Accountable Care Collaborative FY 2024-25

In compliance with Sections 25.5-5-419 and 25.5-415, C.R.S.

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Submitted to: Joint Budget Committee, Health and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate

COLORADO
Department of Health Care Policy & Financing

Contents

Executive Summary

This report from the Department of Health Care Policy and Financing (HCPF) provides an update on the Accountable Care Collaborative (ACC) for FY 2024–25 (July 2024 through June 2025) in accordance with the requirements in both Sections 25.5-419, C.R.S. and 25.5-415, C.R.S.

Since 2011, the ACC has served as the core vehicle for delivering and managing member care for Health First Colorado (Colorado's Medicaid program) as authorized by Section 25.5-5 Part 4, C.R.S. Most full-benefit Health First Colorado members are enrolled in the ACC. In FY 2024-25, Health First Colorado enrollment in the ACC averaged 1,113,700 members.

The ACC is designed to provide cost-effective access to quality health care services while improving member health. It integrates managed fee-for-service physical health care and capitated behavioral health care. Regional Accountable Entities (RAEs) are responsible for promoting member health and well-being by administering the capitated behavioral health benefit, establishing and supporting networks of providers, and coordinating medical and community-based services for members in their region. Two physical health managed care capitation plans, referred to as Managed Care Organizations (MCOs), deliver physical health care in certain areas of the state. In this report, the term managed care entities (MCEs) will be used when discussing activities or responsibilities completed by both the RAEs and MCOs. The ACC's regional model allows it to respond to unique community needs while implementing the key components of member support and care coordination, ranging from health promotion to high-risk case management.

The model in place during the reporting period, referred to as ACC Phase II, was in effect from July 1, 2018, to June 30, 2025. FY 2024-25 was a critical period as HCPF prepared to implement new contracts with the RAEs on July 1, 2025, referred to as ACC Phase III. As Health First Colorado's delivery system, Phase III is an important part of efforts to improve care quality, service, equity and sustainability. Designing ACC Phase III has been a multi-year, stakeholder-informed effort with 135 stakeholder meetings and more than 5,700 attendees over 18 months.

In addition to the milestones achieved in the preparation and implementation of ACC Phase III, this summary provides an overview of some of the accomplishments from the final year of ACC Phase II. This year's efforts demonstrate fidelity to the original goals of the ACC as well as the model's ability to evolve and adapt to member, provider, stakeholder, fiscal and federal demands.

Program Performance

HCPF uses several health quality performance measures to understand ACC program support for member health. The time period for reported results varies across each

measure set depending on the time it takes for the data to be collected and processed. RAEs achieved the following for each quality measure program:

- **Key Performance Indicators (calendar year 2024):** All RAEs met their targets for the following four of the eight measures: depression screening, well-child visits in the first 15 months of life, child and adolescent well visits, timeliness of prenatal care and postpartum care. Additionally, six of seven RAEs met their target for well-child visits from 15 to 30 months old.
- **Performance Pool Measures (FY 2023-24):** All RAEs met their targets for the following two of six measures: the percentage of members with complex needs who received extended care coordination and behavioral health engagement for people releasing from state prisons. Six of seven RAEs met their targets for acute and continuing antidepressant medication management and five of seven RAEs met their targets for contraceptive care for postpartum members.
- **Behavioral Health Incentive Program (FY 2023-24)**: All RAEs met their target for the following one of four measures: engagement in outpatient substance use disorder treatment. Five of seven RAEs met their target for the other three measures: the percentage of members that were seen by a behavioral health provider within seven days of an inpatient hospital stay for a mental health condition, the percentage of members that were seen by a behavioral health provider within seven days of an emergency department visit for substance use disorder services, and the percentage of members in foster care that received a behavioral health assessment.

Performance for the MCOs is assessed differently than for the RAEs. Both MCOs share three quality metrics and have one unique metric specific to their membership and aligned with the goals of the ACC. For calendar year 2024 (the most recent data available), Rocky Mountain Health Plans PRIME met its goals for all four metrics: initiation and engagement of alcohol and other drug dependence treatment, prenatal and postpartum care, screening and follow-up for depression, and diabetes control. Denver Health Medicaid Choice met its goals for well child visits, prenatal and postpartum care, and screening and follow-up for depression. Additionally, Denver Health Medicaid Choice met one part of the multi-part measure for initiation and engagement of alcohol and other drug dependence treatment.

Member Health Initiatives

Improving member health is, and always will be, a key goal of the ACC. In FY 2024-25, HCPF and the MCEs continued to advance population management strategies within the ACC to improve member outcomes and control costs. Across regions, all MCEs implemented innovative, evidence-based programs to address priority conditions like maternity and diabetes, and enhanced care coordination for complex members.

Additional strategies were used to address other conditions that commonly affect the Medicaid population including hypertension, asthma, chronic pain, and mental health and substance use disorders.

MCEs partnered with HCPF on efforts to address health disparities through dedicated plans supporting a Healthy Colorado for All and members' health-related social needs. Notably, MCEs worked closely with permanent supportive housing providers in their regions to support members experiencing homelessness through the Statewide Supportive Housing Expansion pilot. As of December 2024, 869 Health First Colorado members were enrolled and receiving wraparound services. MCEs also collaborated with HCPF and other state agencies to prepare for the implementation of the Colorado System of Care.

Care Access

The ACC continues to identify and support strategies to improve access to care, even while reviewing and implementing critical strategies to manage cost trends. In FY 2024-25, HCPF continued to expand utilization of Colorado Medicaid eConsult, which allows participating providers to submit clinical questions to specialty providers without requiring a traditional referral; a total of 536 primary care medical providers (PCMPs) representing all RAE regions have enrolled and 1,033 eConsults were submitted. HCPF received approval from the Centers for Medicare and Medicaid Services on amendments submitted to the current 1115 waiver to support reentry services for individuals transitioning from correctional facilities, support extended inpatient mental health services for individuals with serious mental illness or serious emotional disturbance, and coverage of health-related social needs services for members experiencing homelessness and matched to certain housing voucher types. All RAEs have expanded their statewide behavioral health networks since June 2023. At the end of FY 2024-25, MCEs increased the total number of contracted behavioral health practitioners by more than 2,300, including licensed psychologists and licensed behavioral health clinicians. This is a 30% increase statewide since June 2023. Additionally in 2024, more than 2,900 members received high-intensity outpatient treatment services for substance use disorder, a 23% increase in the number of members served since the previous year. This was supported by an increase of 107 high-intensity behavioral health outpatient treatment providers across the state.

Operational Excellence and Customer Service

An important role for health plans and payers is to facilitate a good experience for members and providers, so they can navigate the system and spend more time focused on health and well-being.

From a member perspective, the average speed of answer across MCE call centers was approximately 35 seconds. The 2025 Child and Adult Consumer Assessment of

Healthcare Providers and Systems (CAHPS) Health Plan Survey Report assessed patient perspectives of the MCEs and members' ability to access care. One MCE saw a four percentage point increase from last fiscal year for members' satisfaction with care coordination, with satisfaction across MCEs as high as 90.6% for adults and 92% for children. Most members reported satisfaction with getting needed care (at least 79% for adults and 76.4% for children), getting care quickly (at least 80.3% for adults and 78.3% for children) and with their MCEs' customer service (86.4% for adults and 86.6% for children).

MCEs worked to improve provider experience by continuing to make enrollment and claims processing more efficient. In the last month of the reporting period, most MCEs paid 97% or more of adjudicated claims within 30 days, with one MCE paying 92%. Additionally, 100% of providers were credentialed and contracted by the MCEs within 90 days and MCEs responded to 100% of provider inquiries within two days. The average speed of answer across MCE provider call centers was 31 seconds.

Health First Colorado Value

HCPF aims to efficiently administer Health First Colorado, retaining just 4% of the annual budget for administrative expenses. HCPF applies the same value for efficiency to the ACC and utilizes payment methodologies that reward improved quality and outcomes, while maintaining administrative efficiencies. In FY 2023–24, most MCEs experienced a net loss with the behavioral health program posting a margin of -3.7%, while the cumulative margin over the past three years stands at 1.6%. By operating with narrow or even slightly negative margins, the ACC ensures that most of its funding is directed toward enhancing member care.

MCEs also play a key role in supporting providers through practice transformation activities. These activities support providers in accessing resources like the Hospital Transformation Program, the Prescriber tool and other alternative payment models (APMs). A total of 701 practices successfully participated in the second year of the Prescriber Tool APM Program, and 75% of the $612,665 shared savings pool was distributed to providers. Additionally, in FY 2024-25, more than 230 primary care locations participated in APM 2. Together, these strategies enable HCPF to manage rising health care costs, safeguard access to Medicaid coverage, benefits, and provider payments, and advance improvements in quality and health equity.

Priorities for FY 2025-26

In FY 2025-26, HCPF and the RAEs will focus on the implementation of new RAE contracts for ACC Phase III, while ensuring a smooth transition for members and providers. This includes oversight of the expanded expectations for RAEs to provide transitions of care support; aligning payment models and implementing improved Quality Incentive and Shared Savings programs for primary care providers; and

improving program accountability through the use of new performance standards. Following a period of rapid network growth and service expansion in the behavioral health space and recognizing state fiscal challenges and the evolving fiscal impacts of H.R. 1, HCPF will continue to evaluate and monitor the impact of changes that have been implemented to behavioral health services and the effects of those changes on Medicaid behavioral health cost trends. RAEs will be key partners in limiting disruption to patient care and provider experience while ensuring an effective, efficient and sustainable Medicaid program as outlined in the Medicaid Sustainability: Behavioral health and Managed Care Actions memo.

Additionally, HCPF will focus on a number of multi-year efforts, such as the continued collaboration with the Behavioral Health Administration on aligning RAE and Behavioral Health Administrative Service Organization responsibilities, increasing support of members' health-related social needs through the implementation of the 1115 waiver amendments and continued collaboration with the Office of eHealth Innovation to develop the Colorado Social Health Information Exchange, and continuing key activities in advancing innovation to improve quality, access and sustainability.

Introduction: The Accountable Care Collaborative

The ACC balances the efficiency of a single statewide program with the agility to meet the unique needs of Colorado's diverse regions. Its fundamental premise is that regional organizations are in the best position to build community relationships and deliver programs in response to geographic community resources, needs and differences. For this reason, the ACC does not use one central administrative organization, but instead uses RAEs to manage care in each of the state's defined geographic regions. In FY 2024-25, five contractors served as RAEs in seven geographic regions: Rocky Mountain Health Plans (RMHP) in Region 1, Northeast Health Partners (NHP) in Region 2, Colorado Access (COA) in Regions 3 and 5, Health Colorado, Inc. (HCI) in Region 4, and Colorado Community Health Alliance (CCHA) in Regions 6 and 7 (see Figure 1).

