



**COLORADO**

Department of Health Care  
Policy & Financing

## **MINUTES OF THE ACCOUNTABLE CARE COLLABORATIVE (ACC) PHASE II PLANNING FOR INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE**

History Colorado Center  
1200 Broadway, Denver, CO

December 7, 2015

### **1. Attendees**

Please see Appendix I.

### **2. Welcome & Overview**

On December 7, 2015, the Colorado Department of Health Care Policy and Financing (Department) invited behavioral health stakeholders to participate in a meeting regarding development of the Accountable Care Collaborative (ACC) Phase II. The meeting was one in a series of steps that the Department has been and will be taking to work more effectively with stakeholders to develop the details -- the "how" and "what" -- of ACC Phase II.

One of the goals of the next phase of ACC is to integrate physical and behavioral health (BH) – encompassing both mental health and substance use disorder (SUD) - services in order to promote whole person care and improve health outcomes for the individuals and families served through Colorado's Medicaid program. The December 7 meeting's objectives included:

- Understand actions/decisions to date related to ACC Phase II;
- Establish a shared vision for integration of behavioral and physical health under ACC Phase II; and
- Identify opportunities to continue to shape integration.

The meeting was facilitated by the Center for Evidence-based Policy and included presentations from Department leadership and staff including Medicaid Director Gretchen Hammer, Deputy Medicaid Director Laurel Karabatsos, and ACC Strategy Lead Kathryn Jantz.



### 3. Department Presentations

Laurel Karabatsos and Gretchen Hammer welcomed the meeting participants.

#### **Key points from Gretchen Hammer's presentation.**

The Department's goals for ACC Phase II are:

- A. improving care for Medicaid clients,
- B. breaking down siloed medical and BH systems,
- C. braiding multiple funding streams,
- D. increasing use of value based payment, and
- E. holding a single entity – Regional Accountable Entities (RAE) – accountable for client care and well-being across physical and behavioral health services.

HCPF is committed to stakeholder engagement and open dialogue as ACC Phase II is evolving. However, even with continued good faith dialogue, Gretchen acknowledged that HCPF will have disagreements with stakeholders on some issues.

The Department is dedicated to preserving comprehensive programs for people with BH disorders, including alternative services and "in lieu of" residential services. The goal is to leverage the best of managed care and the best of value based purchasing to successfully integrate BH and physical care.

#### **Kathryn Jantz presented on [ACC Phase 2 concepts to date](#). Key points from Kathryn Jantz's presentation.**

The Department is seeking feedback to better understand how to preserve the current infrastructure of paying for hospitalization, alternative services and recovery support services.

There are several opportunities for integrating BH services into the ACC system.

- A. measuring client social well-being and client engagement,
- B. increasing the number of Community Mental Health Clinics (CMHCs) that can serve as primary care medical providers (PCMP),
- C. moving to an integrated health team model to better support the needs of Medicaid clients and
- D. developing a payment methodology that pays directly for services but drives increased value and preserves the best incentives in the Behavioral Health Organization (BHO) capitation payment system.



## 4. Physical and Behavioral Health Integration Opportunities

Meeting participants were asked what opportunities they thought physical/BH integration would provide to improve care and health outcomes for people served through Medicaid. Responses included:

### A. Access:

- a. Opportunity to better define and cover a full continuum of mental health and SUD services, including preventative services, family-based care models, linkages to population health and social services, and coverage of other services not currently covered,
- b. Diagnoses, such as autism or traumatic brain injury, would no longer impair access to care,
- c. Opportunity to improve systems for client referral to appropriate services,
- d. Opportunity to achieve greater equity in access to care across the state, and
- e. Opportunity to increase the power of Medicaid clients to improve their health.

### B. System integration:

- a. Break down siloed, mental health, SUD and physical health systems,
- b. Offering BH/physical care integration across the full continuum can yield an improved health care system that is cognizant of rural health care system sustainability,
- c. Support for SUD services across the continuum, and
- d. Opportunity to show that investments in mental health and SUD services can favorably impact the physical health care system in the longer term.

