to extend the reach of its programming and better reach its diverse member populations. COA believes that creating additional opportunities for care managers to be in the community will enable increased accessibility of care management services for members with complex care needs. Community based interventions with care management will more effectively bring together community resources and meet members where they are at. In particular, COA hopes this collaborative community-based strategy will have an increased impact on several priority populations, such as unhoused, justice-involved and foster care members. Additionally, COA will continue to utilize the expertise and critical knowledge of its Community Cultural Navigators to better understand its member populations and gather important feedback from the communities it serves. The team plans to pilot standardized processes for sharing member feedback collected by community cultural navigator(s) and better utilize this feedback in program improvement strategies. These processes will ensure that COA maintains a responsive feedback loop and develops culturally responsive services, in collaboration with ECP and provider networks, that meet the needs of its members with complex and non-complex care needs.

GOAL 1: Utilize an organization-wide strategic data-driven approach to better understand SDoH priorities and inform community funding initiatives.

Tactic A: Explore innovative sources of SDoH data, as well as analyze all currently available SDoH data to understand trends and priorities within member sub-populations to drive equity.

Tactic B: Prioritize community funding partnerships that are focused on addressing priority SDoH.

Tactic C: Explore how Hospital Transformation Program (HTP) data can be used to address SDoH at the admission, discharge and transfer points.

GOAL 2: Leverage community partnerships to extend the reach of member-facing programming and identify further opportunities for collaboration toward enhancing member engagement and reducing disparities.

Tactic A: Establish two new community partnerships and develop collaborative strategies for engaging members in health programming (Related examples: Mobile Unit, community centers, recovery groups, informal locations).

Tactic B: Establish relationships with additional community partners in order to better reach member populations that are medically underserved through telehealth.

Tactic C: Build a framework for deeper community engagement and care management collaboration and develop additional community-based interventions to enhance COA care management presence in the community.

5. Admin Payments and Incentives

COA is committed to collaborating with provider partners to inform its various payment models and to ensure that the administrative requirements are minimal and do not create barriers to provider success. COA heavily utilizes data and regional metrics to inform rate modeling and to create structures that support providers on an individual and network level in delivering on key performance metrics. COA has implemented nationally recognized measures that help the organization best understand the quality of care that members receive. One major goal in all proposed models is to understand and address any potential inequities in our measurement of provider performance within the COA network as well as in the treatment that COA members receive from providers. COA is committed to reducing existing inequities and is interested in incentivizing providers to report data more consistently on race, ethnicity, and demographic measures. In the coming fiscal year, COA plans to continue improving upon this work and plans to focus its attention on supporting members with complex physical, behavioral and/or social health needs through innovative alternative payment models.

In SFY 2022-2023, COA designed and implemented four distinct primary care administrative payment models where all participating providers could see a path to success. These new models support and enhance provider ability to improve health outcomes that are specific to the populations that they serve (figure 1). COA has designed these models to address as many CMS Core Measures as possible, align with the Department's APM2 model, and incentivize providers to perform high value services that serve as upstream primary care interventions for issues that often lead to high-cost secondary and tertiary care services. The differentiation across models also supplies a robust dataset that enables COA to identify providers exhibiting exceptional performance in producing positive health outcomes throughout their unique target populations. With these data, COA has built out site designation evaluation criteria

and a path for sites to ascend to PCMP+ and ECP status. Figure 1 depicts the four primary care administrative payment models and their associated metrics that will continue into SFY 2023-2024.

