Colorado Health Policy Coalition

COMPILED COMMENTS ON THE ACC 3.0 DRAFT CONTRACT

The Colorado Health Policy Coalition (CHPC) is a cross-sector coalition of 90 health-related organizations engaged in health policy and united to advance health equity in our state. We thank the Colorado Department of Health Care Policy and Financing (HCPF) for your ongoing partnership in developing the third iteration of the Accountable Care Collaborative or ACC 3.0. We know you are busy and hard-working public servants, and we thank you for joining us multiple times during the development of ACC 3.0 to hear our feedback. As our November 20 letter stated, we appreciate many aspects of 3.0, and the draft contract did not disappoint. We want to express our gratitude for your responsiveness to our policy recommendations. As with any initiative of this magnitude, we will always have additional suggestions for your consideration. We have identified the opportunities below to strengthen the draft contract and advance health equity in our state.

1. Ensure RAEs are Not Too Big to Fail

With the consolidation of regions and the significant expansion in scope in ACC 3.0, we are concerned that contractors will need help to meet contract requirements. We appreciate the enhanced expectations around care coordination, the standardized child benefit, and addressing health-related social needs; however, we recommend additional safeguards to ensure fidelity to the contract:

- Limit awards to one region per Offeror.
- Make RAE reports, such as the network adequacy and population health management report, publicly available and easily accessible.
- Add performance standards for access to care, preventive care, or health equity. The CHPC would be happy to work with you to develop these standards.
- Add attestation requirements to ensure contract requirements are met and corrective actions, including financial penalties, for specific contract violations.
- Add contract management staff at HCPF to increase oversight of RAEs.

2. Improve the Medicaid Application and Renewal Process

The unwind of the COVID-19 continuous coverage provision has laid bare the problems with our Medicaid application and renewal process. Month after month, upwards of 40% of Members are disenrolled from Medicaid and CHP+ for procedural reasons, not because they are ineligible for public health coverage. The simultaneous rise in uncompensated care at our clinics and hospitals signals that these individuals are not receiving health coverage elsewhere and will need support re-enrolling in Medicaid and CHP+. Local Public Health Agencies (LPHAs), community-based organizations (CBOs), and health care providers who are trusted entities and have established patient relationships should be leveraged in the

application and eligibility renewal process. Given the capacity problems at the counties and the challenges with the application and renewal process, we urge HCPF to act now to:

a. Expand its network of presumptive eligibility sites and the populations that can be presumed eligible upon application, as allowed by federal law and previously permitted by HCPF.

b. Permit RAEs to assist enrollees in completing and submitting Medicaid renewal forms, as CMS allows.[1]

c. Require RAEs to examine and report to HCPF how they can increase counties' capacity to process eligibility and renewal applications.

d. Require RAEs to provide or fund a minimum of staff at LPHAs, local CBOs or clinics that offer enrollment and renewal assistance for RAE members.

e. Establish a contractual performance standard that requires RAEs to increase the rate of appropriate Medicaid eligibility renewals in their region by X% each year.

f. Establish an incentive for hospitals to enroll eligible newborns in Medicaid at birth.

g. Add a permanent line item to HCPF's budget to support LPHAs and CBOs in helping members with Health First Colorado applications and eligibility renewals.

We would like to understand the size of our uninsured problem. We urge HCPF to work with the All Payers Claims Database, Department of Insurance, and Connect for Health Colorado to determine the health coverage status of those disenrolled from Medicaid and CHP+.

We urge HCPF to establish a workgroup to reform the Medicaid application and renewal process. We are happy to bring ideas and evidence-based practices from other states. We recommend a joint effort between HCPF officials and subject matter experts, community healthcare providers, consumer advocates, and Members.

3. Bolster Prevention and Access to Care

Access to care—primarily preventive, primary, behavioral health, and dental care—reduces chronic conditions and avoidable costs, especially among the 25% of Medicaid Members who do not access any care. Please make primary care primary in our ACC program. Member engagement should start with removing barriers to care and connecting members to preventive care immediately. Value access and prevention in HCPF and RAE value-based payment approaches. Integrate prevention into population health management and care coordination efforts. The quality strategy and Cost Collaborative should prioritize prevention and access to care as much as managing chronic conditions. Below, we've provided contract edits to accomplish these recommendations.

> Page 19, In addition to identifying emerging chronic conditions or emerging health risks, the Health Needs Survey should also identify opportunities to connect members with preventive primary, behavioral, and dental care.
>
> Also, on Page 19, health promotion efforts should start with health literacy efforts to ensure Members understand and can access their benefits. All Members should be

[1] https://www.medicaid.gov/sites/default/files/2023-06/state-strategies-to-prevent-procedural-terminations.pdf

connected with preventive primary care, behavioral health, and dental care, all of which can help prevent the chronic conditions identified as focus areas in section 3.6.

Page 55, can you explain the rationale for the shift from “population *health* management” to “population management.”