### C. Funding and payment:

- a. Closely examine current payment reform pilots and use the results of those pilots to inform policy development in this context,
- b. Opportunities to bring more revenue into the BH system through Certified Community Behavioral Health Clinics encounter-based payments and exploring adoption of a Medicaid health home program (section 2703 of the Affordable Care Act).
- c. Establish a path to global payment at a regional level, and
- d. Improved reimbursement.

## 5. Vision for Integrated Behavioral Health/Physical Care System

Through an exercise facilitated by the Center for Evidence-based Policy, the meeting participants developed a shared vision for an integrated BH/physical care system.



**ACC Phase II Success is:**

An integrated system that is person-centered with aligned and equitable payment and system services and that results in measurable and sustainable change in the health of Coloradans and the systems that serve them.

While a majority of the group noted support for the vision statement, many participants stressed the importance of meaningful stakeholder work on the issues and questions raised at the meeting related to the “how” and “what” of ACC Phase II implementation.

**6. Other Feedback on ACC Phase II**

Through each component of the day’s discussions, many thoughtful key questions were raised by meeting participants. Stakeholders were offered the opportunity throughout the day to post questions on Post-It notes related to components of BH integration:

- Clinical,
- Administrative,
- Financial, and
- other issue areas.

The Center for Evidence-based Policy has organized the questions raised by meeting attendees by major topic area. The questions can be found in Appendix II.

The Department identified the following key themes from the posted questions and discussion throughout the meeting:

**A. ACC Phase II timeline and status of work to date:**

- a. Extend the current timeline calling for release of draft RFP in spring 2016 and full RFP in summer 2016. Consider a phased roll-out or pilot projects.
- b. Transparency related to any changes since the concept paper was issued in October 2015.
- c. Transparency related to discussions with the federal Centers for Medicare and Medicaid Services (CMS) regarding potential federal waivers.
- d. Health Information Technology (HIT): more detail related to provider access to clinical information/data sharing and feasibility of HIT timelines.

**B. Shifting away from full capitation**

- a. Impact of moving from capitation to FFS, especially the consequences for Medicaid coverage of inpatient hospital services, Institutions for Mental Disease (IMD) services, “in lieu of” services, alternative services, care coordination/navigation, outreach and other recovery support services.
- b. Impact of moving from capitation for FFS with respect to access to crisis services.



- c. Sustaining the strengths of the current BHO system, e.g. providers with aligned financial incentives, integrated physical/BH clinical projects, provider credentialing and network management, utilization management, quality assurance and data analytics.
- d. Define how the RAE Per Member, Per Month payment will incentivize appropriate behavior by providers being paid FFS.
- e. Integration of physical and BH financing in a manner that does not dilute funding available for BH services.
- f. Consideration of partial outpatient capitation as an opportunity to retain some capitation payments, per the discussion in the ACC Phase II concept paper.

### **C. Access to services:**

- a. Impact on access in rural areas and rural provider sustainability.
- b. Access to services:
  - i. Access to the current continuum of care/preservation of services, especially for special needs populations,
  - ii. Understanding the impacts of no longer limiting access by diagnosis,
  - iii. Define the role of RAE in medical necessity determinations and how appropriate referrals will be made,
  - iv. Integration with social services and flexibility to meet whole-person needs.
- c. How to retain and strengthen focus on children's needs and healthy development.

### **D. Provider specific questions:**

- a. Community Mental Health Center's (CMHC): With respect to a new CCBHC payment methodology, what is it's linkage to ACC Phase II, and:
  - i. In an encounter-based system, how will payment be designed so that CMHC's don't become volume driven entities?
  - ii. Will encounters outside the office be paid?
  - iii. How will CMHC's providing services in primary care settings be paid?
- b. Contracting and payment equity for non-CMHC BH providers.
- c. SUD provider credentials needed for payment.
- d. Impact on providers currently designated as essential community providers.
- e. Impact on LTSS: Similar discussions are needed with LTSS stakeholders.