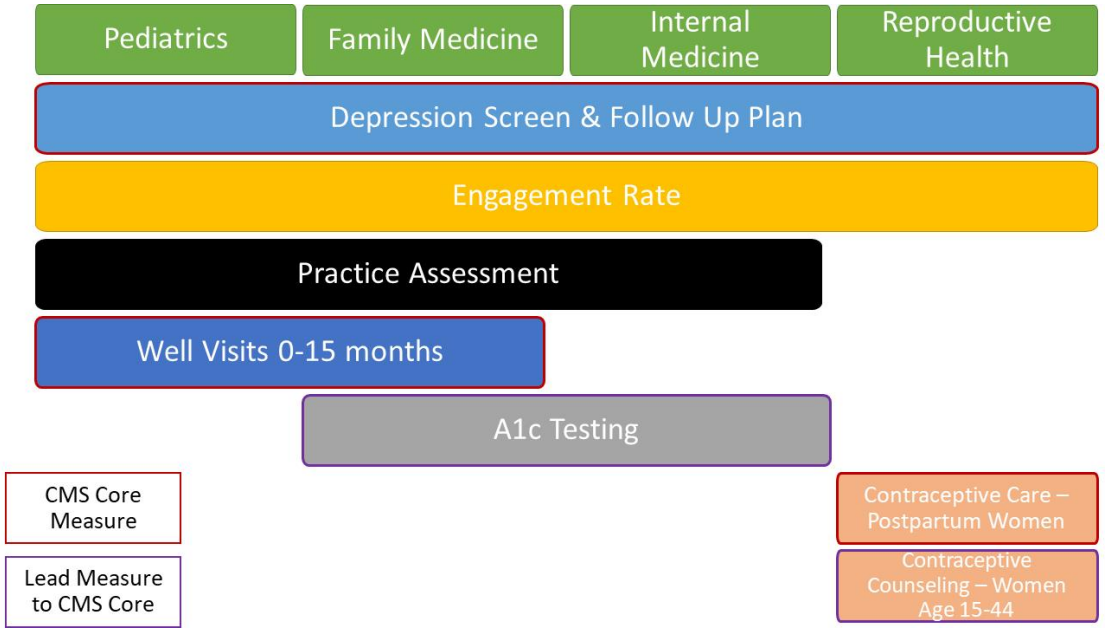

***Figure 1**: FY 2023-2024 4 Distinct COA PCMP Administrative Payment Models – Utilizer Payment*

Since the inception of the COA Administrative Payment Model in 2021, the COA PCMP provider network has made strides towards improving the health of Region 3 members. For instance, Region 3 family medicine and reproductive health providers have improved their engagement rates by 2.4% and 14.5% respectively, despite climbing attribution and significantly increased panel sizes. pediatric and internal medicine engagement rates have decreased by 0.4% and 5.6%. COA expects engagement rates to continue to experience fluctuations through 2023 and mid-2024 as the continuous coverage unwind period continues. All provider types within Region 3 improved their depression screening for engaged members (age 12+) rate. At the regional level, depression screens have improved by 27.2% since 2021.

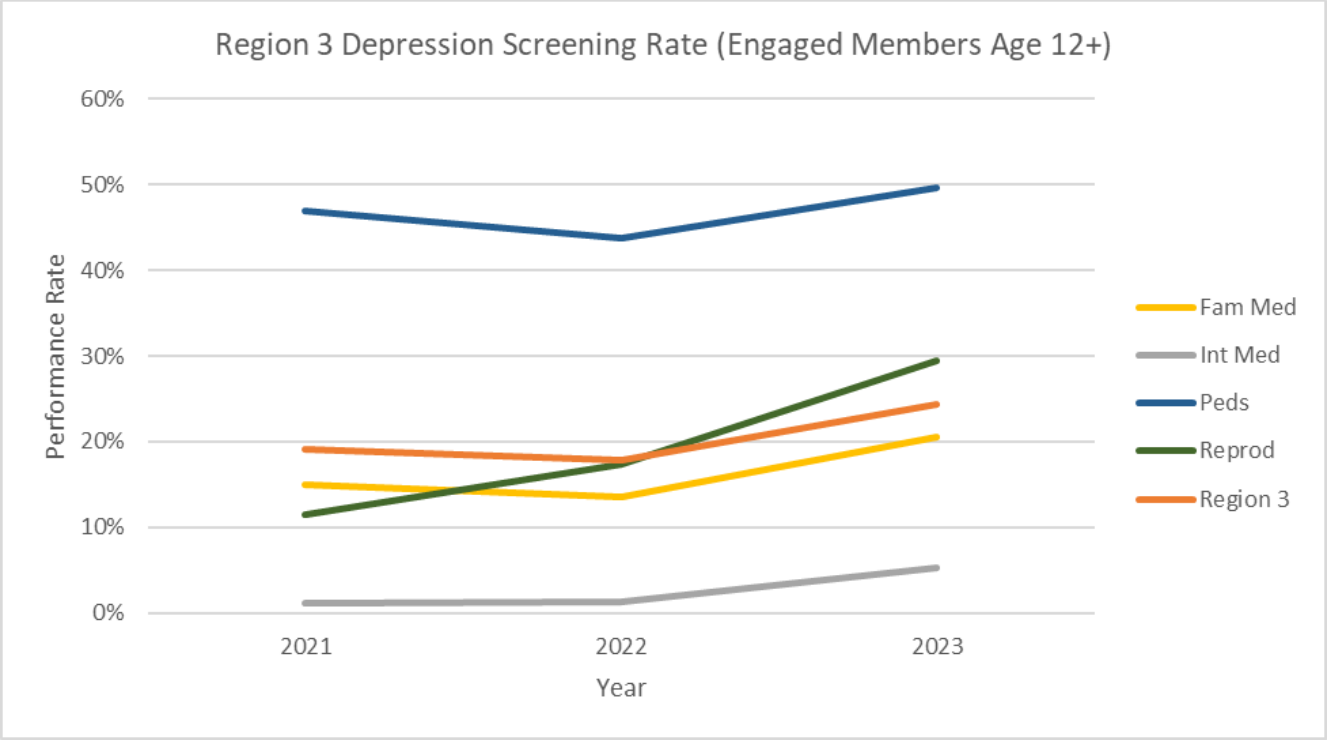

***Figure 2**: Region 3 Depression Screening Rate 2021 - 2023*

Additionally, pediatric and family medicine providers have improved well visits in the first 15 months of life by 10.2% and 9.7%, respectively. Well visits in the first 15 to 30 months of life have improved by 6.0% in the Pediatric cohort and 14.5% in the Family Medicine cohort. Family medicine and internal medicine providers have improved hemoglobin A1c (HgA1c) testing rates by roughly 10.0%. In the Reproductive Health cohort Contraceptive Care – Postpartum has improved by 14.3% and Contraceptive Counseling has decreased by 12.7%. COA can attribute performance fluctuations to changes in the participants participating in the Reproductive Health cohort and small denominator sizes for contraceptive metrics.

