Value Based Payments Legislative Report

Pertaining to Calendar Year 2023

Date 11/01/2024

Submitted to: The Joint Budget Committee and Joint Health Committees

COLORADO
Department of Health Care Policy & Financing

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I. Introduction

Value-based payment programs reward providers for improving the value of health care by increasing cost effectiveness or improving patient outcomes and equity. The Centers for Medicare and Medicaid Services (CMS) aim to have most Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care by 2030.[1] The Colorado Department of Health Care Policy and Financing (the Department) aims to tie 50% of Medicaid payments to value based arrangements by 2025 to support its mission to improve health care equity, access and outcomes for Health First Colorado members while saving Coloradans money on health care.[2]

In calendar year 2023, CMS projected that the national health expenditure has grown 7.5%, and the Medicaid program is the second-largest consumer of General Fund.[3] As health care costs continue to rise, it is increasingly important to improve the value of care the Department provides its members and to curb the growth of expenditures in the Medicaid program. Rising expenditures for health-related services require additional General Fund appropriations to the Department, and these rising expenditures jeopardize funding for other programs in Colorado.

Section 25.5-4-401.2, C.R.S. requires the Department to submit an annual report "…describing rules adopted by the state board and contract provisions approved by CMS in the preceding calendar year that authorize payments to providers based on performance." This statute requires that the Department include:

- A description of performance-based payments included in state board rules, including which performance standards are targeted with each performance-based payment;
- A description of the goals and objectives of the performance-based payments, and how those goals and objectives align with other quality improvement initiatives;
- A summary of the research-based evidence for the performance-based payments, to the extent such evidence is available;
- A summary of the anticipated impact and clinical and nonclinical outcomes of implementing the performance-based payments;
- A description of how the impact or outcomes will be evaluated;
- An explanation of steps taken by the state department to limit the administrative burden on providers;

[1] https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper

[2] https://hcpf.colorado.gov/value-based-payments

[3] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

- A summary of the stakeholder engagement process with respect to each performance-based payment, including major concerns raised through the stakeholder process and how those concerns were remediated;
- When available, evaluation results for performance-based payments that were implemented in prior years; and
- A description of proposed modifications to current performance-based payments.

This report features six value-based payment models pursuant to section 25.5-4-401.2, C.R.S. Unless otherwise specified, details of the Department's value-based payment pertain to work completed in calendar year 2023. The six programs highlighted in this report include:

1. **Alternative Payment Model 1 (APM 1):** a primary care value-based payment that evaluates provider performance and improvement on electronic clinical quality measures (eCQMs), administrative, and structural quality metrics. Providers in APM 1 can earn an increase to their fee schedule payment for meeting quality goals and have their payments reduced if they do not meet the quality goals.
2. **Alternative Payment Model 2 (APM 2):** a two-track program including a per member per month (PMPM) prospective payment, and a shared savings incentive payment for successful management of 12 high-cost chronic conditions. APM 2 shares the APM 1's quality model.
3. **Payment Alternatives for Colorado Kids (PACK):** a subprogram of APM 2 tailored to the distinct needs of the pediatric population.
4. **Prescriber Tool Alternative Payment Model:** a shared savings model for prescribers utilizing a Real Time Benefit Inquiry module to make prescription therapy more cost-effective.
5. **Maternity Bundled Payment:** a shared-saving payment model that covers the entire perinatal period for pregnant and birthing people.
6. **Essential and Comprehensive Safety Net Behavioral Health Provider Alternative Payment Model:** a behavioral health value-based payment that uses quality measures for safety net provider accountability and a prospective payment system for reimbursement.

Not included in this report are the Accountable Care Collaborative (ACC) pay-for-performance programs, skilled nursing facility pay-for-performance programs, and the Hospital Transformation Program (HTP), which can be found in their respective annual legislative reports located on the Department's website.

The Department's broad adoption of value-based payments has constructed a clear path for improving member health, increasing affordability, and closing the health disparity gap. In addition to the programs discussed in this report, the Department is partnering with subject matter experts and stakeholders to initiate value-based

payment programs in key areas such as Colorado Providers of Distinction, dental care, and the Program of All-inclusive Care for the Elderly (PACE). These programs will be included in future reports when they are authorized by the General Assembly and meet the reporting requirements of section 25.5-4-401.2, C.R.S.