**E. Sustaining the integrity of the behavioral health system treatment and recovery support services (mental health and SUD)**

- a. Substance use disorder (SUD) providers noted there was very little mention of SUD in the concept paper, and that the current Medicaid program does not support full SUD continuum of care. They are concerned about SUD services getting “lost” in a fully integrated system.
- b. Given federal conditions of Mental Health and Substance Abuse block grant funding, there is not clarity on how or whether federal block grant dollars can be braided/blended.
- c. Sustaining overall BH system funding, including fully funding SUD services in an integrated system and maintaining mental health as a priority in an integrated system

**F. Meaningful stakeholder input**

- a. To build trust: Improve communication through transparency, specificity, honesty and clear communication of HCPF decisions.
- b. Good faith consideration of, and response to questions raised by stakeholders. Recognize integrity and good faith of HCPF and all stakeholders in this effort, including stakeholder concerns about the potential impact of ACC Phase II.
- c. Provide regular updates through Department communication vehicles.
- d. Modify the ACC Phase II implementation timeline given the magnitude of change.
- e. Regional Care Collaborative Organization and BHO transparency throughout this process.

**G. Effective client and stakeholder engagement:**

- a. Increase use of smaller issue- or stakeholder-specific work groups:
  - i. Clearly defined scope and goals of each work group segmented by population and issues for each population,
  - ii. Stakeholders identify their representatives to the groups,
  - iii. Ensure HCPF participation in work groups.
- b. Use focus groups to help problem solving with state.
- c. Convene local community and regional meetings.
- d. Establish a process for HCPF to solicit feedback on specific issues.
- e. Provide ongoing opportunities for stakeholders to submit written comments.



### Appendix I: In Person Attendee List

In-Person Attendees		
First	Last	Organization
Kelly	Adams	Premier Treatment Services
Todd	Addleson	Continuum of Colorado
Taylor	Ann	Rocky Mountain Youth Clinics
Louise	Apodaca	
Ruth	Aponte'	Aponte' & Busam/Childrens Hospital
Julie	Bansch-Wickert	Disability Law Colorado
Skip	Barber	CAFCA
Elizabeth	Baskett	CCHA
Holly	Batal	Denver Health
Adam	Bean	Colorado Community Health Alliance
Christy	Blakely	
Kim	Boe	West Springs Hospital, Inc.
Angela	Bonaguidi	UCD ARTS
Kevin	Bower	Netsmart
Joseph	Bowers	Friendly Harbor-Oueblo
Autumn	Boyer	Behavioral Healthcare Inc
Robert	Bremer	Colorado Access
Marcia	Brenowitz	North Star Rehabilitation and Care Community
Kasey	Brewer	Rocky Mountain Health Care Services
Nelson	Brock	CMWN
Jacqueline	Brown	Southeast Health Group
Katie	Brown	PEOPLE HOUSE
Carl	Clark	Mental Health Center of Denver
Lisa	Clements	Beacon Health Options
Frank	Cornelia	CBHC
Deborah	Costin	CASBHC
Coral	Cosway	Colorado Behavioral Healthcare Council
Clifton	Croan	Enigami Behavioral Health, LLC
Nina	Cruchon	Rocky Mountain Human Services
Daniel	Darting	Signal Behavioral Health Network
Charles	Davis	Crossroads' Turning Points, Inc.
AJ	Diamontopoulos	DRCOG
Kristen	Dixon	University of Colorado, Addiction Research and Treatment Services
Cyndi	Dodds	SummitStone Health Partners
Jo Anne	Doherty	Kaiser Permanente
Cynthia	Doty	Peak Vista Community Health Centers