7.1.1.2 Contractor shall implement population health management strategies that *connect members to preventive care services that avoid and reduce the effects of disease*

7.1.1.5. Contractor shall have a comprehensive approach to population health management that uses data to stratify the population and offers a range of interventions to support

> Members, with a particular focus on *connecting Members to preventive primary, behavioral health, and dental care;*
>
> Members with chronic conditions, co-occurring conditions, and complex health and health-related social needs.

7.2.1.4. Contractor’s population health management activities shall include, but not be limited to, the following:

“Connecting Members to U.S. Preventive Service Task Force A & B Recommended Services”

7.3. Care Coordination Program Requirements

7.3.1.6. Focuses on prevention, *including connecting Members to U.S. Preventive Service Task Force A & B Recommended Services.*

7.3.3. Contractor shall implement a Care Coordination Program that includes at a minimum, but is not limited to, the following activities:

> *Connecting Members to U.S. Preventive Service Task Force A & B Recommended Services.*

7.3.4.1. Preventive health promotion shall include:

> *Connecting Members to U.S. Preventive Service Task Force A & B Recommended Services.*

7.3.5.3.1. Contractor’s prevention tier shall offer, at a minimum, the following Care Coordination activities:

> *Connecting Members to U.S. Preventive Service Task Force A & B Recommended Services.*

Add a deliverable requiring RAEs to report on prevention efforts like the deliverables for condition management and the complex health management reports.

We appreciate that the quality strategy will include preventive health metrics; however, performance standards require an upfront investment. The draft contract has many performance standards related to acutely ill members and cost savings but only one

performance standard related to prevention (EPSDT). We urge HCPF **to add a performance standard requiring at least XX % of Members to receive a preventive service each year of the contract.**

Pages 81 & 91, under practice transformation activities, insert “Working with Network Providers to increase equitable access to preventive primary, behavioral health, and dental care.”

Page 86, under VBP education activities, insert “strategies to increase equitable access to care, including preventive primary, behavioral health, and dental care.”

Page 95, clarify that the RAEs PCMP Payment Program shall “increase equitable access to *preventive primary, behavioral health and dental care.”*

Page 97, under RAE Pay for Performance Programs, “equitable access to preventive primary, behavioral health, and dental care” should be an activity for which providers can receive incentive payments.

Page 153, “**Ensuring equitable health outcomes for all enrollees**.” should be a goal of the ACC and a Guiding Principle of the “Outcomes, Quality Assessment, and Performance Improvement Program”

Page 153, a Guiding Principle of the Outcomes, Quality Assessment, and Performance Improvement Program should be “increasing equitable access to preventive primary, behavioral health, and dental care.”

Page 166, a fundamental goal of the Cost Collaborative should be to “increase equitable access to preventive primary, behavioral health, and dental care.” To support the Cost Collaborative, RAEs should identify opportunities to connect members with preventive health care that prevents unnecessary and avoidable costs.

4. Prioritize Health Equity & Improve Outcomes in the Proposal Scoring Process

Finally, we have recommendations regarding the offeror's questions and scoring process. Thank you for soliciting our feedback on this part of the RFP process; our recommendations are critical to ensuring ACC 3.0 increases access to care, improves health outcomes, and advances health equity statewide.

- Offerors should demonstrate how they will accomplish the core functions of a Medicaid delivery system, such as those measured by the CMS core metrics, including access to care, preventive services, reduction of chronic conditions, ED, and hospital follow-up.
- Offerors should demonstrate how they will work with counties to help families apply for all eligible public benefits and support them through the application and renewal processes.
- Offerors should demonstrate how they will meet core public and population health needs, as determined by the communities in the region, including access to medical home services, usable and responsive care coordination, and member-centered programming.
- For each community in their proposed region, Offerors should submit a community-specific plan outlining existing health disparities and how they will be addressed in

partnership with Medicaid members, who will be empowered in ways relevant to each community plan.