A sub-group of COA providers receive enhanced capitation rates for their care management work with members, and an even higher capitation rate for their extended care coordination interventions with complex members. For the providers that receive the enhanced complex PMPM (PCMP+ & ECP sites), payment is calculated by analyzing claims engagement and extended care coordination engagement with their attributed complex member population. Practice facilitators continue to support providers through complex member and extended care coordination definition changes to ensure full understanding and adoption of the

various facets of the complex care portion of the value-based payment model. Compared to 2021, complex claims engagement decreased from 72.6% to 69.2% at the end of 2022. This decrease can be attributed to the complex member definition changes that occurred during the 2022 measurement period. As time passes with the newly adopted complex member definitions, COA expects the complex member claims engagement rate to improve. Complex extended care coordination engagement has increased by 34.1% in Region 3, demonstrating the efficacy of incenting providers to prioritize care coordination of their attributed members with complex needs. COA continues with these measures in the SFY23-24 administrative payment models.

ECP providers receive an enhanced PMPM for care management of all attributed members. In SFY 2022-2023, COA created a new set of measures to determine payment. These metrics have also carried over to the SFY 2023-2024 administrative payment models (figure 3).

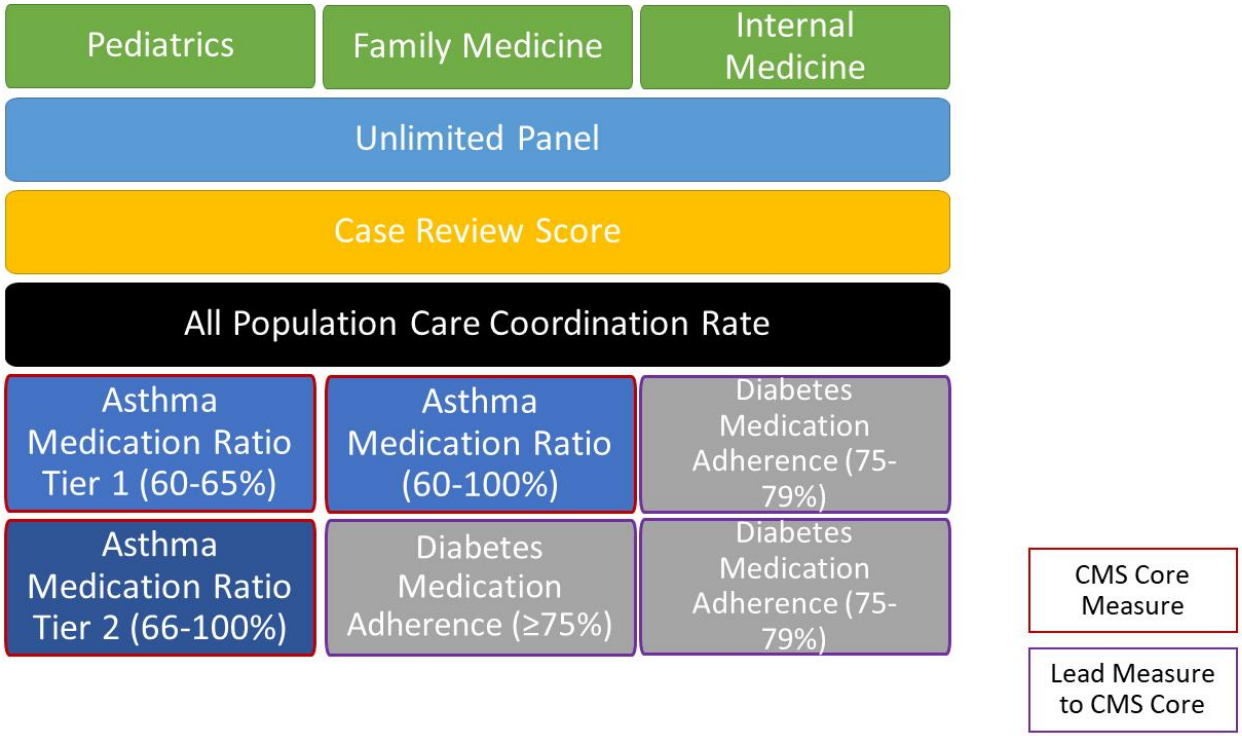

Figure 3: SFY 2023-2024 Administrative Payment Models – ECP Care Management Payment

The intent of the "All Population Care Coordination" metric is to identify providers that are doing significant amounts of care coordination with their attributed population and to divert more funds to their practices from providers that are supporting care coordination for a relatively low proportion of their attributed members. Medication adherence metrics apply to ECP sites with at least 20 members with asthma and/or 20 members with diabetes. Family medicine providers must demonstrate at least 75% medication adherence for their population of members with diabetes to earn an additional $0.50 PMPM, and at least 60% medication adherence for their members with asthma to earn an additional $0.50 PMPM, for a maximum add-on payment of $1.00 PMPM. The Pediatric and Adult Internal Medicine payment models focus on one chronic condition due to the population served but must demonstrate higher medication adherence levels to attain the full $1.00 PMPM (figure 3).