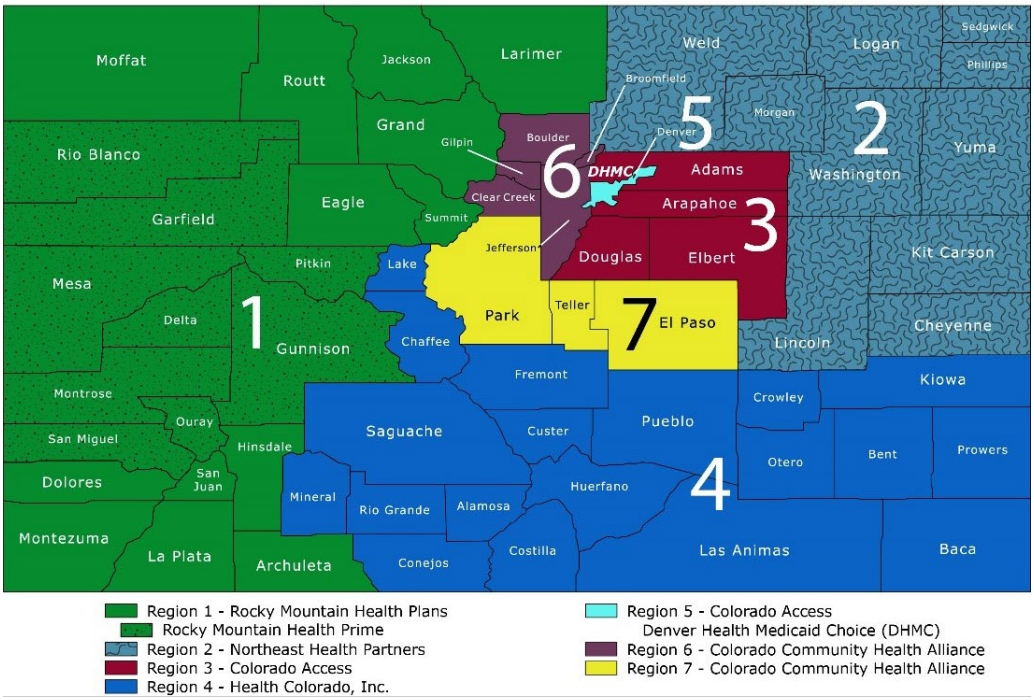
The RAEs are responsible for promoting member health and well-being by establishing and supporting networks of providers, coordinating medical and community-based services in the region and administering the capitated behavioral health benefit. For physical health care services, RAEs contract with networks of primary care medical providers (PCMPs) within their geographic regions that serve as medical homes for their assigned members. HCPF pays the RAEs a flat care management per-member-per-month (PMPM) fee that RAEs use for the full spectrum of care coordination and case management services, member engagement, practice support, population health and community investment. This care management PMPM payment was the same for every region in FY 2024-25 and is not used to reimburse primary care claims; PCMPs bill HCPF directly, fee-for-service, for most physical health care claims.

To administer HCPF's capitated behavioral health benefit, each RAE contracts with a statewide network of behavioral health providers that provide mental health (MH) and substance use disorder (SUD) services for members. HCPF negotiates actuarially sound rates for covered behavioral health services with the RAE for each region. Rates can vary depending on historic utilization patterns and unique regional variations that affect pricing. RAEs accept financial risk under this arrangement; behavioral health providers submit claims for services to the RAEs, which process and pay those claims.

Although the ACC is itself a type of managed care, it is not a capitated comprehensive risk model for physical health care. In compliance with state law, two physical health managed care capitation plans, referred to as Managed Care Organizations (MCOs), also participate in the ACC. RMHP PRIME, authorized through C.R.S. 25.5-5-415, is operated as part of the Region 1 RAE contract. Elevate (Denver Health) Medicaid Choice (DHMC), authorized through C.R.S 25.5-5-402, delivers physical health care in the Denver metro region and, in ACC Phase II, subcontracted with the RAE in Region 5 to administer the capitated behavioral health benefit. Both MCOs are designed to maximize the integration of behavioral health and physical health services for

enrolled members. In this report, the term managed care entity (MCE) will be used when discussing activities or responsibilities completed by both the RAEs and MCOs.

Figure 1. Accountable Care Collaborative Phase II Regional Map



MCEs play an important role in addressing emergencies and challenges that arise in their region. Regional flexibility helped the MCEs to provide services to rapidly increasing membership during the COVID-19 public health emergency (PHE) and helped members adjust to the end of the PHE in 2023. MCEs helped identify and ensure access to services for members at high risk of severe COVID infection and identify members who were potentially homebound and needed access to vaccines. They also worked closely with HCPF to identify and address disparities to promote vaccination efforts for all members. When the federal government officially notified Colorado that the PHE would end in May 2023, HCPF worked with the MCEs to immediately begin outreaching members and providers about potential coverage changes, upcoming renewal dates and member and provider responsibilities. MCEs will continue to be important partners as HCPF responds to state budget challenges and impending federal Medicaid changes from H.R. 1.

Enrollment in the ACC

Most full-benefit Health First Colorado members are enrolled in the ACC. HCPF uses a formula to attribute new members to a PCMP, though members can select a different PCMP at any time. Based on the geographic location of the PCMP, the member is assigned to a RAE. HCPF uses a similar formula to enroll members in each MCO, however members have 90 days following enrollment to opt out if they wish. Each

MCO has an enrollment cap; as of June 30, 2025, DHMC had a cap of 100,000 members and RMHP PRIME had a cap of 60,000 members.

Enrollment in the ACC was significantly affected by the PHE when the federal government temporarily required Medicaid programs to maintain health care coverage for all members regardless of changes in their eligibility status. Since March 2020, average ACC enrollment has fluctuated as high as 1,624,534 members. With the end of the PHE, enrollment has continued decreasing to pre-pandemic levels. In FY 2024-25, Health First Colorado enrollment averaged 1,113,700 members compared to 1,274,668 in FY 2023-24.[1]

Table 1. Average enrollment in the ACC by population, FY 2024-25

Population	RAE Enrollment	RMHP PRIME Enrollment	DHMC Enrollment	Total
Children without disabilities	411,220	32	27,843	**439,095**
Adults without disabilities, eligible due to the Affordable Care Act expansion	311,240	18,837	33,818	**363,895**
Adults without disabilities, eligible before the Affordable Care Act expansion	188,398	11,686	14,850	**214,934**
Children and adults with a disability, including Medicare-Medicaid members	85,713	5,660	4,403	**95,776**
TOTAL	**996,571**	**36,215**	**80,914**	**1,113,700**

Preparing for ACC Phase III

New contracts with the RAEs, referred to as ACC Phase III, launched on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to improve care quality, service, equity and affordability. Designing ACC Phase III has been a multi-year, stakeholder informed effort with 135 stakeholder meetings and over 5,700 attendees over 18 months. Program improvements were developed to achieve the following five goals:

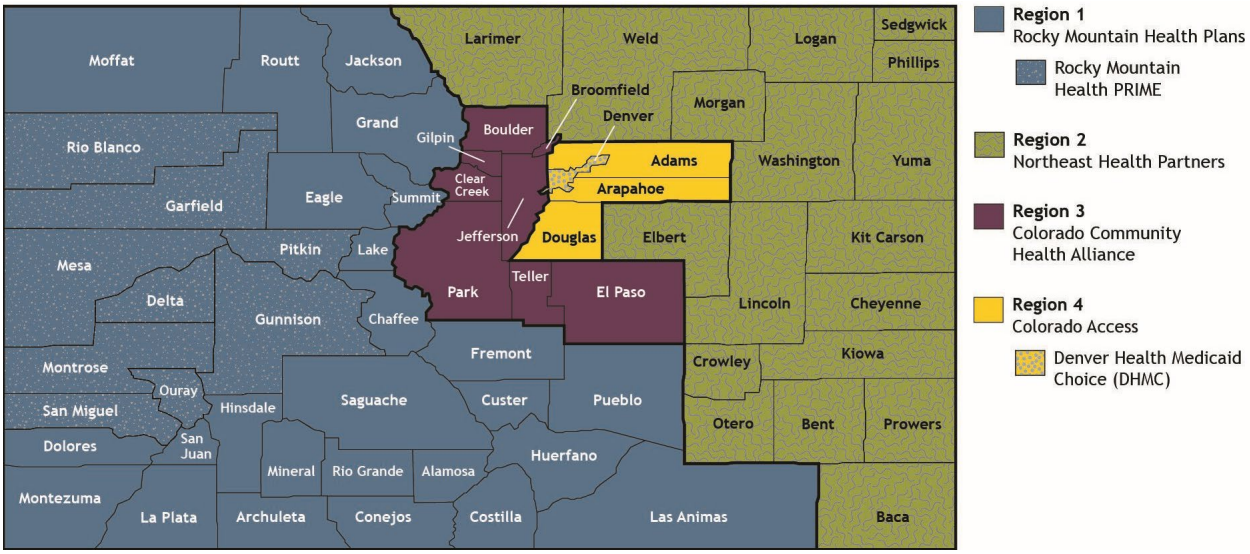
1. Improve quality care for members.
2. Close health disparities and promote health equity for members.
3. Improve care access for members.

[1] ACC enrollment does not include members enrolled in the Program of All-Inclusive Care for the Elderly (PACE), CHP+, Emergency Medicaid Services or members with partial Medicaid benefits. For further information on enrollment in HCPF programs during the PHE unwind, please see the Continuous Coverage Unwind webpage.

4. Improve the member and provider service experience.
5. Manage costs to protect member coverage, benefits, and provider reimbursements.

While the new contracts began outside of this reporting period, HCPF achieved critical milestones throughout FY 2024-25 in preparation for the implementation of ACC Phase III. In August 2024, an evaluation committee of subject matter experts reviewed responses to the Request for Proposal and issued an intent to award four contractors. HCPF worked closely with the contractors, each of which served as RAEs in Phase II, to execute final contracts in Spring 2025. Simultaneous to this, HCPF staff worked diligently to implement necessary system changes, develop educational materials and other resources about the transition, and continue stakeholder discussions to ensure community concerns were considered in transition preparations. The following organizations will serve as RAEs in each region of the state:

Figure 2. ACC Phase III Region Map



To provide stability amidst the significant changes in the health care landscape in recent years, from the COVID-19 public health emergency to the establishment of the Behavioral Health Administration (BHA), the structure of the ACC and the core functions of the RAEs will remain the same. HCPF will continue the capitated behavioral health benefit to encourage the effective utilization of the full continuum of behavioral health services and provide avenues for addressing health-related social needs (HRSNs). RAEs will continue to receive a care management payment from HCPF for providing care coordination, provider support and management of whole-person care. Incentive payments will continue to tie a portion of RAE funding to achieving established outcome targets.

ACC Phase III builds on lessons learned over the past 14 years of the program. Key improvements include:

- Reducing the number of regions from seven to four to ensure sustainable investment in regional infrastructure and better leverage RAEs' efficiencies.
- Increasing care coordination requirements with an emphasis on supporting members' care transitions, especially from inpatient or residential settings. RAEs will have additional resources in Phase III to ensure these members receive follow-up care and prevent avoidable readmissions thanks to the legislature's approval of our FY 2025-26 budget request.
- Advancing program accountability to improve quality, close disparities and drive affordability.
- Adjusting how members are attributed to a PCMP to more closely reflect current care relationships.
- Implementing member incentives to support healthy behaviors in key program areas, like maternal health.
- Supporting a Healthy Colorado for All by requiring dedicated personnel, staff training and a regional committee.
- Aligning payment models managed by the RAEs and HCPF to create a singular, comprehensive payment structure and reduce administrative burden for providers.
- Evolving the PCMP structure from a Primary Care Medical Home to an Accountable Care Organization (ACO)-like model, which rewards outcomes not just actions.
- Continuing innovation through cost and quality indicators, eConsults and the Colorado Social Health Information Exchange.
- Improving processes for children and youth accessing behavioral health care services by supporting the implementation of the Colorado System of Care (CO-SOC).