II. Primary Care Alternative Payment Models

a. Introduction – Accountable Care Collaborative

The Department is proposing substantial revisions to its primary care value-based payment framework as part of its November 1, 2024 decision item for Phase III of the Accountable Care Collaborative. These modifications will streamline current value-based payments to create more value and reduce administrative burden on providers through alignment of measurement and payments to measure and pay only once. These changes are supported by the APM 2 and PACK design and stakeholder feedback process, stakeholders voiced the need for simplification of Department systems and operations. Primary care providers currently have opportunities to participate and receive quality-based payments through the ACC and through the Department's Alternative Payment Models for Primary Care (APM 1, APM 2, and upcoming PACK). This structure has created confusion for providers and has resulted in multiple, duplicative approaches to measuring and paying a provider for achieving quality targets.

In the ACC Phase 3 Decision Item submitted to the Joint Budget Committee on November 1st, 2024, the Department is proposing modifications to integrate aspects of current Alternative Payment Models with the ACC under a comprehensive primary care payment framework, where the Department is measuring and paying for quality once to reduce administrative burden for providers. The Department will continue to pay primary care providers directly for the delivery of Medicaid covered services, while the Regional Accountable Entities (RAEs) will pay primary care providers all payments not directly tied to the delivery of Medicaid covered services, such as payments for achieving quality performance targets.

These modifications will effectively fold APM 1, the Chronic Conditions Shared Savings component of APM 2, the upcoming PACK model, and ACC Quality Payments into one aligned quality and incentive payment program. The proposed model also contains updated payment strategies to support pediatricians, small clinics, and rural providers to ensure continued access for members. These changes directly address stakeholder concerns regarding the administrative burden of current model designs, and lack of design considerations for specific provider types. APM 2 prospective PMPM payments are reimbursement for the delivery of services and will continue to be paid by the Department.

b. Alternative Payment Model 1

The Department's first program emphasizing value over volume, Alternative Payment Model 1 modifies traditional fee-for-service (FFS) to reward improved quality of care while containing costs for Primary Care Medical Providers (PCMPs). APM 1 was created

due to increasing need for sustainability and affordability in Medicaid. The Department continues to collaborate with stakeholders to ensure program success and close alignment with payment reforms across the delivery system. Health First Colorado providers with 500+ attributed members are automatically enrolled into APM 1.

The Department, in direct and continuous partnership with stakeholders, has advanced three goals for the APM:

1. Investment in primary care to promote sustainability and long-term value
2. Flexibly reward performance, outcome accountability, and access to care
3. Align with other payment reforms across the delivery system

These goals align with the next phase of the Department's Accountable Care Collaborative (ACC) and support the Department's foundational principles of strengthening and transforming care.

APM 1 is designed to improve member outcomes, introduce outcome accountability, and reward PCMPs for quality care. PCMPs are rewarded for meeting a quality threshold by earning points for performing well or improving on quality measures. Providers who reach the threshold receive an enhancement to their FFS rates. Foregone enhancements earmarked for providers who fail to meet the quality threshold are redistributed to successful providers. Points are earned through achieving standards of the APM 1 Measure Set, which is subdivided into structural measures, administrative measures, and electronic clinical quality measures (eCQMs). All APM 1 measures incentivize mutually beneficial clinical and non-clinical outcomes that promote better service and access for Health First Colorado members. Measure selection minimizes administrative burden by offering primary care practices the flexibility to tailor reporting to their needs.

In 2023, Program Year 2022 quality score results were calculated for the 318 non-Federally Qualified Health Center (FQHC) locations and 20 FQHC locations. 278 (87%) non-FQHC locations achieved the quality score threshold. The remaining 40 practices (13%) were subject to rate decreases, averaging –0.84% which paid on average 99.16% of FFS. All 20 FQHC locations achieved the quality threshold, so there were no negative rate adjustments. In Program Year 2023, all 20 FQHC locations again achieved the quality threshold. Program Year 2023 results for non-FQHCs are not yet available and will be included in next year's report.

The Department continued its annual program year update process with stakeholder engagement in the fall of 2023 to prepare for Program Year 2024. This included several listening sessions seeking stakeholder feedback on the impacts of utilizing only Medicaid data for eCQMs versus all-payer data.