Changes to the SFY 2023-2024 administrative payment models include the retirement of the Controlled Chronic Conditions: ED Reduction (C3EDR) Program and the redistribution of the associated $0.50 PMPM among the utilizer clinical metrics. Due to additional COA investment in the primary care administrative payment model, the relative PMPM value of most of the clinical metrics in the model increased.

The table below illustrates the breakdown of PMPM ranges for practices and the count of utilizers assigned to those practices in the SFY 2023-2024 payment model. The majority of members are attributed to practices making more than $3.00 PMPM.

Utilizer PMPM range	Count of Utilizers	Count of Practices	% of Total Utilizers	% of Practices
< $2.00	1972	5	0.6%	3.0%
$2.00 to $2.99	27619	34	8.7%	20.1%
$3.00 to $3.99	173765	83	54.5%	49.1%
$4.00+	115409	47	36.2%	27.8%

Beginning in January 2021, COA and Kaiser Permanente (KP) partnered to launch a value-based program that transitioned the ECP payment into a value-based payment linked to member health outcomes. The purpose of this value-based program was twofold: to shift payment focus from the volume of care coordination activities delivered to improved clinical care and member health outcomes associated with care coordination; and to support and align with priorities identified for Accountable Care Collaborative 3.0. COA and KP agreed to align selected HEDIS metrics in disease control and screening that improve health outcomes for members and reduce health care spending.

In the first 18 months of the program (January 2021 to June 2022), COA and KP partnership achieved the following improvements in member health:

- 12.8% reduction in diabetes poor control rates

- 1.1% improvement in blood pressure control
- 33.3% improvement in breast cancer screening rates

Improvement in the diabetes control measures prevented over 600 inpatient days, across both Regions 3 and 5, and produced health care savings of approximately $3.00 to $3.25 PMPM. COA and KP will continue to partner in this program. Measure performance is reviewed quarterly between COA and KP leadership and quality improvement teams. Measures are added or removed from the program pending an annual performance review and priority areas identified by the Department.

In SFY 2022-2023 the metrics of focus changed to include the following condition management and prevention metrics: Controlling High Blood Pressure, Comprehensive Diabetes Control: Poor Control, Asthma Medication Ratio, Breast Cancer Screening, Childhood Immunization Status (Combination 10), and Immunizations for Adolescents (Combination 2). KP is slated to meet 10% HEDIS 90th percentile gap closure goals for Asthma Medication Ratio, Controlling High Blood Pressure, Childhood Immunization Status, and Immunizations for Adolescents. Results of the SFY 2022-2023 performance period will be available in Q2 of SFY 2023-2024. The intent of the SFY 2023-2024 program will be to introduce two health outcome disparity gap closure measures and to continue to improve upon condition management and prevention metrics.

COA started an early adopter incentive payment for providers joining the Department's APM2 program at the beginning of SFY 2022-2023 and paid out $140,000 to 19 practice sites that joined APM2 during the year (one payment per TIN). This incentive payment will be ongoing through the end of SFY 2023-2024 and will be paid out on a quarterly basis to new APM2 participants.

Additionally, COA and AllHealth partnered in SFY 2022-2023 to launch a value-based payment program to shift payment from the volume of billable activities rendered to an emphasis on targeted clinical care and improved health outcomes for Health First Colorado Members. The collaborative strategy was to build an innovative, performance-based payment model that provides financial incentive for providing top tier care and improved health outcomes for Health First Colorado members while lowering any avoidable costs associated with managing complex behavioral health conditions. AllHealth's earning potential in this payment model hinges on an evaluation of the quality and capacity of AllHealth's processes and operations as a safety net provider. AllHealth's subsequent metric performance payments will be determined by their earned quality score and achieved performance goal. While final performance results are not yet available, AllHealth has improved their Follow Up After Hospitalization for Mental Illness within seven days rate by 21.0% from baseline, while their Suicide Risk Assessment for All Intakes rate has remained stable and the Safety Planning After Positive Risk Assessment rate has improved by 6.0% from baseline.