While a significant focus of FY 2024-25 has been on the preparation for ACC Phase III, the remainder of this report focuses on key highlights from the final year of ACC Phase II.

Member Health Quality Performance Measures

HCPF uses several sets of health quality performance measures to understand ACC program support for member health. These include Key Performance Indicators (KPIs), Performance Pool incentive measures and Behavioral Health Incentive Program (BHIP) measures. HCPF withholds a portion of the RAE care management PMPM payments to fund the KPI and Performance Pool incentives; there is a separate funding pool for the BHIP measures. See the Health First Colorado Value section of this report for

information about how RAE payments were broken out for FY 2024-25. MCOs have separate measures and incentive funding and are not eligible for these programs.

HCPF works with each RAE individually to set annual performance targets for measures based on previous performance, changing priorities and other factors. For some measures, HCPF sets different tiers for the performance targets, which equate to different incentive payment rates. In these instances, RAEs that meet the Tier 2 target receive a higher incentive payment. HCPF intentionally sets high standards for achievement of performance measures, requiring RAEs to achieve a certain percentage growth or reduction, depending on the target. In some cases, the RAEs have already reached high standards of performance which makes it difficult for them to achieve further improvement to earn an incentive payment. Further information about how HCPF sets performance targets can be found in the specification documents for each quality measure set.

Key Performance Indicators

KPIs provide insight into physical and medical health care utilization. HCPF calculates KPIs on a rolling quarterly basis. Due to the time it takes for data to be collected and processed, the reported results are from calendar year 2024.[2] RAEs can earn a part or all of the care management PMPM withhold amount if they reach KPI performance targets. Definitions for each indicator can be found in Appendix A.

Table 2. KPI performance by RAE, 2024

RAE	Depression Screening	Oral evaluation, dental services	Well-child visits: first 15 months	Well-child visits: 15-30 months	Child & adolescent well visits	Timeliness of Prenatal Care	Postpartum Care	ED (per 1000 members per year)
1 (RMHP)	23.3%	49.3%	70.4%	74.0%	51.8%	72.8%	66.7%	604.7
2 (NHP)	25.9%	52.1%	63.3%	62.5%	42.7%	76.2%	72.2%	712.8
3 (COA)	27.2%	50.6%	64.6%	70.0%	50.5%	75.8%	66.8%	654.7
4 (HCI)	22.3%	48.9%	62.7%	64.9%	43.1%	70.3%	73.1%	591.3
5 (COA)	28.5%	54.3%	65.5%	72.5%	56.6%	78.1%	69.3%	706.6
6 (CCHA)	20.2%	49.6%	63.9%	69.4%	48.6%	76.8%	68.3%	572.6
7 (CCHA)	33.7%	49.0%	62.8%	66.7%	41.0%	70.3%	71.9%	747.9

Key:
Green = Met Tier 2 Goal, Yellow = Met Tier 1 Goal, White = No Goal Met

[2]Previous reports used an April to March performance period for KPIs. Due to data calculation delays as a result of vendor transitions, this report uses calendar year 2024 instead of April 2024 to March 2025.

Table 3. Risk-adjusted PMPM by RAE, 2024 (compared to ACC average risk-adjusted PMPM of $578.25)

RAE	Risk-adjusted PMPM
1 (RMHP)	$565.26
2 (NHP)	$486.06
3 (COA)	$647.55
4 (HCI)	$514.22
5 (COA)	$628.13
6 (CCHA)	$598.39
7 (CCHA)	$627.78

Key:
Green = Met target of less than ACC average risk-adjusted PMPM

ACC Performance Pool

The Performance Pool is funded with money not disbursed for KPI performance incentives. It is often used to respond flexibly to timely needs and priorities. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. The reported results are from FY 2023-24 rather than FY 2024-25 due to the time it takes for the data to be collected and processed. Definitions for each Performance Pool measure can be found in Appendix B.

In addition to these measures, HCPF utilized Performance Pool funds to incentivize RAE planning and work related to eConsult utilization and to support providers impacted by the membership changes of the PHE unwind mitigation.

Table 4. Performance pool measures by RAE, FY 2023-24

RAE	Extended care coordination	Premature birth rate	BH engagement for people releasing from prison*	Asthma medication ratio	Antidepressant medication management: acute and continuation	Contraception postpartum
1 (RMHP)	82.5%	10.4%	33.0%	48.9%	67.6% 47.7%	34.5%
2 (NHP)	91.0%	9.9%	33.0%	48.2%	71.7% 46.0%	39.5%
3 (COA)	43.0%	10.3%	33.0%	43.0%	70.4% 48.4	39.3%
4 (HCI)	63.0%	10.9%	33.0%	39.3%	68.3% 49.8%	43.6%

RAE	Extended care coordination	Premature birth rate	BH engagement for people releasing from prison*	Asthma medica-tion ratio	Antidepressant medication management: acute and continuation	Contraception postpartum
5 (COA)	55.6%	10.4%	33.0%	45.8%	66.9% 43.3%	38.6%
6 (CCHA)	46.7%	10.0%	33.0%	45.9%	72.9% 52.5%	35.5%
7 (CCHA)	48.0%	11.5%	33.0%	48.8%	69.1% 49.3%	29.0%

Key:
Green = Met target
*Given challenges with the Department of Corrections roster, RAEs are measured as a collective group and earn incentive money only if the collective group meets its target. This target was developed to align with HCPF's Wildly Important Goal for justice-involved members.

Behavioral Health Incentive Program Measures

The BHIP measures provide insight into how ACC members access and utilize behavioral health care. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, funds distributed to the RAEs in FY 2024–25 were for the RAEs' performance during FY 2023–24. Definitions for each BHIP measure can be found in Appendix C.

Table 5. BHIP performance by RAE, FY 2023-24

RAE	Engagement in Outpatient SUD treatment	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD	BH assessment for children in foster care
1 (RMHP)	28%	32.6%	28.9%	17.2%
2 (NHP)	31.4%	25.5%	25.4%	15.7%
3 (COA)	29%	36.3%	30.7%	17.3%
4 (HCI)	13.4%	30.1%	26.3%	34.2%
5 (COA)	31.2%	32.8%	28.3%	39.2%
6 (CCHA)	24.4%	34.9%	26.3%	16.2%

RAE	Engagement in Outpatient SUD treatment	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD	BH assessment for children in foster care
7 (CCHA)	21.1%	28%	25.5%	18.3%

Note: The Depression Screening measure is not presented here due to pending updates to the measure calculation.
Key:
Green = Met target

MCO Medical Loss Ratio Metrics

Performance for the MCOs is assessed differently than for the RAEs. Both MCOs share three quality metrics and have one unique metric specific to their membership and aligned with the goals of the ACC. While RAE performance towards quality measures impacts the amount of the PMPM withhold that they receive, MCO performance towards quality metrics impacts their medical loss ratio (MLR) floor. The MLR refers to how much money an MCO spends on providing medical services versus administrative services expenses and profit. The higher the MLR, the greater the percentage of revenue must be spent on care. For example, a health plan with an MLR of 89% spent 89% of its revenue on services; a health plan with an MLR of 83% retained more dollars for its administration and profit. Medicaid managed care plans are federally required to have an MLR of at least 85%.

Under their contracts with HCPF, MCOs are required to start with an MLR floor of 89%. The MCOs can lower this MLR floor based on performance towards their quality metrics. The metrics for each MCO are explained in Appendix D. The following quality metric results are from calendar year 2024 rather than FY 2024-25 due to the time it takes for the data to be collected and processed.

Table 6. RMHP PRIME Performance on MLR Metrics, 2024

RMHP MLR Metrics	Performance	RMHP Goal for Performance Period	Goal Met?
Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 56.7% Engagement: 13.6%	Initiation: 55.7% Engagement: 12%	Yes Yes
Metric 2: Prenatal and Postpartum Care: Prenatal Care (NQF1517)	Prenatal Care: 95.6 %	Prenatal Care: 93.7%	Yes
Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Postpartum Care: 89.9%	Postpartum Care: 84.8%	Yes
Metric 3: Screening for Depression and Follow-up	68.2%	67.5%	Yes

RMHP MLR Metrics	Performance	RMHP Goal for Performance Period	Goal Met?
Metric 4: Diabetes HbA1c Poor Control >9.0%*	24.2%	29.5%	Yes

*Diabetes HbA1c Poor control is an inverse measure, lower scores indicate higher performance.

Table 7. DHMC Performance on MLR Metrics, 2024

DHMC MLR Metrics	Performance	DHMC Goal for the Performance Period	Goal Met?
Metric 1: Well-Child Care First 15 Months 15-30 Months 3-21 Years	 67.3% 72.1% 48.8%	 59.3% 61.2% 44.7%	 Yes Yes Yes
Metric 2:Prenatal and Postpartum Care: Prenatal Care (NQF1517) Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Prenatal Care: 87.8% Postpartum Care: 83.5%	Prenatal Care:81.8% Postpartum Care: 77.5 %	Yes Yes
Metric 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 46.4% Engagement: 9.9%	Initiation: 43.7% Engagement: 11.06%	Yes No
Metric 4: Screening for Depression and Follow-up Plan	50.36%	19.9%	Yes

Member Health Initiatives

HCPF uses a population management framework to improve Health First Colorado member outcomes by promoting wellness, managing chronic conditions to prevent disease progression and coordinating care for members with complex care needs. Data-driven strategies are used within this framework to identify and stratify members by risk level across each region to deliver the right care, to the right member, at the right location and time. This framework also helps reduce the total cost of care by keeping members healthier. A key ACC strategy is to work with the MCEs on programs that improve member health and control costs for conditions that commonly affect the Medicaid population, including maternity, diabetes, hypertension, asthma, congestive heart failure/coronary artery disease, chronic obstructive pulmonary disease, anxiety, depression, chronic pain and substance use disorder.

The sections that follow provide further information on the ACC's focus areas for member health: diabetes, maternity, complex and other conditions, health equity, HRSNs, supporting justice-involved members and services for children and youth. All MCEs developed or used programs that met minimum HCPF standards, including

cultural relevance, data use and use of evidence-based programs, to better manage member health in their regions and control costs.

Diabetes

Diabetes requires complex monitoring and management by members and their providers to prevent complications such as blindness, kidney failure, heart disease, stroke and lower-limb amputations. As a result, it is an expensive chronic condition to manage. Below are highlights from the MCEs' diabetes programs in FY 2024-25:

- DHMC: Launched the digital care management platform, Wellframe, which includes diabetes management programming and allows for bi-directional communication and biometric data sharing between members and their care manager.
- RAE 1 (RMHP) and RMHP PRIME: Provided funds for healthy foods and personalized nutrition support to members through the Food as Medicine program. RMHP also offered incentives to members who improved their HbA1c and diabetic retinopathy screening scores.
- RAE 2 (NHP): Expanded support for diabetes management across 16 PCMP clinics through the Practice Transformation Milestone Program and joined the Colorado Diabetes Advisory Group to strengthen collaboration with statewide stakeholders.
- RAE 3/5 (COA): Offered multiple digital chronic condition management solutions for members including Dario, an app-based and online platform providing members with digital programming, coaching, a blood pressure cuff, and a blood glucose monitor.
- RAE 4 (HCI): Administered the text-based Care4Life virtual coach program for broad outreach, providing education and diabetes-specific patient self-management tips for healthy management of diabetes.
- RAE 6/7 (CCHA): Supported the pilot program, Community as Medicine, which provides equity-centered group health coaching for members with chronic health conditions that receive care at STRIDE clinics.