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Bob	Dyer	Foothills BH Partners
Joshua	Ewing	CHA
Alan	Fine	Foothills Behavioral Health Partners
Adela	Flores-Brennan	Colorado Consumer Health Initiative
Doyle	Forrestal	CBHC
Rashonda	Gordon	Denver Health/Healthy Communities
Debi	Grebenik	Maple Star
Jennifer	Grote	Denver Health
Patrece	Hairston Peetz	
Jennifer	Hale-Coulson	Beacon Health Options
Harriet	Hall	Jefferson Center for Mental Health
Cara	Hebert	Behavioral Healthcare Inc
Lauren	Heintz	Clayton Early Learning
Margaret	Hernandez	IDEA Forum, Inc
Kathleen	Herrmann	BHI, Inc
Elizabeth	Hickman	Centennial Mental Health Center
Jeniffer	Hill	Colorado Mental Health Wellness Org
Kevin	Hobbs	Crossroads' Turning Points, inc.
Tracy	Hofeditz	Belmar Family Medicine
Michael	Huotari	RMHP
Terri	Hurst	
Marlene	Hyer	Colorado Coalition for the Homeless
Jan	Jenkins	CO Refugee Wellness Ctr.
Tracy	Johnson	Denver Health
Ben	Johnson	CHA
scott	jones	Beacon Health Options
Kristy	Jordan	Signal Behavioral Health Network
Margie	Kaems	Aurora Mental Health
Tamara	Keeney	Colorado Health Institute
Tami	Kendall	Denver North Care Center
Mindy	Klowden	Jefferson Center for Mental Health
Gwen	Koenig	SAFY
Kiara	Kuenzler	Foothills Behavioral Health Partners
Jennifer	Lacov	Behavioral Healthcare, Inc
Barbara	Ladon	Newpoint Healthcare Advisors
Emma	Lamothe	Mile High Health Alliance
Michael	Lott-Manier	Mental Health America of Colorado
Diana	Maier	Foothills Behavioral Health Partners
Kate	Margolis	University of Colorado/Children's Hospital Colorado
Kay	Martin	Solvista Health
Tina	McCory	Colorado Health Partnerships, LLC

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Gretchen	McGinnis	Colorado Access
Matthew	Meyer	Mental Health Partners
Jennifer	Miles	Miles Consulting, Inc.
Erin	Miller	Colorado Children's Campaign
Gary	Montrose	The Independence Center
Laura	Morris	Savio House
Glenn	Most	Wedt Pines
Lois	Munson	Senior Counseling Group
Ashley	Murphy	BHI
Jonathan	Muther	Salud Family Health Centers
Bill	Myers	Mental Health Partners
Jenny	Nate	Rocky Mountain Health Plans
Ann	Noonan	MPH CO
Katie	Pachan Jacobson	CCHN
Marcela	Paiz	IDEA Forum, Inc
Meghan	Phillips	Weld County Area Agency on Aging
Heather	Piernik	BHI
Tamara	Player	Community Reach Center
Lisa	Potter	Mental Health Partners
LARRY	POTTORFF	NORTH RANGE BEHAVIORAL HEALTH
Amber	Quartier	Behavioral Healthcare Inc
Janet	Rasmussen	Clinica Family Health Services
Janet	Rasmussen	Clinica Family Health Services
David	Rastatter	Colorado Access
Randy	Ratliff	SummitStone Health Partners
Lee	Repasch	HMA
Shirley	Rhodus	El Paso County Department of Human Services
Brittany	Rogers	Colorado Access
Jeremy	Sawyer	CDHS
Susan	Seiler	AspenPointe
Brad	sjostrom	West Pines
Cassidy	Smith	Peer Asst. Services
Kathie	Snell	Aurora Mental Health
Rose	Stauffer	Beacon Health Options
Kerry	Swenson	El Pueblo Adolescent Treatment
John	Talbot	Jefferson Center for Mental Health
Ayelet	Talmi	Children's Hospital Colorado
Meg	Taylor	Physician Health Partners/RCCO 6
Lauren	Tolle	Aurora Mental Health Center
Myron	Unruh	Beacon Health Options
scott	utash	Advocacy Denver

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Debbie	Wagner	
abbey	walda	RMOLTC
Christine	Wanifuchi	Asian Pacific Development Center
Bonnie	Wasli	Valley View Hospital
Tina	White	Crossroads' Turning Points, Inc.
Terry	Williams	Nehemiah Behavioral Health, LLC
Angi	Wold	UCD - ARTS
Natalie	Wood	Peer Assistance Services
Zach	Zaslow	Colorado Children's Hospital



## Appendix II: Meeting Attendee Questions

The following questions were submitted by meeting attendees using post-it notes. While questions were originally collected by the categories of Clinical, Administrative, Financial, and Other Issue Areas, we have organized them by smaller topic areas.