APM 1 participants were also given the opportunity to participate in Key Informant Interviews and other stakeholder work done to evaluate the Department's primary care APMs. Stakeholder engagement and provider feedback on the Program Year 2024 Medicaid-only eCQM reporting requirement was met with some stakeholder concern for provider groups who struggle working with their EHRs to report data specific to

Medicaid members. To address provider concerns the Department worked on expanding training provided by the RAE practice facilitators to support practices in reaching these reporting requirements by the Program Year 2024 quality data reporting period.

Practices began reporting measures this way in 2023 to set baselines for Program Year 2024, where PCMPs who choose to report an eCQM must have the capability to report Medicaid-only data.

While scores are not yet available, the Program Year 2023 data and Program Year 2024 baseline data submitted by participating PCMPs shows an increase in providers reporting Medicaid-only eCQM data. The Department will assess the Medicaid-only data that PCMPs report to gain greater insight on the quality of care given to Medicaid members.

c. Alternative Payment Model 2

APM 2 is a voluntary payment model launched in 2022 and builds upon the existing quality framework of the APM 1 model. The goal of the APM 2 model is to give PCMPs revenue stability and flexibility so that they can provide additional support in managing members' health and improving care outcomes while reducing disparities. To achieve these goals, participating providers in APM 2 receive fee-for-service payments, partial capitation payments, and incentive payments.[4]

Per member per month (PMPM) payments are paid upfront with a calculated rate to participating providers for eligible attributed members, each month. PMPMs replace part or all a PCMP's utilization based (FFS) revenue. This work aligns with evidence-based recommendations from the National Academy of Sciences, which suggested that hybrid payment methodologies such as this are a mechanism that supports high-quality primary care.[5] PCMPs choose what portion of their expected revenue to receive upfront (up to 100%) to provide stable and consistent revenue. Prospective payments provide flexibility and opportunities for investment in forms of care not tied to specific visits, like outreach and care coordination, which aren't reimbursable with traditional fee-for-service. Participation in the PMPM is risk-free for the first year of enrollment, which means the Department guarantees participating providers will be paid no less than they otherwise would if they didn't participate in the program, and the provider can keep the difference in payment if the total PMPM is higher than the total shadow billed FFS amount. In subsequent years of participation, reconciliation is tied to a practice's APM 1 quality score. This means if providers fail to meet the APM 1 quality metric, they are not guaranteed to be paid what they otherwise would if they didn't participate in the program if the reconciliation finds the PMPM payment

[4] https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Guidebook%202023.pdf

[5] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

was higher than FFS. Additionally, if the total PMPM payment was higher than their shadow billed FFS payment, the Department would recoup the difference.

Shared savings incentive payments reward providers for cost-effective chronic condition management. Savings above a 2% threshold of average historical cost are split evenly with providers and the Department. Participation is upside risk only for the incentive payments, which means that if costs exceed the historical average providers are not at risk for any over expenditure. To be eligible to retain any shared savings providers must meet the APM 1 quality threshold.

There is a distinct APM 2 program specifically for FQHCs to comply with federally mandated FQHC reimbursement requirements. Federal law requires that FQHCs receive a rate that is at equal to or higher than their calculated Prospective Payment System, a national rate adjusted by location. Any alternative payment models available to FQHCs must adhere to this requirement. FQHCs may still receive a PMPM, although they must participate at 100% PMPM as opposed to the non-FQHC track, which allows participants to elect any percentage between 0-100%. FQHCs may also participate in the shared savings incentive payment portion of the program.

In 2023, the Department reconciled PMPMs to fee-for-service for Program Year 2022. Eight practices took some level of PMPM in Program Year 2022, the lowest at 5% and most practices electing 100% PMPM. For all practices, the PMPM for the year was higher than the cost of shadow billed FFS claims for the relevant members and months by a total of $1.5 million across all participants. Thus, no practices were underpaid in APM 2, and no upwards reconciliation was required. Because APM 2 features risk-free participation for the first program year, no practices were at risk for their PMPM payments during the reconciliation conducted in 2023 and the amount of PMPM spent above the shadow-billed fee-for-service won't be recouped. This overpayment was caused by how the prospective payment rates were set. Payment rates were set using base data from 2019 and 2022. The Department had estimated that Medicaid member primary care utilization would begin to return to pre-COVID utilization over time. This did not occur during the 2023 performance period and the inclusion of pre-COVID data in rate setting caused the rates paid to participants to be too high. To overcome this the Department stopped using pre-pandemic data in the 2024 rate setting cycle and began reducing provider rates to maintain budget neutrality.