Maternity

Maternal health continues to be a priority for HCPF and the ACC. In addition to measuring their performance for several Centers for Medicare and Medicaid Services (CMS) core maternity metrics, such as timeliness of prenatal care, MCEs are required to have programs supporting pregnant and postpartum members. Below are highlights from the MCEs' maternity programs in FY 2024-25:

- DHMC: Continued outreach for maternal care management services and increased prenatal and postpartum visits.

- RAE 1 (RMHP) and RMHP PRIME: Offered virtual perinatal support through programs including Babyscripts (education and incentives), SimpliFed (lactation consulting), and Wellhop (group-based prenatal and postpartum support).
- RAE 2 (NHP): Offered care management to pregnant members through the program Taking Care of Baby and Me, which includes outreach and screening for members to connect them to services and supports based on their individual needs.
- RAE 3/5 (COA): Provided routine care management through the Healthy Mom Healthy Baby program and digital engagement through Text4Baby, a text-based initiative to increase prenatal and postpartum visits, increase flu shot uptake and improve birth outcomes.
- RAE 4 (HCI): Utilized Healthy Rewards to incentivize member engagement in perinatal care.
- RAE 6/7 (CCHA): Connected pregnant members with "Injoy", a mobile application that delivers evidence-based prenatal, childbirth and postpartum education.

Complex Care Coordination

High acuity, complex conditions put a person at risk for serious health outcomes. These conditions are often chronic and usually require intensive management and specialized care. Complex care coordination is an essential part of the ACC population management strategy that helps organize and support members' health care and HRSNs in order to improve health outcomes, increase independence and reduce health care costs. Below are some highlights from the MCEs' strategies to support members with complex conditions:

- DHMC: Screened for complex care coordination needs by evaluating medical complexity, functional limitations, social inequities, health care utilization, environmental factors and individual preferences.
- RAE 1 (RMHP) and RMHP PRIME: Launched enhancements to their care management platform for real-time tracking of transitions of care and increased direct collaboration with schools, jails and hospitals to support members during key care transitions.
- RAE 2 (NHP): Utilized telehealth platforms like Bicycle Health and Charlie Health to close care gaps in opioid use disorder treatment and intensive outpatient services.
- RAE 3/5 (COA): Maintained connection and follow-up with members using enhanced care coordination digital engagement tools including text and Interactive Voice Recognition for members with complex care needs.

- RAE 4 (HCI): Tracked and evaluated their delegated Extended Care Coordination performance and developed a workflow and referral tracking process in their care management platform.
- RAE 6/7 (CCHA): Screened members for unmet HRSNs during transitions from high levels of care for treatment of a MH or SUD diagnosis.

Other Conditions

In addition to the programs and targeted strategies in the previous sections, MCEs use a variety of methods to address other conditions members may experience, including:

- DHMC: Provided a digital self-management program for controlling blood pressure to members.
- RAE 1 (RMHP) and RMHP PRIME: Introduced multiple app-based tools to increase access and engagement with self-directed behavioral and physical health support.
- RAE 2 (NHP): Implemented Open Airways for Schools, an evidence-backed, school-based asthma self-management program for kids aged 8 to 11.
- RAE 3/5 (COA): Partnered with VitalCare to increase access to behavioral health respite services for families and caregivers of adolescents with complex care needs. COA also continued its partnership with the Children's Wellness Center to facilitate programming that ensures timely behavioral health assessment of both foster and kin care youth.
- RAE 4 (HCI): Provided access to Wisdo Health, an online peer support platform aimed at reducing loneliness and social isolation, for all their members.
- RAE 6/7 (CCHA): Utilized Pyx, a technology platform to encourage member engagement, to support member participation in healthy activities, such as attending behavioral health follow-up services after discharge from inpatient or emergency levels of care and attending well-care visits for members under 21.

Healthy Colorado for All

As regional entities, MCEs continue to be an important partner in the commitment to meaningfully address and eliminate health disparities for the communities they serve, referred to as Healthy Colorado For All (HCFA). In FY 2024-25, MCEs submitted their first annual HCFA reports which illustrate current strategies, identified priority populations, achievements, challenges, data collection methodologies and future strategies to address the focus areas outlined in their FY 2023-24 HCFA plans. Areas of focus include vaccinations, maternity and perinatal health, behavioral health and prevention. For example, in FY 2024-25, RAE 1 (RMHP) improved access to prenatal and maternal care in rural and underserved communities by collaborating with the Southern Ute Tribe and the Western Slope Native American Resource Center and

providing access to digital tools like Babyscripts and WellHop to enhance education and engagement for these members.

Health-Related Social Needs

HRSNs are the nonmedical needs, such as food and housing security, that impact health. Research has indicated HRSNs can account for as much as 50% of health outcomes[3]. A focus on supporting the HRSNs of members has been a part of the vision for the ACC since its inception and is increasingly a priority through other programs at HCPF and across the state. With their regional focus, the MCEs are uniquely positioned to make the necessary connection between health care and nonmedical drivers of well-being. For example, DHMC assessed the HRSNs of their members and provided referrals to food security resources like Project Angel Heart, a Denver-based nonprofit whose mission is to provide medically tailored meals to people with severe illnesses.

While HCPF and the MCEs have several ongoing initiatives, like continued collaboration on the Colorado Blueprint to End Hunger, the following sections highlight unique projects from FY 2024-25 to address the HRSNs of members.

1. *HRSN Feasibility Studies*

The Colorado General Assembly passed House Bill 23-1300 and House Bill 24-1322 directing HCPF to assess the feasibility of expanding coverage for HRSNs and continuous eligibility, though CMS is no longer approving state requests to cover the latter. Both bills provided funding for contracted support to complete the studies. Although House Bill 23-1300 was signed earlier, its findings are due later.

House Bill 24-1322 required HCPF to study the feasibility of covering specific housing and nutrition services. It also authorized HCPF to pursue an 1115 waiver amendment, which was submitted in August 2024 and approved in January 2025. The feasibility study required by House Bill 23-1300, due January 2026, will include a broader review of HRSN services. In addition to housing and nutrition, it will examine services for individuals impacted by natural disasters, interpersonal violence and other needs identified through stakeholder engagement. Findings from this study will guide future HRSN policy decisions.

2. *Statewide Supportive Housing Expansion (SWSHE) Pilot*

In December 2024, HCPF completed the multi-year Statewide Supportive Housing Expansion (SWSHE) project, a permanent supportive housing (PSH) pilot funded by the

[3] Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. American journal of preventive medicine, 50(2), 129–135. https://doi.org/10.1016/j.amepre.2015.08.024

American Rescue Plan Act and implemented with the Colorado Department of Local Affairs (DOLA). The project paired DOLA-funded housing vouchers with services like housing navigation, intensive case management and physical and behavioral health care coordination. Its goal was to explore sustainable funding for pre-tenancy and tenancy support services for Health First Colorado members with unmet health needs.

By the end of the project, 869 members received supportive housing services and many were connected to PSH for the first time. Supportive services included housing searches, securing identification documents, moving assistance, transportation, housing retention support and health care navigation. Nearly two-thirds of all enrolled participants had experienced long-term homelessness. The Urban Institute's final evaluation of this project found promising results: Compared to unhoused peers, members enrolled in SWSHE had more primary care and mental health visits and a 90% housing stability rate after one year. They were also significantly less likely to use emergency shelters than the unhoused comparison group.

Twenty-eight PSH providers participated in this project statewide, nine of which were located in rural areas. Many of the MCEs had strong relationships with these providers and were instrumental in referring members with a history of homelessness to PSH during the pilot. This ultimately informed new sections within the ACC Phase III MCE contracts, which now formally require the MCEs to maintain or establish a network of PSH providers in their regions. SWSHE also informed new initiatives for HCPF, including the development of new per diem and monthly rates for an expanded set of PSH services and HCPF's 1115 waiver amendment, detailed in the Care Access section of this report.

3. Community Re-Investment Grants

RAEs have the option to fund local community organizations, public health departments, health care providers and others for innovative, community-centered projects that support health and address barriers to care. The goal is to strengthen health neighborhoods, improve the quality of care, and enhance health, wellness, and life outcomes for Health First Colorado members, all while reducing overall expenditures.

In FY 2024-25, all RAEs provided community investment grants to more than 340 recipients, totaling approximately $16.6 million. These grants supported organizations or projects filling a critical need in their communities, such as programs to support immunization efforts for marginalized populations, address the affordable housing shortage or expand fresh food surplus redistribution programs. For example, RAE 6 (CCHA) partnered with the Colorado-based non-profit, WeeCycle, to provide recycled essential baby gear to local Colorado families in need.

4. *Social Health Information Exchange*

HCPF continued to collaborate with Colorado's Office of eHealth Innovation on the development of the Colorado Social Health Information Exchange (CoSHIE). This technology is designed to securely share social health information to enable Case Management Agencies (CMAs), RAEs, care coordinators, community health workers and health care providers to connect Health First Colorado members to programs. These will include: state programs; RAE programs like prenatal care, diabetes care and support; and HRSN supports like community food banks, homeless shelters or housing vouchers. Both agencies are working to build community partnerships to support individuals with disabilities, connect individuals to safe and affordable housing, reduce barriers to care for individuals navigating substance use disorder, and reconnecting individuals exiting incarceration to their communities. All of these programs are intended to improve whole-person care, access, equity, quality and sustainability.

Services for Children and Youth

Children and youth, especially those in the child welfare system or who require residential treatment, are among the most vulnerable Coloradans. They often need multiple services from different agencies, each with its own complex system subject to different federal and state regulations. HCPF participates in several collaborative efforts with Colorado Department of Human Services (CDHS), BHA, MCEs, hospitals, counties, providers, advocates and families that focus on fixing technical systems issues and on serving members with many complex needs.

In addition, several MCEs partnered with local and state government agencies and community organizations to address issues in their region that affect children and youth. For example, in FY 2024-25, RAE 3 (COA) supported Advocates for Children (CASA)'s Foundations Program, which helps young adults transitioning out of foster care by providing mentorship, life skills training and education and employment support to those with Foster Youth to Independence housing vouchers through South Metro Housing Options.

Below are examples of collaborative initiatives in FY 2024-25 related to children and youth that involved HCPF and the MCEs.

1. *Implementation of the Colorado System of Care (CO-SOC)*

CO-SOC is the designated framework developed collaboratively by HCPF and BHA to serve children and youth with complex or high acuity behavioral health needs. In February 2024, HCPF entered into a settlement agreement to resolve a federal lawsuit. A key requirement for the settlement agreement is the creation of an implementation plan that demonstrates how HCPF will build a systematic approach to providing Health First Colorado members under the age of 21 with intensive

behavioral health services in their homes and communities. In addition to requirements laid out in the settlement agreement, House Bill 24-1038 also lays out specific requirements for HCPF to develop a system of care.