Subject	Comments/Questions
RAE	<ul style="list-style-type: none"> <li>• Need greater clarity on the roles and responsibilities of the RAE vs HCPF.</li> </ul>
BHO's and capitation	<ul style="list-style-type: none"> <li>• How will the strengths of BHO be maintained, e.g. providers with aligned financial incentives, integrated projects, health navigation and increased SUD services?</li> <li>• What aspects of BHO's does HCPF want to end?</li> <li>• Where is there lack of accountability in the current system?</li> <li>• Consider available data re BHO performance to fully understand their performance.</li> <li>• Risk that integrated financing will result in inequity to BH system/services.</li> <li>• If BHO's are no longer operating, given RAE's the same tools that BHO's had.</li> <li>• How to address loss of a single entity –BHO- that can increase use of EBP's through credentialing, provider network, UM and analytics if there are multiple entities carrying out these responsibilities?</li> <li>• Movement away from capitation is inconsistent with trend in other states.</li> <li>• Could expand current BHO contracts to bring in diagnoses and services that are currently excluded.</li> <li>• Without capitation, lose ability to use Medicaid funds for IMD and (b)(3) services.</li> <li>• Potential to lose current clinically integrated sites through cooperation of CMHC's, CHC's and FQHC's.</li> </ul>
ACC Phase 2 timeline	<ul style="list-style-type: none"> <li>• Need to extend current deadline to work out details and avoid unintended consequences.</li> <li>• Phase 2 should be piloted before a full roll out.</li> </ul>
Crisis services and inpatient care	<ul style="list-style-type: none"> <li>• How will PCMP's refer for psychiatric crisis care?</li> <li>• How will there be incentives to minimize IP care and create transitional step down services?</li> <li>• How will psychiatric hospitalization be paid for and managed?</li> </ul>



Subject	Comments/Questions
<b>Care coordination</b>	<ul style="list-style-type: none"> <li>• Will care coordination be a reimbursed service?</li> <li>• How will expectations around care coordination be defined?</li> <li>• What training will be offered?</li> <li>• How to sustain health navigation strategies of CMHC's?</li> <li>• Will there be a standardized care coordination tool?</li> </ul>
<b>BH continuum of care</b>	<ul style="list-style-type: none"> <li>• How will the BH continuum of care developed by BHO's be sustained?</li> </ul>
<b>Access to services -- Medical necessity and referral</b>	<ul style="list-style-type: none"> <li>• How will medical necessity be determined, if not by diagnosis?</li> <li>• What screening tools will be used to determine MN for BH services?</li> <li>• How will appropriate referrals be available, especially to BH services?</li> <li>• Will there be a standardized risk and assessment instrument? Who will create and implement it?</li> </ul>
<b>Utilization management</b>	<ul style="list-style-type: none"> <li>• Who will carry out this function?</li> <li>• RAE will need real time access to UM authorization of IP services to coordinate services.</li> </ul>
<b>Covered services</b>	<ul style="list-style-type: none"> <li>• Will telehealth and on-line services be incentivized?</li> <li>• How to sustain (b)(3) and IMD services?</li> <li>• Include prevention and wellness services, as well as other non-traditional services. How will these be valued for payment?</li> <li>• Will SBIRT be used to screen and refer for SUD services?</li> <li>• Can support services such as housing and transportation be funded?</li> <li>• Will outreach, etc. to engage clients in care be a covered service?</li> <li>• How will peer services be covered and funded?</li> <li>• How will interpreter services be covered and funded?</li> <li>• Will methadone for guest dosing be covered? (?)</li> <li>• Will new integrated BH codes be opened and paid? Will health and behavior codes be paid?</li> </ul>