<u>Plans for the upcoming fiscal year:</u>

Previous provider feedback has indicated a need for clear criteria for sites to ascend to PCMP+ and ECP site designations, which allows them to earn higher capitation rates. This input precipitated an intense effort to develop clinical, engagement, and structural performance standards along with a site review process to identify high-performing sites that may be interested in taking on

increased care management responsibilities and becoming a PCMP+ or ECP. An integral piece of this work was the building of a dataset to detect individual sites that are achieving clinical and engagement performance standards. These data are reviewed annually at the *site level* to assess high performance across clinical metrics and operational readiness to ascend to a higher site designation that adheres to care management best practices. To be eligible for a PCMP+ site designation, a clinic must score in the COA 80th percentile on at least two clinical metrics for a minimum of nine of the 12 months in the previous calendar year measurement period. Sites that ascend to the PCMP+ designation will be required to maintain this level of performance for a minimum of two years before being eligible for an ECP site designation review. This two-year period gives COA the ability to collect and evaluate care management data and quality of care planning activities. A site would be eligible to become an ECP after completing two years as a PCMP+ and performing well on care management performance metrics.

COA identified five Region 3 PCMP sites during the SFY 2023-2024 site designation review that were meeting clinical and engagement performance standards. Three of the five sites had one of the required structural requirements in place. While none of the five identified sites are eligible to become PCMP+s at this time, all sites will be outreached for a conversation regarding their interest in working towards becoming a PCMP+ and receiving an infrastructure investment from COA to implement missing structural requirements.

During SFY 2023-2024 COA also plans to partner with AllHealth and four additional Community Mental Health Centers (CMHCs) to begin a new 18-month CMHC value based payment program focused on improvements in safety net provider quality, Follow Up After Hospitalization for Mental Illness, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Antidepressant Medication Management, and Initiation and Engagement of Substance Use Disorder Treatment; along with suicide screening and safety planning. The design of the SFY 2023-2024 CMHC value-based payment program involved significant provider collaboration and communication. In the past year, COA held six provider stakeholder meetings that included input from five CMHCs: AllHealth, Aurora Mental Health & Recovery, Community Reach, Jefferson Center for Mental Health, and WellPower. CMHCs were able to engage in the model design process, debate the value and reasonability of selected measures, and collaborate in the design of the quality and structural assessment. The first six months of the program will prioritize completing the quality and structural assessment, building out CMHC reporting capabilities and measurement of suicide screen and safety planning, and measurement of seven day follow up after an inpatient stay rates. Beginning January 2024, COA will include Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Antidepressant Medication Management, and Initiation and Engagement of Substance Use Disorder Treatment in the program measure suite.

Additionally, the Enhanced Care Provider Investment Payment, formerly the Vulnerable Populations Provider Support Payment, began in July 2022 to reward sites providing enhanced care services that aid in the delivery of whole-person care and address member needs outside the scope of what would be captured on a medical claim. In Region 3, three providers were awarded funds based on self-reported data provided by the practice facilitator staff. Examples of enhanced care services included in the initial funding cohort were food pantry access, needle exchange, onsite housing/housing supports, etc. Over the past year the Enhanced

Care Provider Investment Payment underwent a comprehensive program redesign. This redesign brought in additional programmatic and evaluation structures which allowed COA to open this funding opportunity to the larger PCMP provider network. Provider eligibility criteria includes the following:

1. Region 3 and/or Region 5 PCMPs participating in a COA Administrative Payment Model.
2. PCMPs should have onsite staffing and/or supports in place to administer the enhanced care project. The intent of these funds is not to support off-site referrals to care or community organizations.
3. Funds must be dedicated towards improving access to enhanced care for medically and socially underserved populations.
4. Able to provide attestation of culturally responsive care training for staff at the organization.

The application window for SFY 2023-2024 closed on July 31, 2023, and COA looks forward to reviewing a robust pool of applications to increase access to enhanced care services for medically and socially underserved populations.

GOAL 1: Expand provider partnerships to include increased accountability for improving health outcomes for members with complex physical, behavioral and/or social health needs.

- Tactic A: Implement phase 1 of a 3-phased value-based payment model with five CMHC organizations that focuses on improved health outcomes for members with severe mental illness.
- Tactic B: Strategically invest funds in provider programming that will support COA members at increased risk for adverse health outcomes including, but not limited to, refugee, unhoused, medically fragile and/or non-English speaking populations.

R3 TOTAL PRACTICES OR AGENCIES ELIGIBLE FOR ARRANGEMENT PROGRAM					170				
#	Type of Arrangement	Arrangement Description	PMPM ($)	KPI ($)	Performance Pool ($)	# of Participating Practice Sites	% of Total Practice Sites	Eligibility Requirements for Practice participation*	Additional Comments
*Key to table and supporting documentation									
For cells highlighted blue see companion pdf titled: FY23-24 COA Admin Payments Companion Document									
For cells highlighted yellow see companion pdf titled: DRAFT FY23-24 COA KP VBP Program Document									
For cells highlighted green see companion pdf titled: DRAFT FY23-24 COA Pay for Performance Program Document									
1	Utilizer PMPM (Addendum 1C - Pediatric PCMP Providers)	**Utilizer PMPM Base contract** (Addendum 1C) applies to all Pediatric PCMPs, PCMP+ and ECPs. A site's utilizer payment is calculated according	$2.00-$8.00			47	27.6%	Must be a contracted PCMP in the COA network	If a provider site does not have 10 attributed