The vision for CO-SOC is to create an array of services that meet the needs of members and families so that, as appropriate, they can remain in their homes or communities instead of requiring services to be obtained in residential or inpatient settings, especially those that require out-of-state placement. In cases where families interact with multiple systems, CO-SOC helps members and families navigate between systems, such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education and others. CO-SOC will provide an evidence-based approach to delivering services in a well-designed manner to address the needs of the members receiving services. In addition, CO-SOC is structured to incorporate the voices of families in the design of services and development of program policies. In FY 2024-25, HCPF convened multiple stakeholder advisory committees, including one dedicated to amplifying the voices of children, youth and families with lived experience, to direct this work.

The MCEs will play a significant role in the implementation of CO-SOC. HCPF meets regularly with the MCEs to provide program updates, understand barriers they may face and ensure that they are prepared to ensure work force capacity and support the implementation plan.

2. *HCPF, RAEs, CDHS and Counties Forum*

HCPF continued to lead a forum bringing together HCPF, RAEs, CDHS, counties, BHA and the Behavioral Health Administrative Service Organizations (BHASOs), referred to as HRC2B2, to address behavioral health issues affecting child welfare. This year, the forum focused on:

- Understanding how child welfare agencies would be impacted by the transition to ACC Phase III and the BHASO implementation.
- Planning the shift of residential behavioral health services from fee-for-service to the behavioral health capitation managed by the RAEs.
- Implementing CO-SOC.
- Coordinating the implementation of BHA's payment of room and board for residential behavioral health treatment.
- Increasing availability of therapeutic foster care.
- Finalizing regular data analysis to monitor how child welfare-involved youth interact with the behavioral health system compared to other populations.
- Convening a bi-weekly workgroup to improve alignment and address concerns related to the Enhanced Standardized Assessment (formerly the Independent Assessment).

These initiatives reflect the need for continued collaboration and long-term investment to improve behavioral health outcomes for youth involved in the child welfare system.

Care Access

Colorado Medicaid eConsult

eConsult platforms allow PCMPs to submit clinical questions to specialty providers without requiring a traditional referral. This model allows PCMPs to access specialist expertise when they are unable to deliver the necessary specialty care during a patient visit, supporting more timely and efficient care coordination. February 2025 marked the one-year anniversary of the launch of the Colorado Medicaid eConsult platform, developed in partnership by HCPF and Safety Net Connect (SNC). HCPF also reimburses PCMPs for eConsults conducted through approved third-party eConsult platforms.

Colorado Medicaid eConsult aims to bridge gaps in specialty care access, particularly in rural and frontier communities. By minimizing geographical barriers, the platform helps manage members with chronic health conditions and reduces the long wait times traditionally associated with in-person specialist appointments. With 21 adult specialties and 16 pediatric specialties available, Colorado Medicaid eConsult expands the range of electronic medical expertise accessible to members across the state.

In FY 2024-25, HCPF continued to expand Colorado Medicaid eConsult:

- The RAEs received $5.5 million from Performance Pool funding to support regional providers in the adoption and utilization of eConsult platforms by providing targeted outreach, technical support and financial incentives. With RAE support, a total of 526 PCMPs representing all regions have been enrolled and trained to use the platform since its inception. An additional 208 PCMPs are enrolled and in the process of completing training.
- There were 1,033 eConsults, with the vast majority of cases managed at the primary care level. Consulting providers typically respond within one business day, ensuring prompt clinical guidance and supporting timely, coordinated care for members.
- SNC successfully recruited specialists in Geriatric Medicine, Pediatric Nephrology and Pediatric Rheumatology, following initial challenges in securing providers in certain specialty areas.
- HCPF engaged with stakeholders to design the expansion of Colorado Medicaid eConsult. Effective July 1, 2025, the platform will support specialty-to-specialty consultations, enabling a wider range of providers to initiate eConsults as treating practitioners.

Expanding Access through the 1115 Waiver Amendment

On Jan. 13, 2025, HCPF received approval from CMS for the following 1115 waiver demonstrations submitted as amendments to the current 1115 "Expanding the Substance Use Disorder (SUD) Continuum of Care" Waiver:

- HRSN demonstration: housing and nutrition interventions through a partnership with DOLA for members who meet certain social and clinical criteria.
- SMI/SED demonstration: reimbursement for acute inpatient and residential stays in Institutes for Mental Disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED). This will allow HCPF to reimburse for up to 60 days while maintaining an average length of stay of 30 days per episode for each member staying in an IMD.
- Reentry demonstration: prerelease services for individuals transitioning from correctional facilities. Coverage under the reentry demonstration will include case management services and medication-assisted treatment (MAT) for SUD 90 days prior to release, and a 30-day supply of medications upon release from Department of Corrections and Division of Youth Services facilities.

Colorado's current demonstration waiver was approved for Jan. 1, 2021, to Dec. 31, 2025. In addition to requesting amendments, HCPF also requested CMS to extend the current waiver. The proposed extension includes the current SUD demonstration and presumptive eligibility for long-term services and supports. CMS has delayed the approval of the five-year extension and instead granted Colorado an additional year of approval authority through the existing waiver. This means everything approved under the existing waiver can continue, but the new presumptive eligibility provisions will not be approved at this time.

Behavioral Health Sustainability Actions

In May of 2025, HCPF prepared the Medicaid Sustainability: Behavioral Health and Managed Care Actions memo to clarify FY 2025-26 expectations with the RAEs to ensure alignment with the Medicaid Sustainability Framework. Following a period of rapid growth of networks and service expansion in the behavioral health space over the last several years, and recognizing state fiscal challenges and evolving the evolving fiscal impacts of H.R.1, it is critical for HCPF to evaluate and monitor the impact of changes that have been implemented to behavioral health services and the effects of those changes on Medicaid behavioral health cost trends. Some examples include:

- A 115% increase in paid behavioral health services from FY 2018-19 ($586M) to FY 2024-25 ($1,261B) — increasing at +23% trend rate per year.[4]

[4] The growth in the provider network, increased provider rates, addition of new benefits and BH transformation initiatives led to a 115% increase in paid BH services.

- Residential services from FY 2020-21 to FY 2023-24 increased from $24M to $84M.
- Outpatient services increased from $465M to $596M from FY 2020-21 to FY 2023-24.[5]
- A 286% increase in paid peer services from FY 2021-22 to FY 2023-24 — almost a +95% trend per year.[6]
- From FY 2021-22 to FY 2023-24, following the prohibition of prior authorization reviews for psychotherapy services, there was a +$38M increase, despite the significant reduction in caseload. This included a 61% increase in 25 or more visits per year and a 98% increase in 56 or more visits per year.

While confirming HCPF's values and priorities, the memo outlines the serious risk that comes without action to manage trends, clarifies expectations of the RAEs and lays out a direction for behavioral health care: to preserve necessary services for vulnerable members in fiscally responsible ways. HCPF has identified strategies that allow maintenance of the broadest array of services while complying with the Medicaid Sustainability Framework. HCPF has prioritized quality care and plans to use cost and quality metrics to support continued development of provider networks by targeting specific areas of need within each network to grow access to services needed within each community. The Joint Budget Committee in the 2025 Legislative and Special Session approved a number of changes to the behavioral health system, including reductions in behavioral health incentive programs, limiting peer services to specific provider types and services, reducing funding for underutilized provider training services, and removing the restriction on prior authorization for psychotherapy services.

In addition to reduction and policy changes that help manage trend, HCPF has continued to identify opportunities to increase federal match for expanded behavioral health programs through 1115 demonstration waivers authorized by the Colorado legislature. Following CMS approval of these demonstrations in January 2025, HCPF sought approval for a reinvestment plan as required by CMS under 1115 waiver authority. The General Assembly passed Senate Bill 25-308 to create two cash funds to allow HCPF to implement federally matched Medicaid coverage of reentry services and health-related social needs, and to reinvest the state savings in the Department of Corrections, DOLA, and CDHS. Reinvestment of funds is required under federal law

[5] The service groups included High Intensity Outpatient ($14M in FY 2020-21 and $26M in FY 2023-24), Inpatient Hospital ($83M in FY 2020-21 and $94M in FY 2023-24) and Outpatient Prevention and Treatment ($368M in FY 2020-21 and $476M in FY 2023-24)

[6] The peer support services data included: Behavioral Health Outreach Service (H0023), Self-Help/Peer Services (H0038) and Skills Training and Development (H2014).

and must be done in alignment with the programs that have been financed through the 1115 waiver.

Collaboration with BHA

In FY 2024-25, HCPF worked closely with BHA to plan for the alignment of regions and work performed by the RAEs and newly implemented BHASOs. Where RAEs are responsible for overseeing behavioral health service delivery for Health First Colorado members, the BHASOs oversee the statewide behavioral health safety net and may pay for service of uninsured and underinsured Coloradans. Care coordination was identified as one of the key focus areas needing clear and detailed alignment in recognition of the need to collaborate as more Coloradans continue to cycle on and off of Medicaid after the public health emergency. HCPF and BHA worked together to align the RAE and BHASO scopes of work around care coordination to ensure that members transitioning between systems do not experience duplication of efforts nor gaps in care. Beginning July 1, 2025, this includes:

- Requiring the RAEs and BHASOs to have collaborative agreements in place that establish standards, processes and workflows for cross-agency communication and coordination; defined roles and responsibilities; data sharing; and a process for escalating member concerns when necessary.
- Implementation of a standardized tiering system (Tier 1 Care Navigation, Tier 2 Care Coordination, Tier 3 Care Management) to ensure Coloradans transitioning between RAEs and BHASOs due to changes in Medicaid status will continue to receive the same level of care coordination support in both systems.
- Warm handoffs between care coordinators when a member is transitioning from a RAE to a BHASO and vice versa, as well as the sharing of care coordination documentation, such as care plans and needs assessments, to prevent duplication of effort and gaps in care.

Integrated Care Sustainability Policy

In accordance with House Bill 22-1302, HCPF has funded short-term grants to support further integration of behavioral health services in primary care settings through December 2026. To date, more than 170 sites have expanded or implemented integrated behavioral health care. In addition to funding grants, House Bill 22-1302 directed HCPF to complete a report on the program and outline strategies to sustain integrated care. Through this report, HCPF developed the Integrated Care Sustainability Policy, effective July 1, 2025, which includes the following:

- The previous fee-for-service Short-Term Behavioral Health visit policy ended. These services will be covered under the behavioral health capitation managed by the RAEs.

- Based on stakeholder feedback, specific code sets have been opened for PCMPs to bill fee-for-service to HCPF, with the intention of expanding the policy to all primary care providers in the future.
- In ACC Phase III, PCMPs may receive an additional per-member-per-month payment from their RAE if they meet certain criteria for providing integrated care in their practices.

Ultimately, this policy was developed to improve member health and access to care by better supporting practices in providing integrated physical and behavioral health care.