FQHCs who participated in the PMPM beginning July 1, 2022, were evaluated and determined to have received more through APM 2 than compared to their PPS rates, in accordance with the federal requirements for FQHC APMs. However, the comparison between PMPM payments and the fee-for-service equivalent of APM 1 encounter rates (also an authorized APM that pays higher than PPS) showed that APM 2 FQHC PMPMs exceed the equivalent payments at the APM 1 encounter rate. Like the non-FQHC track, this was also brought on by the use of pre-COVID data, which did not reflect actual utilization in the performance period. As the Department only has authority to pay the APM 1 encounter rate, PMPM rates now utilize an updated trend to control the PMPM rates' increases over time and maintain budget neutrality.

Fourteen practices participated in the chronic condition shared savings payment, including all 8 that participated in the PMPM. Two achieved the minimum savings rate

of 2%, earning incentive payments totaling $105,865 (50% of the total savings). Savings were generated by successful practices reducing avoidable events such as a patient going to the emergency room rather than to their primary care doctor.

Beginning July 1, 2023, the funds from the Department's FY 2023-24 R-6 budget request, "Supporting PCMP Transition with Value Based Payments" went into effect. As outlined in R-6, this included a 16% rate increase to the PMPM for participants who elect more than 25% of their revenue to be prospectively paid. Participants who elect less than 25% received a prorated amount. Practices already participating in the model automatically received the rate increase corresponding to their participation level, and an additional 6 groups (some representing multiple locations) joined the model with some level of PMPM on July 1. Several other practices joined APM 2 the subsequent enrollment date, October 1st, 2023. 2023 was also the first year that FQHCs could participate in the shared savings incentive payments. Results will be calculated in 2024. The increase in enrollment in 2023 allowed the Department to achieve its FY 2023-24 Wildly Important Goal of increasing APM 2 participation by early 2024.

At the end of 2023, the Department began a robust evaluation process to support model improvement and redesign. This included more than 40 Key Informant Interviews with Department subject matter experts, a diverse group of PCMPs (participating, interested, and not interested), members and advocacy organizations. These interviews were used to form an early evaluation framework of APM 2 and recruit participants for a Design Review Team (DRT) stakeholder process, encompassing 11 2-hour work sessions to begin in early 2024. In addition to the robust reconciliation analyses and work described above, the Department also began to evaluate key design elements and build recommendations for a refreshed model better aligned with Phase 3 of the ACC and other Department initiatives. Feedback from the stakeholder work conducted in 2023 included key themes surrounding a lack of clear, member-centric goals as well as the absence of consistently available data to inform performance improvement efforts. The administrative burden of current model design and minimal considerations for certain subpopulations of PCMPs, including small, rural, and pediatric clinics were also recurring themes from this period of stakeholder engagement. These themes would resurface in the 2024 DRT process, along with insightful ideas the Department is taking into consideration for implementation in coming program years. The Department will include the stakeholder feedback gathered in 2024 in next year's legislative report.

d. Payment Alternative for Colorado Kids

The Department is developing Payment Alternatives for Colorado Kids (PACK) APM in response to stakeholder feedback that APM 2 is not tailored to the provision of pediatric primary care. PACK will operate alongside APM 2 and is expected to launch July 2025 with pediatric-specific incentives rewarding wellness care, immunizations, screenings, care coordination, and integrated care as part of ACC Phase 3.

The Joint Budget Committee approved the Department's FY 2022-23 budget request R-6 "Value-Based Payments," authorizing the Department to begin creating a

pediatric-specific APM in partnership with pediatric primary care stakeholders and a contracted vendor. The contract with the vendor began in the fall of 2023. The Department then began its pre-design research phase to plan a stakeholder-driven model design process for 2024 which will be detailed in next year's legislative report. The Department co-facilitated two focus groups and 17 key-informant interviews with providers, provider associations, advocates, and parents/guardians of members to inform a framework and theory of change for the stakeholder driven design review process and internal model design discussions. Pediatric stakeholders expressed support for a payment model specific to children and there was consensus for the Department's creation of this program.