Subject	Comments/Questions
<p><b>Payment methodology</b></p>	<ul style="list-style-type: none"> <li>• Will FFS rates be sufficient to sustain providers, especially rural providers?</li> <li>• Will FFS reimburse for more than one DRG per day?</li> <li>• How will payments support addressing social determinants of health?</li> <li>• Will there be severity adjustments in payment methodology?</li> <li>• How will non-CMHC BH providers be paid – based on current FFS fee schedule?</li> <li>• How will CTSS be reimbursed?</li> <li>• Can MHC's sustain county offices under a FFS system.</li> <li>• How to support access to full array of SUD services in FFS model?</li> <li>• How to ensure that BH is treated equitably in any shared savings model?</li> <li>• How will BH services offered through PCMP's be paid?</li> <li>• How will infrastructure costs associated with the shift to Phase 2 be recognized?</li> <li>• Will value based payments be sufficient to drive provider transformation?</li> <li>• If the RAE is accountable for health outcomes, they should control payments to providers for clinical services.</li> <li>• Implement 1281 more broadly (partial cap).</li> <li>• How will the payment system incentivize partnerships for clinical integration, e.g. partial cap, shared savings?</li> <li>• Can the system incentivize provision of developmental screens, well child visits, vaccines?</li> </ul>
<p><b>Provider concerns</b></p>	<ul style="list-style-type: none"> <li>• How will certified CAC counselors be included/addressed?</li> <li>• Who will carry out provider credentialing functions?</li> <li>• Will HCPF be able to provide sufficient practice support given the degree of change?</li> <li>• Can school-based health centers quality as PCMP's?</li> <li>• Will hospitals be paid with the UPC rate absent capitation?</li> <li>• Would behavioral health centers be considered specialty providers or generalists?</li> <li>• Will this effect how RCCF's are paid?</li> </ul>
<p><b>Federal MH and SUD block grants</b></p>	<ul style="list-style-type: none"> <li>• How will federal block grant funds be administered?</li> <li>• Without MSO's or BHO's, how will BG funds be braided with Medicaid funding?</li> </ul>



Subject	Comments/Questions
CCBHC	<ul style="list-style-type: none"> <li>• How does CCBHC model fit into ACC Phase 2 re scope of services and payment?</li> <li>• Will HCPF use the CCBHC payment methodology if it does not get a federal demonstration grant?</li> <li>• Can SUD providers receive encounter-based payments?</li> <li>• Can geographic encounter rate adjustments be considered to sustain rural CMHC's?</li> <li>• Will encounters in settings other than an "office" be paid? What about community, home, school-based or in a PCP's office?</li> </ul>
Special populations	<ul style="list-style-type: none"> <li>• How will unique needs of the following populations be met:                             <ul style="list-style-type: none"> <li>○ IDD,</li> <li>○ severe mental illness (including ensuring access to a sustained relationship with a PCP; people with co-occurring MI/SUD or MI/chronic disease need more than a PCMH – use sec. 2703 health home model)</li> <li>○ Traumatic brain injury</li> <li>○ Justice involved individuals (including Medicaid suspension while incarcerated)</li> <li>○ Child welfare and foster children (treatment foster care)</li> <li>○ Children</li> </ul> </li> </ul>
Outpatient capitation option reference in concept paper	<ul style="list-style-type: none"> <li>• How is "highly integrated" defined? Who would this option apply to?</li> <li>• Why offer this opportunity only to 2 provider systems?</li> </ul>
HIT	<ul style="list-style-type: none"> <li>• Will there be sufficient HIT resources to meet the goals of ACC Phase 2?</li> <li>• Regular reports from Provider Portal needed, especially for high risk clients.</li> <li>• How to ensure that treatment plan and health records follow the patient.</li> <li>• How are/will 42 CFR Part 2 SUD privacy issues be addressed in the HIE?</li> <li>• The expectations and timeline for HIT are unrealistic.</li> </ul>
QI/QA	<ul style="list-style-type: none"> <li>• How will QI be addressed in ACC Phase 2?</li> <li>• How will QI/UM functions currently carried out by BHO's be addressed, i.e. uniform benefits, training and implementation of clinical guidelines, CME?</li> <li>• How will cultural competency, diverse community needs and accessibility be addressed?</li> <li>• What will ACC Phase 2 outcome measures be, particularly for SUD services?</li> <li>• How will RAE carry out QA functions?</li> <li>• How will success of ACC Phase 2 be measured, in dollars and care outcomes?</li> </ul>



Subject	Comments/Questions
LTSS	<ul style="list-style-type: none"> <li>• How will the SEP structure and referral process be affected?</li> <li>• Will payment for LTSS be changed?</li> </ul>
Waiver	<ul style="list-style-type: none"> <li>• What will the waiver ask for? IMD/alternative services/(b)(3) services?</li> <li>• Will the waiver authorize shared savings methodologies?</li> <li>• How will budget neutrality be achieved?</li> <li>• Has HCPF explored DSRIP payments as a tool to capitate and not lose hospital fee revenue?</li> <li>• Will HCPF share CMS feedback/questions with stakeholders and update stakeholders on status of negotiations with CMS?</li> </ul>