Behavioral Health Provider Network

HCPF is committed to building provider networks so that all members can access the care they need. Federal and state managed care regulations require strict monitoring of provider access and adequacy to ensure members' needs are met. HCPF monitors behavioral health network adequacy through annual network adequacy reports and quarterly reports on network development. All network data submitted to HCPF is validated and reviewed for accuracy by a third-party external quality review organization.

As regional entities, RAEs have the flexibility to develop provider networks to meet their unique geographic needs. In cases where RAEs have identified gaps in their network, they have adopted innovative strategies to build the capacity of their networks so they can deliver comprehensive behavioral health services. They may contract with new providers from other state systems (e.g., child welfare or criminal justice), establish new service modalities (e.g., telehealth), create value-based payments, recruit new providers or help existing provider practices expand their capacity to serve new populations or offer new services.

In FY 2024-25, the ACC added over 2,300 contracted behavioral health practitioners from the previous year, including licensed psychologists and licensed behavioral health clinicians. This is a 30% increase in the number of contracted practitioners statewide since June 30, 2023.

Table 8. Number of MCE-contracted behavioral health practitioners from June 30, 2023 to June 30, 2025

MCE	Behavioral Health Practitioners as of June 30, 2023	Behavioral Health Practitioners as of June 30, 2024	Behavioral Health Practitioners as of June 30, 2025
DHMC	8,302	9,059	10,309
1 (RMHP)	4,064	5,631	6,746
2 (NHP)	3,480	4,504	5,834

MCE	Behavioral Health Practitioners as of June 30, 2023	Behavioral Health Practitioners as of June 30, 2024	Behavioral Health Practitioners as of June 30, 2025
3 (COA)	8,300	9,062	10,309
4 (HCI)	3,480	4,506	5,834
5 (COA)	8,302	9,059	10,309
6 (CCHA)	7,421	9,193	9,504
7 (CCHA)	7,421	9,193	9,504
Statewide	**11,417**	**12,478**	**14,807**

Note: The following MCEs share a network: DHMC and RAE 5, RAEs 2 and 4, RAEs 3 and 5, and RAEs 6 and 7. Statewide counts are de-duplicated.

1. Behavioral Health Network Adequacy Analysis

In FY 2024-25, HCPF completed a multi-year project with a contractor to assess access to behavioral health providers. This analysis was broken into three phases: Phase I identified the extent of "phantom providers" that were enrolled with HCPF and contracted with the MCEs, but not actively billing for services; Phase II examined member demographic characteristics, behavioral health diagnoses and behavioral health service utilization; and Phase III analyzed telehealth utilization and conducted additional analyses to identify potential network gaps within MCE networks by service types, county and provider types. As a result of this analysis and as part of improvements for ACC Phase III, HCPF now requires MCEs to exclude phantom providers from their provider directories and the network adequacy reports. The full reports are available in the American Rescue Plan Act (ARPA) Project Completion Summary.

2. SUD Network

In FY 2024-25, there were 293 additional contracted SUD providers statewide across all SUD service levels, expanding access to the continuum of services available to members. In 2024, more than 2,900 members received SUD high-intensity outpatient treatment services, a 23% increase in the number of members served since the previous year. This was supported by an increase of 107 high-intensity outpatient treatment providers across the state. Additionally in 2024, more than 8,000 members received residential and hospital SUD treatment services, a 24% decrease in the number of members served since the previous calendar year. Initial authorization denials for residential services have continued to decrease through the fourth year of the 1115 waiver demonstration to about 3%. HCPF and the RAEs are working to further improve SUD networks by supporting SUD providers in the transition to meet new national licensing and level of care standards from the American Society of Addiction

Medicine. This includes new expectations for the integration of withdrawal management services in treatment facilities instead of as a stand-alone service.

Long-Term Services and Supports Care Coordination

1. *RAE and CMA Collaboration*

HCPF supports a monthly RAE-CMA Cross Agency Forum (CAF) to strengthen coordination for members receiving both care coordination and case management. Co-led by rotating RAE and CMA leadership, the CAF provides policy updates, aligns workflows and facilitates case consultations across agencies. Attendees of the CAF include representatives from all four RAEs and all 15 CMAs. The CAF also encourages RAEs and CMAs to support one another with case consults and highlight successful collaboration stories that have occurred since the start of the CAF.

A success story highlights one such collaboration: A RAE and CMA partnered to support an adolescent member with Autism Spectrum Disorder who had been hospitalized for unsafe behaviors. While residential treatment was recommended, placement options were limited due to the member's diagnosis. The team worked together to transition the member from the Children's Extensive Support Waiver to the Children's Habilitation Residential Program Waiver, opening access to more facilities. When the only suitable program required child welfare involvement, the RAE and CMA helped the family open a voluntary case and coordinated with child welfare on a discharge plan. The member is now in safe residential care with a plan to return home.

In Phase III, RAEs have expanded requirements to collaborate with entities that serve shared members, such as Dual Eligible Special Needs Plans, community-based organizations and BHASOs, to improve coordination and ensure members are getting the care they need. As a result, HCPF will continue the CAF into FY 2025-26 with plans on incorporating other entities that provide care coordination services in these collaboration efforts.

2. *Members At-Risk of Institutionalization*

In October 2024, HCPF entered into an agreement with the U.S. Department of Justice to support members at risk of institutionalization in accessing services that allow them to live in community settings. While many of these members are on waivers and connected to CMAs, some are not. MCEs worked in collaboration with HCPF staff to develop a process to outreach members without existing CMA relationships. Through this process, MCEs are connecting members to general care coordination, waiver services and housing-related supports. The outreach process was implemented in late FY 2024–25 and continues to be refined. Additional information is available on the Nursing Facility Diversion Projects webpage.

Inpatient Hospital Transitions of Care

The Inpatient Hospital Transitions (IHT) program launched on Sept. 9, 2024, replacing the Inpatient Hospital Review Program 2.0. IHT focuses on complex inpatient hospital transitions from one level of care to another. This program is not tied to inpatient authorizations or claims payments, but is instead designed to enhance coordination between hospitals and MCEs for smoother and more effective discharge planning. Hospitals initiate communication with MCEs using the IHT Questionnaire, focusing on certain patients with complex discharge plans and all inpatients at day 30 of hospitalization and every 30 days thereafter. HCPF tracks the frequency in which members receive follow-up care after discharge from an inpatient facility to ensure members' needs are being met. A dedicated Joint Operating Committee, composed of HCPF staff, hospitals and MCEs, met monthly through the end of 2024 to address implementation questions and share best practices.

Operational Excellence and Customer Service

Access to care depends on having processes that are responsive to the needs of both providers and members. An important role for health plans and payers is to facilitate a good experience for members and providers so that they can navigate the system and spend more time focused on health and well-being.

Member Experience

HCPF assesses member experience in a few different ways, one of which is the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey. CAHPS Health Plan Surveys are a set of standardized questions used throughout the health care industry to assess patient perspectives on care, which allows the ACC to compare the survey results to national standards. The 2025 Health Plan Survey asked members (or their parents/guardians) questions about how they like their doctor, whether they were able to get needed care in a timely manner, provider communication, health plan customer service and coordination of care.

Ratings varied across MCEs for each factor, but most members reported satisfaction with the questions in table 9. Survey conclusions indicate that HCPF and the MCEs should continue building provider networks and addressing provider barriers to ensure access to care.

Table 9. MCE Performance on CAHPS Surveys

MCE	Getting needed care	Getting care quickly	Satisfaction with care coordination	Satisfaction with their doctor's communication	Satisfaction with MCE customer service
RAE Aggregate	Adults: 79.8% Children: 83.3 %	Adults: 80.3% Children: 88.4%	Adults: 85.9% Children: 80.0%	Adults: 93.4% Children: 94.6%	Adults: 86.4% Children: 86.3%

MCE	Getting needed care	Getting care quickly	Satisfaction with care coordination	Satisfaction with their doctor's communication	Satisfaction with MCE customer service
DHMC	Adults: 79.0% Children: 76.4%	Adults: 85.3% Children: 78.3%	Adults: 90.6% Children: 92.0%	Adults: 94.6% Children: 91.9%	Adults: 86.8% Children: 86.6%
RMHP PRIME*	Adults: 84.5%	Adults: 84.4%	Adults: 84.5%	Adults: 94.3%	Adults: 94.2%

*Only children with disabilities are currently enrolled in RMHP PRIME, which is a very small percentage of their membership. As such, there are no children's survey results available for this MCO.

Another way to assess member experience is by measuring the responsiveness of each MCE call center. HCPF closely monitors the MCEs' call volume, average call response times and call abandonment rate. If the MCEs miss contractual standards for these call center metrics, HCPF takes corrective action to hold them accountable. In FY 2024-25, the average speed of answer across MCE member call centers was approximately 35 seconds and most MCEs reported call abandonment rates of 1.1% or lower. When DHMC's average speed of answer and member call abandonment rates spiked beyond contractual requirements, HCPF took immediate corrective action. DHMC hired new staff and implemented new processes and training that resulted in significant improvements in the final six months of FY 2024-25.

Table 10. Member call center data by MCE, FY 2024-25

MCE	Average member monthly call volume	Member response times (avg. speed of answer)	Member call abandonment rate
DHMC	2,263	134 seconds	9.0%
1 (RMHP)/RMHP PRIME	3,515	8 seconds	0.6%
2 (NHP)	362	2 seconds	0.1%
3 (COA)	1,561	41 seconds	1.2%
4 (HCI)	361	2 seconds	0%
5 (COA)	1,561	41 seconds	1.2%
6 (CCHA)	1,620	13 seconds	0.7%
7 (CCHA)	659	14 seconds	0.8%

Note: The following MCEs share a member call center: RAEs 2 and 4, and RAEs 3 and 5.

Provider Experience

A positive provider experience depends on several factors, including smooth enrollment and contracting, timely processing of claims payments and timely responses to questions. As managed care entities for behavioral health, RAEs are responsible for contracting with providers and ensuring a good provider experience

that will lead to better care and outcomes for members. RAEs also contract with PCMPs and work closely with other physical health providers in the region. RAEs are responsible for processing behavioral health claims that fall within the managed behavioral health benefit and paying providers the contracted rate. In compliance with federal regulations, HCPF requires that the RAEs adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party.

Providers submitting claims to their RAE must provide adequate documentation and adhere to the provider's contract with the RAE. Claims can be denied if they do not meet medical necessity requirements. More often, they are denied due to inaccurate billing and documentation. Each RAE has a call center and provider relations staff to help providers with billing questions. They are required to respond to provider questions within two days. Table 11 shows performance on each provider service requirement in the last month of the reporting period.

Table 11. Performance on provider service requirements by MCE, June 2025

MCE	% of clean claim payments within 30 days (standard: 90%)	Response to provider inquiries within two days (standard: 100%)	Credentialing and contracting within 90 days (standard: 90%)
DHMC	99.1%	100%	100%
1 (RMHP)/RMHP PRIME	99.9%	100%	100%
2 (NHP)	97.8%	100%	100%
3 (COA)	92.3%	100%	100%
4 (HCI)	98.7%	100%	100%
5 (COA)	99.1%	100%	100%
6 (CCHA)	100%	100%	100%
7 (CCHA)	100%	100%	100%

A provider's experience is better when they can get help and answers to questions in a timely manner. In FY 2024-25, the average speed of answer across MCE provider call centers was 31 seconds. Similar to member call center performance, HCPF monitors the following provider call center metrics to maintain accountability for the MCEs. HCPF took additional corrective action for DHMC's provider call center performance that resulted in significant improvements in the final six months of FY 2024-25.