2024 is an important year for PACK's development following stakeholder input on foundational program policy. Like APM 2's approach, PACK used key informant interviews to establish a suite of program goals and a model design framework including quality measurement, payment, performance improvement, and program sustainability. Planning for these sessions involved developing a syllabus and facilitation curriculum for 11 two-hour design review team sessions in 2024. The Department recruited 21 stakeholders to serve as design review team participants, representing a diverse cross-section of the stakeholder community, like that of the key informant interviews. Following stakeholder engagement in 2024, the Department will plan implementation and operations, ensuring alignment with other value-based payment initiatives and youth-focused programs that recognize the importance of specially designed measures, policies, payments, and priorities unique to children.

III. Prescriber Tool Alternative Payment Model

The Prescriber Tool Alternative Payment Model (APM) launched on October 1, 2023 to include providers in the drug cost affordability solution. As a leading contributor of rising health care expenditure, management of prescription drug utilization is a top priority for Colorado.[6] The program incentivizes Preferred Drug List compliance through use of the Prescriber Tool.

The Prescriber Tool is a versatile platform accessible to prescribers through most electronic health record (EHR) systems consisting of four modules: electronic prescribing (eRx), electronic prior authorization (ePA), real-time benefits inquiry (RTBI), and an opioid misuse risk module.[7] With these resources, providers can make rapid and transparent decisions with ease and enabling providers to select the most cost-effective drugs.

The Prescriber Tool APM has three main goals: expand prescription drug affordability, reduce administrative burden for prescribers, and improve patient health outcomes and service. Operational goals for Program Year 1 (10/1/2023 – 6/30/2024) sought

6 https://hcpf.colorado.gov/sites/hcpf/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20Second%20Edition.pdf

7 https://hcpf.colorado.gov/prescriber-tool-alternative-payment-model

increased awareness and uptake in use of the RTBI module by rewarding providers for engaging with the Department's data validation efforts and prescribing preferred medications.

To accomplish this, the Department provided RTBI use and PDL compliance data with eligible providers and sought feedback on accuracy. The Department required practices to complete a training module and a survey. The 855 practices that completed these requirements earned a shared savings incentive based on savings attributable to usage of the Prescriber Tool. As these activities and payment were made in 2024, more detail on Program Year 1 success will be included in next year's report.

The Department established these goals and program design following a soft launch including 223 practices in early 2023. In this soft launch, the department shared RTBI use information with the group via dashboard. One large hospital system representing many practices reviewed the data shared with them and shared concerns the data may be inaccurate. In their experience, the tool was triggering automatically 100% of the time, but the Department's data showed much lower use.

This triggered department research into the Prescriber Tool data and reports, where the Department worked with its pharmacy benefit manager and their subcontractor, and EHR vendors. Due to large variance in tool configuration across EHRs and their various versions, the Department was unable to completely resolve the issue. Program Year 1 design was a continuation of this research, where the Department sought feedback on the accuracy of the data validity. The outcome was inconclusive, and the Department continues to research ways to improve data collection of provider utilization.

IV. Maternity Bundled Payment Program

The Maternity Bundled Payment program is an episode-based payment program that targets the two leading causes of maternal morbidity and mortality in Colorado: mental health conditions and substance use disorders.[8] This program addresses health disparities, service quality, and continuity of care for pregnant and birthing members and their newborns by paying participating obstetrical providers for outcomes and costs rather than services.[9]

The Maternity Bundled Payment program covers all prenatal care, care related to labor and delivery, and postpartum care for Health First Colorado pregnant and postpartum parents. Obstetric care providers who deliver the baby and provide prenatal services or who provide prenatal services (but do not deliver the baby) can join the program.

The Department rewards participating providers through shared savings earned from meeting practice-specific episodic cost thresholds. Actual episode cost is reconciled

[8] https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view

[9] https://hcpf.colorado.gov/bundled-payments

retrospectively against the threshold. After the first year of participation, providers must also meet quality metric performance goals to earn the incentive shared savings payment. To maximize provider enrollment, the Department will not withhold or recoup any payments if the provider did not generate any savings.