		to provider performance on five metrics: 1) **engagement rate score**, 2) **practice assessment score**, 3) **screening for depression score (engaged members)**, 4) **well-visits in the first 15 months of life score**, and 5) **well visits in the first 15 to 30 months of life score**. Performance across these metrics is used to determine the site's utilizer payment. Providers will not receive a utilizer payment for members identified as non-utilizers. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.						with a population served of Pediatrics.	Members eligible for the well-visits in the first 15 months of life or well-visits in the first 15-30 months of life metrics, the site will be scored on the child and adolescent well-visit metric.
2	Utilizer PMPM (Addendum 1C - Family Medicine PCMP Providers)	**Utilizer PMPM Base contract** (Addendum 1C) applies to all Family Medicine PCMPs, PCMP+ and ECPs. A site's utilizer payment is calculated according to provider performance on five metrics: 1) **engagement rate score**, 2) **practice assessment score**, 3) **screening for depression score (engaged members)**, 4) **well-visits in the first 15 months of life score**, and 5) **A1c testing for diabetics score**. Performance across these metrics is used to determine the site's overall utilizer payment. Providers will not receive a utilizer payment for members identified as non-utilizers. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.	$2.00-$8.25			103	60.6%	Must be a contracted PCMP in the COA network with a population served of Family Medicine.	If a provider site does not have 10 attributed members eligible for the well-visits in the first 15 months of life or well visits in the first 15-30 months of life metrics, the site will be scored on the child and adolescent well visit metric.
	Utilizer PMPM (Addendum 1C -	**Utilizer PMPM Base contract** (Addendum 1C) applies to all family	$1.25-$6.00			13	7.6%	Must be a contracted	

	Adult Internal Medicine PCMP Providers)	medicine PCMPs, PCMP+ and ECPs. A site's utilizer payment is calculated according to provider performance on four metrics: 1) **engagement rate score**, 2) **practice assessment score**, 3) **screening for depression score (engaged members)**, and 4) **A1c testing for diabetics score**. Performance across these metrics is used to determine the site's overall utilizer payment. Providers will not receive a utilizer payment for members identified as non-utilizers. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.						PCMP in the COA network with a population served of internal medicine.	
3	Utilizer PMPM (Addendum 1C - Reproductive Health PCMP Providers)	**Utilizer PMPM Base contract** (Addendum 1C) applies to all PCMPs, PCMP+ and ECPs. A site's utilizer payment is calculated according to provider performance on four metrics: 1) **engagement rate score**, 2) **screening for depression score (engaged members)**, 3) **contraceptive care uptake – postpartum women score**, and 4) **contraceptive counseling – all women ages 15 to 44 score**. Performance across these metrics is used to determine the site's overall utilizer payment. Providers will not receive a utilizer payment for members identified as non-utilizers. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.	$1.00-$3.50			7	4.1%	Must be a contracted PCMP in the COA network with a population served of reproductive health.	
4	Non-Utilizer PMPM (Addendum 1C - All PCMPs)	**Non-Utilizer PMPM** - All providers get $0.50 PMPM for non-utilizers. ECPs continue to receive the care management payment for non-utilizers to ensure that there is no confusion	$0.50 - $4.75			170	100.0%	Must be a contracted PCMP in the COA network.	

		about which members they "should/shouldn't" be care managing. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.							
5	Complex PMPM (Addendum 2C - ECPs only; Addendum 4C - PCMP+ only)	**Complex PMPM** - PCMP+ and ECPs receive an enhanced PMPM depending on their performance on two (2) metrics, **Complex Claims Engagement** and **Complex Extended Care Coordination**. These two (2) metrics are blended to determine a site's enhanced PMPM. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.	$4.50-$18.75			39	22.9%	Must be a contracted PCMP+ or ECP in the COA network	There are 2 PCMP+ sites in Region 3.
6	Care Management PMPM (Addendum 2C - ECPs only)	**Care Management PMPM** - ECPs receive a CM PMPM that is calculated according to the clinics performance in providing care coordination to their attributed membership (**Overall Care Management Engagement** rate), presence of **unlimited Medicaid attribution** as recorded by HCPF, and their **Care Plan score** (submission of individualized care plans for a sample of RAE Members). ECPs have the opportunity to earn an add-on payment for performance on **medication adherence metrics for diabetes and asthma**. Model program and measure specification documents can be found on coaccess.com/providers/resources/vbp.	$2.50 - $4.25			37	21.8%	Must be a contracted ECP in the COA network. The medication adherence add-on payment requires the site to have a minimum of 20 attributed members with asthma and/or diabetes to be eligible. Pediatric and adult internal medicine models focus on one chronic condition while the family medicine	