Table 12. Provider call center data by MCE, FY 2024-25

MCE	Average provider monthly call volume	Provider response times (avg. speed of answer)	Provider call abandonment rate
DHMC	1,437	68 seconds	7.7%
1 (RMHP)/RMHP PRIME	2,976	23 seconds	1.3%
2 (NHP)	407	4 seconds	0.1%
3 (COA)	1,956	44 seconds	0.8%
4 (HCI)	407	4 seconds	0%
5 (COA)	1,956	44 seconds	0.8%
6 (CCHA)	1,271	16 seconds	0.7%
7 (CCHA)	1,271	16 seconds	0.7%

Note: The following MCEs share a provider call center: RAEs 2 and 4, RAEs 3 and 5, and RAEs 6 and 7.

Member and Provider Engagement

The ACC has both a statewide Program Improvement Advisory Committee (PIAC) and regional PIACs to better inform programmatic decisions. The statewide PIAC is managed by HCPF and facilitated by two co-chairs. It includes representatives from various provider groups, advocacy organizations, members and other stakeholders. At regular public meetings, the statewide PIAC considers actions related to the ACC and provides formal recommendations to HCPF for program improvement. The PIAC also utilizes three subcommittees that focus on behavioral health, provider and community experience, and performance measurement and member engagement. By contract, each RAE must also manage a regional PIAC. These groups, composed of regional stakeholders, help RAEs identify local challenges and concerns as well as opportunities for improvement.

HCPF also uses feedback from state and regional Member Experience Advisory Councils (MEACs) to help identify and address potential concerns with the ACC. These groups are composed entirely of Health First Colorado and CHP+ members, or their family members/guardians. Similar to the PIAC structure, the statewide MEAC is managed by HCPF, while regional MEACs are managed by the RAEs.

HCPF regularly discusses a broad scope of topics related to the ACC program. Priority topics in FY 2024-25 included ACC Phase III planning such as PCMP payment and member communications; review of ACC performance metrics; HCPF's strategies to respond to state budget constraints and upcoming federal changes; planning and updates related to the safety net system, implementation of Cover All Coloradans and supporting disability competent care; and health equity work.

MCE Accountability

HCPF oversight of the MCEs begins by ensuring contract requirements comply with extensive federal and state statutes and regulations. All MCE contract language must be approved by CMS. The contracts include stringent statements of work and are amended bi-annually to adjust for environmental changes, operational realities, and new state priorities, including those identified by providers and members. HCPF reviews comprehensive deliverables submitted by the MCEs that document operational and financial performance, program strategies, network performance and governance structures. HCPF enforces all of this via a thorough contract remedy process to address deficiencies in MCE contract performance. When MCEs are not meeting contract elements, they are placed on action monitoring plans or corrective action plans. Additionally, HCPF has a process for providers to submit escalation requests directly to the department in the event that they require assistance resolving issues with their MCE. HCPF compiles this information, shown in table 13, to review with each MCE during regular check-in meetings, as well as during quarterly meetings that include leadership from both HCPF and the MCE.

Table 13. Accountability Monitoring by MCE, FY 2024-25

MCE	Provider Escalation Requests*	Action Monitoring Plans	Corrective Action Plans
DHMC	4	1	0
1 (RMHP)/RMHP PRIME	11	1	0
2 (NHP)	16	2	0
3 (COA)	12	0	0
4 (HCI)	21	3	0
5 (COA)	12	0	0
6 (CCHA)	36	0	0
7 (CCHA)	34	0	0

*It is common for an escalation request to include multiple MCEs, as applicable. These counts are not unique counts of individual requests for escalation.

Health First Colorado Value

The ACC is designed to provide value to Colorado, ensuring that members get the right services, at the right place, for the right price and the right health outcome. The ACC provides the foundational structure for HCPF's payment strategy and the space to test alternative payment models to drive affordability, quality, access and equity across Health First Colorado. This enables HCPF to better control cost trends, protect provider reimbursements, and ensure member benefits and program access, especially during economic downturns.

To evaluate the effectiveness of cost control, HCPF looks at the overall Medicaid claim cost trend, which is measured in several ways. One way is to look at the cost

trend, or the rate at which health care costs are increasing. From July 2024 to June 2025, the per-member-per-month trend was 26.2%. During the evaluation period, the approved across the board provider reimbursement increase, which has a direct impact on Medicaid cost trend, was 2%. In addition, there were large, targeted rate increases for certain services, in particular for the home and community-based services waivers and nursing facilities. The trend in total claims paid was 10%, which reflects an average monthly membership decline of 12.9% due to the PHE.

ACC Budget

HCPF strives to efficiently administer Health First Colorado and only retains 4% of the annual budget for administrative expenses. HCPF has applied the same value for efficiency to the ACC; this section describes the ACC's budget and summarizes ACC efforts in the past year to increase value and control costs. Costs for the ACC include:

- **Payments for medical and behavioral health care**: These payments cover the cost of care. For most medical/physical health services, HCPF pays fee-for-service claims directly to the provider that delivered the service. The exceptions are the two MCOs, which receive a capitated payment for physical health services provided to members. Most behavioral health services are covered as part of a capitated benefit.
- **RAE administration and care coordination:** PMPM payments go to the RAEs for the administration, care coordination and population health work of the program. By contract, the RAEs must distribute at least 33% of these payments to their PCMPs for the work they do to serve as medical homes.
- **Incentives:** These payments incentivize and reward RAEs for meeting or exceeding performance targets. These include KPI payments, which are drawn from a portion of the RAE's care management PMPM payment and set aside to incentivize RAEs to meet or exceed the targets for these performance indicators. RAEs can also receive BHIP payments, which are used to incentivize performance on behavioral health indicators. Finally, the Performance Pool is a flexible pool of funds that is used for a variety of improvements or performance incentives. RAEs regularly distribute most of their incentive payments to their contracted providers.

Table 14. ACC Budget, FY 2024-25

ACC Budget Category	FY 2024-25 Expenditures
Payments for Services	
Fee-for-service payments	$11,274,151,066
DHMC MCO capitation payments	$277,734,948
RMHP PRIME MCO capitation payments	$257,090,531
Behavioral health capitation payments	$1,172,329,688
Administrative and Incentive Payments	
Care management PMPM payments	$148,329,689
KPI payments	$16,891,336
BHIP payments	$54,319,916*
Performance pool payments	$24,830,011
Total ACC Expenditures	**$13,225,677,185**

*Due to delays in posting payments, this amount also includes incentives earned in FY 2023-24.

MCE Profit Margins and MLRs

MLR and profit margin are both used to measure financial performance for each MCE. Profit margin is calculated by subtracting both medical and administrative expenses from total revenue, then dividing the result by total revenue. This indicates whether an MCE is operating at a profit or loss relative to its total funding. Similar to MCOs, MLR is used to measure how much RAEs spend providing behavioral health services through the behavioral health capitation versus administrative services and profit. MCEs are required to maintain a minimum MLR of 85%, meaning at least 85% of their spending is to provide behavioral health services. In instances where MCEs have an MLR less than 85%, they are required to return funding to HCPF.

In FY 2023–24, most MCEs experienced a net loss. Overall, the behavioral health program posted a margin of -3.7%, while the cumulative margin over the past three years stands at 1.6%. A negative margin means that the cost of operations and administration was higher than the total annual budget for the MCE. By operating with narrow or even slightly negative margins, the ACC ensures that most of its funding is directed toward enhancing member care.

Table 15. MCE Behavioral Health Revenue, FY 2023-24

MCE	MLR	Profit Margin
DHMC	92.3%	-1.6%
1 (RMHP)	96.4%	0%
2 (NHP)	80.2%	-0.3%

MCE	MLR	Profit Margin
3 (COA)	96.7%	-6.6%
4 (HCI)	90.6%	-4%
5 (COA)	96.2%	-7.8%
6 (CCHA)	94.6%	2%
7 (CCHA)	102.9%	-7%
Statewide	**N/A**	**-3.7%**

MCO Cost of Care

The cost of care for members in capitated managed care plans includes three elements: the physical health capitation for members, the behavioral health capitation for members and the cost of any services that are not covered by the capitation (fee-for-service payments). The fee-for-service category includes long-term services and supports, medical transportation, and some Early and Periodic Screening, Diagnostic, and Treatment services for children. Capitated MCOs are designed to be budget neutral; capitation payments must be at or below 98% of the fee-for-service equivalent.

Although RMHP PRIME and DHMC are both MCOs, they are structured differently and their cost of care shouldn't be directly compared. RMHP PRIME only covers children with a disability and adults. Because their population tends to be higher acuity, the services they pay for tend to be more expensive. In contrast, DHMC covers all children and adults, which spreads the cost of services for higher acuity members over a larger population. The reported results are from FY 2023–24 rather than FY 2024–25 due to the time it takes for the data to be collected and processed.

Table 16. MCO Cost of Care, FY 2023-24

Cost	DHMC	RMHP PRIME
Physical Health Capitation: Total payments for medical care.	$254,084,912	$248,267,089
Behavioral Health Capitation: Total payments for MH and SUD care.	$66,664,358	$43,673,167
Fee-for-Service Payments: Payments for services not covered under the capitation.	$84,830,752	$75,643,345
Delivery Paid Amounts: Payments made to DHMC for maternal deliveries. These are unique to DHMC.	$7,186,756	N/A
Total Cost of Care: Sum of physical and behavioral health capitation payments and fee-for-service payments	$412,766,778	$367,583,600
Cost of Care PMPM: The amount of money paid or received monthly for each individual enrolled in the managed care plan.	$411.95	$712.13

Hospital Transformation Program

The Hospital Transformation Program (HTP) funds and supports incentive payments to improve health care access and outcomes by tying provider fee-funded hospital payments to quality-based initiatives. Hospital-led projects aim to benefit not only Health First Colorado members but all Coloradans through better outcomes, system performance and collaboration with health partners.

The HTP completed its third performance year on Sept. 30, 2024. Hospitals showed strong improvement across all RAE-related measures since the first performance year, with the most performance improvement for notification of positive perinatal and post-partum depression and anxiety screenings to the RAE, and behavioral health and substance use disorder discharge coordination. In FY 2024-25, RAE 2 (NHP) made progress supporting hospitals on the Eastern Plains by helping to facilitate referrals and appropriate transitions between levels of care for members using refined data transmission processes. These results reflect effective care coordination and improved communication between hospitals and RAEs, ultimately supporting better outcomes for members across Colorado.

Prescriber Tool

Launched in 2021, the Prescriber Tool enhances prescription drug transparency and affordability by delivering pharmacy benefit information at the point of care. Supported by the RAEs, HCPF has successfully promoted the tool, with nearly half of active Health First Colorado providers using at least one of its four modules: electronic prescribing, electronic prior authorization, real-time benefits inquiry and the opioid misuse risk module.

In 2023, HCPF introduced the Prescriber Tool Alternative Payment Model (APM) to engage providers in reducing drug costs. Over 700 practices participated in the second year of this APM, with 75% of the $612,665 shared savings pool distributed to providers. RAEs played a key role in outreach and education, helping update contact information and promote tool benefits.