The Maternity Bundled Payment program concluded its third year of operation in October 2023 with nine obstetrical practices enrolled, representing approximately 30% of Health First Colorado births in the state. Results from program year three will be available in late calendar year 2024. In the prior program year (ended October 2022), 7 of the 8 participating providers generated $4.1 million in total savings, of which $1.75 million was paid to providers, with reductions made pro rata to the providers that did not meet all of their quality goals. Savings resulted from greater use of delivery facilities with lower base rate, change in delivery mix to more vaginal deliveries and migration to lower cost genetic testing. Of the 3 providers subject to quality goals, passing rates ranged from 40 to 60 percent, with all 3 reducing their rate of Newborn Complications, 2 of the 3 reducing their Low Birth Weight percentage, 1 of the 3 improving their Contraceptive Care, and 1 of the 3 reducing their rate of Severe Maternal Morbidity. None of the 3 improved their level of Depression Screening (results are under review by Providers and may change due to appeals based on data issues).

The Department is redesigning the maternity APM In response to stakeholder feedback to improve health outcomes and close health disparities. To do so, the Department has planned Design Review Teams that include providers, administrators, advocacy groups, and Health First Colorado (Medicaid) members that began convening in 2024.

The Department will respond to stakeholder feedback on investments in care delivery, member choice and experience, and flexibility to provide patient-centered care. The Department will also align with Department policies including the doula benefit and extended postpartum coverage that have been developed to support equity in access, outcomes, and experience.

V. Essential and Comprehensive Safety Net Behavioral Health Provider Alternative Payment Program

Pursuant to HB 22-1278, the Department, in collaboration with the Behavioral Health Administration (BHA), developed and implemented cost informed APMs for Essential and Comprehensive Safety Net Behavioral Health Providers. These APMs introduce greater accountability to the community to increase member access to inclusive services. The Department is directing RAEs to pay safety net providers using the Department-developed APMs. As of July 1, 2024, RAEs must reimburse Essential Safety Net (Essential) providers, at a minimum, according to a cost-informed Essential Provider Fee Schedule[10]; this fee schedule is based on historical reimbursement for services that are now defined by the BHA as Essential Safety Net Services in program regulations at section 2 CCR 502-1-12.4.

[10] https://hcpf.colorado.gov/sites/hcpf/files/July%202024%20SBHS%20Billing%20Manual.pdf

As of July 1, 2024, Comprehensive Safety Net (Comprehensive) Providers are reimbursed under a prospective payment system (PPS) methodology[11]; a PPS is a flexible, advanced reimbursement model that ties payment to daily encounters instead of to individual services. This means that a provider will receive an encounter payment for each patient they see in a day, and the payment is the same regardless of which services are provided so long as the services are covered by the PPS rate. The PPS is provider specific, as it is based on each Comprehensive provider's actual costs, including the cost of serving people who are uninsured or underinsured. The PPS provides flexible, sustainable and predictable funding. In addition to requiring RAEs to reimburse Comprehensive Providers at their PPS rate, they must also offer the Comprehensive providers in their Region a VBP arrangement for meeting measurable outcomes that improve member access to quality care.

Starting in the spring of 2020 through implementation, the Department has convened a broad group of cross-sector collaborators including safety net providers, RAEs, independent consultants, and advocates who met and collaborated on the design of the Comprehensive Provider PPS APM. Stakeholder engagement processes gave way to various planning considerations undertaken by the Department such as accommodating provider variation and a need for payment stability while minimizing administrative complexity. The Department and the BHA engaged in a multi-pronged effort to provide education, training, and technical assistance to providers and other stakeholders on behavioral health safety net system updates. The Department launched a Safety Net Provider site, which features resources and support for behavioral health providers[12]; this includes opportunities to engage, training announcements, training materials, frequently asked questions, and access to additional resources.

VI. Conclusion

The Department's market-leading shift to value-based payments is a key strategy to improve member outcomes, close health disparities, and increase affordability. Stakeholders are fundamental to these programs' success and to achieving these goals – the Department ensures providers have the tools and resources needed to meet this critical mission.

[11] https://hcpf.colorado.gov/sites/hcpf/files/BH%20Prospective%20Payment%20Fact%20Sheet.pdf

[12] https://hcpf.colorado.gov/safetynetproviders