								model focus of both chronic conditions.	
7	Kaiser Permanente Pay for Performance Administrative Payment Model	KP receives the Utilizer and Non-utilizer PMPM payments according to the model described above. However, their care management PMPM payment is withheld for the duration of the performance period (July 1, 2023 to June 30, 2024) and will be paid out according to their performance on 4 required metrics. In order to receive full payment, KP must achieve the HEDIS national 90 percentile or close the gap by 15%. KP can achieve partial credit on a metric if they close the gap by at least 7.5% ($0.48 PMPM).	$0-$3.85			9	5.3%	Must be contracted Kaiser Permanente PCMP site in the COA network.	The performance period for this program is July 1, 2023 to June 30, 2024. All dollars will be accrued and KP will be paid out in fall/winter, 2024 according to their performance. **Note:** The FY 2023-2024 program is currently under negotiation and will be finalized after submission of this deliverable.
8	Child and Adolescent Well Visits KPI Distribution Model	Dollars are distributed to PCMPs in direct proportion to the percentage of hits they contributed to the numerator. 50% paid according to provider performance on Well Visit Part 1; 50% paid according to provider performance on Well Visit Part 2.				150	88.2%	Must be a contracted family medicine or pediatric PCMP in the COA network.	

9	Oral Evaluation KPI Distribution Model	Dollars are distributed to PCMPs based on 100% PCMP panel performance. Providers in the top quartile share equal amounts of 50% of these dollars; second quartile shares equal amounts of 30% of these dollars; third quartile shares equal amounts of 20% of these dollars; bottom quartile is not eligible for these dollars.				170	100.0%	Must be a contracted PCMP in the COA network.	
10	Behavioral Health Engagement KPI Distribution Model	Dollars are distributed to PCMPs in direct proportion to the percentage of hits they contributed to the numerator		**example:** 10% of numerator hits = 10% of KPI dollars		149	n/a (many of the providers paid were not part of the PCMP network, as they were BH providers)	Must be a contracted provider (PCMP or BH provider) in the COA network.	Metric retired for SFY 2023-2024. Remaining funds from the previous SFY will be distributed summer 2023.
11	Prenatal Care KPI Distribution Model	Dollars are distributed to PCMPs in direct proportion to the percentage of hits they contributed to the numerator		**example:** 10% of numerator hits = 10% of KPI dollars		170	100.0%	Must be a contracted PCMP in the COA network.	Metric retired for SFY 2023-2024. Remaining funds from the previous SFY will be distributed summer 2023.
12	ED Visit KPI Distribution Model	Dollars are distributed based on PKPY performance for attributed population with asthma or diabetes. Payment is linked to PCMP performance on preventing avoidable ED visits related to asthma or diabetes. 100% provider performance (providers performing at the regional average or better). 50% paid according to provider tier performance for asthma. 50% paid according to provider tier performance for diabetes				161	94.7%	Must be a contracted family medicine, adult internal medicine, or pediatric PCMP in the COA network.	

13	Depression Screen & Follow-up Plan KPI Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
14	Timeliness of Prenatal & Postpartum Care KPI Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
15	Extended Care Coordination Performance Pool Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.				39	22.9%	Must be a contracted PCMP+ or ECP in the COA network	Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
16	Premature Birth Rate Performance	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval,							Distribution model is currently under

	Pool Distribution Model	final payment distribution methodology will be shared with the Department and the COA provider network.							development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
17	Behavioral Health Engagement for Members Releasing from State Prisons Performance Pool Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
18	Asthma Medication Ratio Performance Pool Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.
19	Antidepressant Medication Management Performance Pool Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology

									and number of eligible sites will be available after COA Governing Council approval.
20	Contraceptive Care for Postpartum Women Performance Pool Distribution Model	TBD - COA is currently developing a payment distribution model for this metric. Pending COA Governing Council approval, final payment distribution methodology will be shared with the Department and the COA provider network.							Distribution model is currently under development. Finalized methodology and number of eligible sites will be available after COA Governing Council approval.

*Eligibility requirements that a practice must possess in order to qualify for this type of payment arrangement. Requirements might include: open panels, use of community health workers, on-site care coordination, advanced screening, etc.

Appendix A:

Network Management Strategic Plan Goals SFY 2022-2023

PCMP and Behavioral Health Provider Network Development Goals:

Goal 1: Leverage demographic data including but not limited to language, gender/pronoun preferences, minority-owned, race, ethnicity, populations-served, and geographic location for internal database systems to inform network adequacy.

Outcome: By June 30, 2023, revamp the appendix by forming a team of key stakeholders (marketing, IT, EPMO) to identify and implement top three priority improvements.

Status: Complete

Additional Comments: None

Goal 2: Increase utilization of Colorado Access telehealth program.

Outcome A: By June 30, 2023, increase utilization of this service through increased internal trainings and process improvements to increase efficiency and follow-up.

Status: Ongoing

Additional Comments: COA has experienced a decrease in telehealth utilization in the past year. Details about this decrease in utilization are included in the narrative.

Outcome B: By June 30, 2023, expand the VCCI program to include additional primary care practices, and to continue to explore opportunities to partner with entities like The Delores Project, where telehealth can be used to increase access to behavioral health services for the Colorado Access member population.

Status: Ongoing

Additional Comments: None

Goal 3: Partner with Signal Behavioral Health Network (Signal) to coordinate services for members.