- Offerors should demonstrate their commitment to meeting the local needs of communities throughout that region. Proposals should include concrete methods of ensuring responsiveness and accountability to members, providers, and community-based organizations. Proposals with letters of support from these stakeholders should be scored higher.
- Offerors should describe how they will ensure Medicaid members know where to go to access their benefits. For each community in their proposed region, Offerors must submit a community-specific plan outlining existing relationships between health care providers and community-based organizations. Offerors must also outline their plan for supporting and strengthening those existing relationships and building new ones, including specific outreach and partnership goals and strategies. The partnerships outlined in the plans cannot be one-sided; they must be accompanied by letters of support from local partners.
- Offerors should share their Network Adequacy plans and indicate how they will increase access to multilingual and multicultural providers and providers with staff with the same life experiences, backgrounds, and language fluency as the community being served.
- Proposals should be scored higher when Offerors commit to employing Medicaid enrollees, community agencies, and members of historically underrepresented and marginalized communities as peer navigators, care coordinators, and other positions that work directly with enrollees.
- Offerors should provide strategies to develop the workforce at a local level through scholarships, grants, internships/apprenticeships, incentivizing benefits, expanding support workforce, and enhancing training/certification programs. Other strategies that should be encouraged include working with local schools or training programs and capitalizing on interstate compacts that Colorado has approved.
- Offerors should explain how they will leverage non-clinical staff, such as peers, community health workers, and doulas, to expand access to health services. And how they will support Medicaid members in receiving care in the community when that is their preference. Members should be informed of birthing centers and home visiting programs, which improve health outcomes and save money.
- Offerors should demonstrate how they will expand after-hours care in the region, including preventive care appointments. Proposals that commit financial support to providers for offering care in the evening and on the weekends should be scored higher.
- Offerors should provide a detailed, concrete plan to increase access and efficiency of NEMT in the region. This plan should address known member needs, including linguistic and culturally appropriate language access, verifiable and accountable timeliness and reliability, reduced wait times for rides and reimbursements, and other needs as communicated by Medicaid members.
- Offerors should provide a plan for serving unique populations, such as those with complex medical needs, disabilities, or Children and Youth with Special Health Care Needs, including a specific plan for providing needed case management.
- Offerors should demonstrate partnerships with local community-based organizations to connect members with services to address food, housing, and economic insecurity. Proposals should include letters of support and a detailed plan for providers, counties,

and CBOs to communicate to connect members to services, including a closed-loop referral system.

To ensure consistency and clarity around the Offeror's community and provider partnerships, HCPF could provide a **template letter of support** that allows partners to choose from four varying degrees (levels) of partnership.

The local community should score proposals. At least one Medicaid member, health care provider, consumer advocate, and a local non-profit community-based organization should be included on HCPF's scoring committee for each RAE region.

Finally, we urge HCPF to require **ACC 2.0 RAEs to work with network providers, local CBOs, consumer advocates, and Members** to **develop and implement a transition plan** that ensures equity and continuity of care in the region.

We are grateful for your partnership and your time. Thank you for joining our meeting. We look forward to hearing your response to our requests and our ongoing partnership as we move through the subsequent phases of developing and implementing ACC 3.0.

Sincerely,

Your Colorado Health Policy Coalition

Through the Colorado Health Policy Coalition, more than 90 of our state's health care organizations stand united to advance health equity in Colorado, which exists when everyone can achieve optimal health. Structural discrimination and economic hardship impact health outcomes unjustly, compromising our communities' strength. Understanding – through measurement and community engagement – how health reform efforts impact health equity is necessary to ensure that overall health improvements serve to reverse health inequities. The Colorado Health Policy Coalition partners with our state's leaders in engaging in health system transformation efforts that achieve health equity.

Copy:
Charlotte Crist
Cristen Bates
Pete Walsh
Susanna Snyder
Mark Quierolo
Adela-Flores Brennan
Rachel Reiter
Marivel Klueckman
Dave Ducharme

Colorado Health Policy Coalition (CHPC) Members Engaged ACC 3.0 Advocacy Efforts

Alzheimer's Association, Colorado Chapter
American Academy of Pediatrics, Colorado Chapter
American Cancer Society in Colorado
AARP, Colorado Chapter
Family Voices Colorado
Health District of Northern Larimer County
Healthier Colorado
Hunger Free Colorado

Arapahoe County Public Health
Association of Family Medicine Residencies, CO
Boulder County
Caring for Colorado
Care on Location
Children's Hospital Colorado
Center for African American Health
Center for Health Progress
Chronic Care Collaborative
Colorado Academy of Family Physicians
Colorado Association of Family Medical Residencies
Colorado Behavioral Health Council
Colorado Children's Campaign
Colorado Center on Law and Policy
Colorado Children's Health Access Program
Chronic Care Collaborative
Colorado Coalition for the Homeless
Colorado Commission on Family Medicine
Colorado Community Health Network
Colorado Consumer Health Initiative
Colorado Counseling Association
Colorado Cross Disability Coalition
Colorado Fiscal Institute
Colorado Hospital Association
Colorado Immigrant Rights Coalition
Colorado Institute for Family Medicine
Colorado Medical Society
Colorado Nonprofit Association
Colorado Organization for Latina Opportunity & Reproductive Rights
Colorado Rural Health Association
Colorado Safety Net Collaborative
Disability Law Colorado
Jefferson Center for Mental Health
Jefferson County Health Alliance
Jefferson County Public Health
Kids First Colorado
Leukemia & Lymphoma Society, Mountain Region
Life Stance
Live Well Colorado
Mental Health Colorado
Mile High Health Alliance
Mile High United Way
Mindsprings Health
Mountain Family Health Centers
Monument Health
Nine News Health Fair
One Colorado
Progress Now Colorado
Rocky Mountain MS Center
Tri-County Health Department
Tri-County Health Network
UC Health
University of Colorado School of Medicine - Anschutz
West Mountain Regional Health Alliance
Youth Healthcare Alliance