Provider feedback from survey results highlight the tool's ease of use, improved communication through point-of-care benefit visibility and reduced prior authorization times. HCPF is now redesigning the APM to better align with broader initiatives, ease administrative burden and further incentivize adoption.

Alternative Payment Models

Value-Based Payments (VBPs), also known as APMs, link provider reimbursement to quality and outcomes rather than service volume. These models give providers flexibility to focus on coordinated, patient-centered care. HCPF set a goal to tie 50%

of Health First Colorado payments to value-based arrangements by 2025. Preliminary data for FY 2024–25 shows this goal has been met, with an estimated 52% of payments linked to VBPs. MCEs have been important partners in helping HCPF achieve this goal by providing education and support for providers participating in these programs.

1. *APM 1*

APM 1 is a pay-for-performance model designed to enhance member health outcomes and contain costs by introducing performance accountability and aligning financial incentives with quality improvement for PCMPs. In 2023 (the most recent data for all practices), all 20 federally qualified health centers (FQHCs) achieved their quality threshold and were eligible for an enhanced rate. The rate of non-FQHC practices that met the quality score threshold increased from 87% (278 of 318) in 2022 to 90% (307 of 342) in 2023, reflecting improved performance and continued provider engagement with the program. HCPF also engaged with PCMPs, RAEs and other stakeholders on APM 1 program design improvements to support the transition to a new PCMP quality incentive structure in ACC Phase III.

2. *APM 2*

APM 2 includes two programs, prospective payment and shared savings incentive payments. Prospective payment allows PCMPs to receive some or all of their primary care service revenue as prospective PMPM payment, offering greater revenue stability and flexibility. FQHCs may participate in a modified version of the program that provides some flexibility to accommodate the federal payment requirements for FQHCs. In 2024, a total of 239 PCMPs participated in APM 2, including both FQHC and non-FQHC providers, representing a total of 522,594 Health First Colorado members.

Shared savings incentive payments reward PCMPs for cost-effective chronic condition management in which cost savings are split evenly between PCMPs and HCPF. In 2023 (the most recent data), 19 of 40 participating PCMPs achieved a total of $845,676 shared savings, an increase compared to the previous year. The majority of cost reductions occurred within professional and outpatient claims for services such as consultations, imaging, physical therapy, medical equipment/supplies and home health care.

In FY 2024-25, HCPF completed 22 sessions with a small stakeholder program design team to review the current APM 2 program and design a pediatric-specific primary care APM (formerly referred to as Payment Alternatives for Colorado Kids or PACK). These sessions revealed that many pediatric practices have struggled to participate in APMs due to limited financial capacity and thin operating margins. This feedback has informed an updated primary care payment structure in alignment with ACC Phase III.

3. *Maternity Bundled Payment (MBP) Program*

Launched in 2020, the MBP program aims to improve maternal care quality while controlling costs for prenatal, labor and delivery, and postpartum services. The MBP program concluded its fourth year in October 2024 with nine obstetrical practices enrolled, representing approximately 33% of Health First Colorado births. HCPF has held a series of stakeholder sessions to develop a new Maternity APM focused on key areas such as tailoring payments based on distinct episodes of care, inclusion of newborn care services, promotion of team-based care, and postpartum incentive payments.

4. *ACC Phase III Single Comprehensive Primary Care Payment Structure*

In preparation for ACC Phase III, HCPF proposed major revisions to its primary care value-based payment structure, aimed at reducing administrative burden for providers by aligning quality measures across payers and programs, eliminating duplication and improving payment transparency. The proposed changes aim to effectively consolidate the multiple existing APMs across HCPF and the RAEs into a single, comprehensive primary care payment structure in ACC Phase III. Under this framework, HCPF will continue to pay primary care providers directly for the delivery of Health First Colorado-covered services. RAEs will be responsible for administering payments that are not directly tied to primary care service delivery, such as incentive payments for meeting quality performance benchmarks. This division of responsibilities is intended to simplify the payment process and reinforce shared accountability.

Priorities for FY 2025-26

In FY 2025-26, the primary priority will be to continue the implementation of new programs and policies as part of the new ACC Phase III RAE contracts, while ensuring a smooth transition for members and providers. Key focus areas include oversight of expanded care coordination contract requirements, with an emphasis on the RAE expectations to provide support for transitions of care; continued alignment of alternative payment model programs to create a single, comprehensive payment structure for PCMPs, including the implementation of improved Quality Incentive and Shared Savings programs; and moving towards a data-informed program management structure to assess RAEs' contract compliance through new performance standards.

Stakeholder engagement was a priority in designing ACC Phase III and will continue to be a priority in understanding program effectiveness. HCPF will engage stakeholders through the regular PIAC and subcommittee forums to understand their experience with the program and opportunities for improvement.

In addition, HCPF will focus on the following:

- Continued collaboration with BHA to ensure alignment between RAEs and BHASOs.
- Implementation of the approved 1115 waiver amendments to support reentry services for individuals transitioning from correctional facilities, support utilization of the full continuum of behavioral health services for individuals with SMI or SED, and coverage of HRSN services for certain members.
- Continued collaboration with the Office of eHealth Innovation to increase members' access to HRSN support through the CoSHIE.
- Improved coordination of services for children and youth including the implementation of CO-SOC, preparing for the utilization management and payment of children in the custody of county child welfare to move under the behavioral health capitation administered by RAEs, and developing a process for RAE care managers to seamlessly connect eligible children and youth discharging from residential settings with CO-SOC services.
- Continued efforts to reduce Medicaid trends through the Medicaid Innovation, Sustainability and Opportunities project. HCPF has retained a third party consultant to compare our programs, reimbursements, cost management solutions and more to other Medicaid programs around the nation. Our trend management strategies will be refined and expanded based on these learnings as well as stakeholder engagement using an external facilitator to invite broad-based stakeholder input.
- Implementation of Facility Cost and Quality Indicators to provide members and providers with information about the quality of care, cost and patient experience at hospitals and other health care facilities so they can make the most informed decision about where to access or refer care.

The ACC is an iterative program; we are constantly improving policies in response to member, provider and other stakeholder feedback. Visit the ACC webpage for the most updated information and resources about our program.

Appendices

Appendix A. Key Performance Indicator Definitions

The following KPIs were used in FY 2024-25:

1. **Depression Screening and Follow-Up:** Percentage of members age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.
2. **Oral evaluation, dental services**: Percentage of enrolled children under age 21 who receive a comprehensive or periodic oral evaluation within the measurement year.
3. **Well child visits 0-15 months:** Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.
4. **Well child visits 15-30 months:** Percentage of children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
5. **Child and adolescent well visits**: Percentage of child and adolescent members ages 3 to 21 who had at least one comprehensive well-care visit with a primary care physician.
6. **Timeliness of Prenatal Care**: The percentage of deliveries in which members had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
7. **Postpartum care:** Percentage of deliveries of live births on or between April 8 of the year prior to the measurement year and April 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
8. **Emergency department visits**: Number of emergency department visits per 1,000 members per year.
9. **Risk-adjusted PMPM**: Measures whether a RAEs risk-adjusted PMPM cost was less than the ACC average risk-adjusted PMPM cost of $544.50 or reduced from a set baseline.

Appendix B. Performance Pool Measure Definitions

As a result of the timing, funds distributed to the RAEs in FY 2024–25 were for the RAEs' performance during FY 2023–24. Performance pool measures included:

1. **Extended care coordination**: Percentage of members with complex care needs who received extended care coordination as an intervention, which includes a care plan and bi-directional communication with the member through face-to-face conversations, phone or text.
2. **Premature birth rate**: Percentage of premature births (gestation less than 37 weeks) per total live births during the measurement period.
3. **Behavioral health engagement for members releasing from state prisons**: Percentage of members releasing from a Department of Corrections facility with at least one billed behavioral health capitated service or short-term behavioral health visit within 14 days. Given challenges with the Department of Corrections roster, RAEs will be measured as a collective group and earn incentive money only if the collective group meets its target. This target was developed to align with HCPF's Wildly Important Goal for justice-involved members.
4. **Asthma medication ratio**: Percentage of patients aged 5–64 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the performance year. (When asthma is controlled, patients should take more controller medications than emergency rescue medications.)
5. **Antidepressant medication management**: The percentage of members 18 years of age and older who had a diagnosis of major depression, were treated with antidepressant medication and remained on that medication treatment during the acute phase (12 weeks) and continuation phase (at least six months).
6. **Contraceptive care for postpartum women**: Percentage of women aged 15–44 who had a live birth and were provided with either a most effective method of contraception (sterilization, implants, intrauterine devices or systems) or a moderately effective method (injectables, oral pills, patch, ring or diaphragm) within three to 60 days of delivery.

Appendix C. Behavioral Health Incentive Program Indicator Definitions

As a result of the timing, funds distributed to the RAEs in FY 2024–25 were for the RAEs' performance during FY 2023–24. BHIP indicators included:

1. **Engagement in outpatient SUD treatment**: Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
2. **Follow-up within 7 days after an inpatient hospital discharge for a MH condition**: Percent of member discharges from an inpatient hospital episode for treatment of a covered MH diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a MH provider within seven days.
3. **Follow-up within 7 Days after an emergency department visit for a SUD**: Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.
4. **Follow-up after a positive depression screen**: Percent of members engaged in MH service within 30 days of screening positive for depression.
   a. **Note:** Performance for this measure is not included in table 5 due to pending updates to the measure calculation.
5. **Behavioral health screening or assessment for foster care children**: Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment. This metric was intended to incentivize collaboration between counties and RAEs. It is not a reflection of all behavioral health assessments for children in foster care, and many external factors affect it. Statewide RAE performance has improved by more than double since the metric was created in FY 2017–18.

Appendix D. MCO Medical Loss Ratio Quality Metric Definitions

The following MLR metrics were used to incentivize performance for RMHP PRIME:

1. **Initiation and Engagement of Alcohol and Other Drug Dependence: Engagement.** Percentage of members aged 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
    - Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
    - Engagement of AOD Treatment. Percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. (Note: This metric was not used for MLR calculations during FY 2022–23 but will be used starting in FY 2023–24.)
2. **Timeliness of Prenatal and Postpartum Care.**
    - Timeliness of Prenatal Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
    - Postpartum Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
3. **Preventive Care and Screening: Screening for Depression and Follow-Up Plan.** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.
4. **Diabetes HbA1c Poor Control >9.0%.** Percentage of members ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) >9.0%.

For DHMC, the following MLR metrics were used to incentivize performance:

1. **Well-Child Care**
    - Percentage of children who had well-child visits with a primary care practitioner according to the following schedule:

        - Six or more well-child visits in the first 15 months of life.
        - Two or more well-child visits for children ages 15 to 30 months.
    - Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist during the measurement year.
2. **Timeliness of Prenatal and Postpartum Care.**
    - Timeliness of Prenatal Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
    - Postpartum Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
3. **Initiation and Engagement of Alcohol and Other Drug Dependence: Initiation and Engagement**. This measures the percentage of members age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
    - Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
    - Engagement of AOD Treatment. Percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.
4. **Screening for Depression and Follow-Up**. Percentage of beneficiaries ages 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.