Outcome A: By December 31, 2022, develop a process for identifying adolescent members utilizing the iMatter program. (not started, not a high priority)

Status: Shift in priority

Additional Comments: This measure was de-prioritized for other more valuable work. This is no longer a current area of focus.

Outcome B: By June 30, 2023, develop joint partnerships with Signal and specific SUD providers to better ensure members have treatment and recovery needs met. (ongoing collaboration, no additional partnership beyond what we have been doing, we have scaled back a bit on this this year)

Status: Complete

Additional Comments: This work is ongoing. COA continues to collaborate with Signal regularly on SUD, crisis, and BHA related work.

Goal 4: Continue efforts to diversify the behavioral health pipeline.

Outcome: by June 30, 2023, establish a partnership with at least one other college or university in Colorado including but not limited to the University of Denver, Regis University and University of Colorado Denver. (Focused on partnership with MSU, not sure of intentions to expand to other universities, focusing on connections with providers through MSU before potentially expanding in the future)

Status: Ongoing

Additional Comments: This work is ongoing. COA is focused on its partnership with MSU and connections with providers through MSU before potentially expanding to other universities in the future.

Practice Support & Transformation Goals:

Goal 1: Enhance value-based payment implementation across provider network.

Outcome A: Develop standardized toolkit for value-based payment implementation.

Status: Complete

Additional Comments: None

Outcome B: By March 30, 2023, toolkit is being updated quarterly based on team and provider feedback.

Status: Complete

Additional Comments: None

Goal 2: Increase behavioral health engagement by focusing on depression screenings conducted in primary care settings.

Outcome A: By September 30, 2022, develop a depression screening workflow.

Status: Complete

Additional Comments: None

Outcome B: By December 31, 2022, develop a list of members without a behavioral health screen during calendar years 2020 and 2021.

Status: Complete

Additional Comments: None

Outcome C: By June 30, 2023, PCMPs will be trained on proper billing for depression screening services using the allowable service codes in the Department's BHE KPI model.

Status: Complete

Additional Comments: None

Communication Goals:

Goal 1: Enhance communication to the provider network.

Outcome A: By September 30, 2022, Colorado Access will restructure *Navigator* to feature important topics identified by Colorado Access and the Department that providers must know to ensure successful partnerships.

Status: Complete

Additional Comments: The Monthly Navigator is now called the Monthly Provider Update. It includes information for providers around COA operations, Department updates and other topics they need to know in order to be successful as a partner. Click and open rates are tracked each month to understand its success.

Outcome B: By December 30, 2022, Colorado Access will hire 1.0 FTE to support provider communication activities.

Status: Complete

Additional Comments: None

Goal 2: Promote ongoing partnerships between Colorado Access and its providers.

Outcome: By December 30, 2022, Colorado Access will launch a quarterly provider communication to highlight innovative partnerships, programs, and initiatives within the vast provider network.

Status: Complete

Additional Comments: The COA quarterly navigator is up and running. COA has pushed out three newsletters that cover partnership topics related to DEI, SDoH and program successes.

Health Neighborhood and Community Engagement Goals:

Goal 1: Colorado Access, leveraging HTP and provider contracts, will receive SDoH data at the member level.

Outcome A: By June 30, 2023, Colorado Access will engage providers in contract discussions around data sharing of SDoH data.

Status: Complete

Additional Comments: None

Outcome B: By June 30, 2023, Colorado Access will partner with hospitals and Contexture (formerly CORHIO) in determining a mechanism to receive member-level SDoH data after hospital screening.

Status: Complete

Additional Comments: None

Goal 2: Develop process to integrate member health programming (i.e., digital engagement, direct mail, care coordination) with relevant performance metrics to incentivize provider network support in delivering relevant services and care to members.

Outcome A: By December 30, 2022, develop tool to map health programming interventions to performance metrics.

Status: Complete

Additional Comments: None

Outcome B: By March 30, 2023, develop communication tool about member health programs to share with the provider network on a regular basis through e-communications like the Navigator.

Status: Complete

Additional Comments: None

Outcome C: By June 30, 2023, integrate provider network programming and communications into program design process

Status: Complete

Additional Comments: None

Goal 3: Increase the use of in-reach services for members in DOC.

Outcome: By December 31, 2022, operationalize targeted in-reach services for members in DOC through provider partnerships (Servicios de la Raza, Ascent, and Tribe Recovery Services)

Status: Complete

Additional Comments: This work is ongoing. Partnerships are strong and continue to develop.

Goal 4: Increase access to culturally responsive and relevant resources for Black Health First Colorado birthing families in Region 3 through community partnerships.

Outcome A: By January 30, 2023 launch a project to create a community-owned online hub village where Colorado Black birthing families can find resources on medical/behavioral health professionals and community resources, as well as engage in online classes and support groups.

Status: Shift in priority

Additional Comments: COA is working with partners to assess the best way to support this work from a systems-level.

Outcome B: By June 30, 2023, the online platform created with branding for beta testing with community focus groups.

Status: Shift in priority

Additional Comments: COA is working with partners to assess the best way to support this work from a systems-level.