Department of Health Care Policy and Financing

Funding Request for the FY 2025-26 Budget Cycle

Request Title

R-06 Accountable Care Collaborative Phase III

Dept. Approval By: _____ ____ **Supplemental FY 2024-25**

OSPB Approval By: _____ ____ **Budget Amendment FY 2025-26**

X **Change Request FY 2025-26**

Summary Information	Fund	FY 2024-25 Initial Appropriation	FY 2024-25 Supplemental Request	FY 2025-26 Base Request	FY 2025-26 Change Request	FY 2026-27 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$12,077,687,938**	**$0**	**$12,143,547,673**	**($2,465,730)**	**$1,273,591**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,606,129,879	$0	$3,589,059,753	($1,254,288)	$776,450
	CF	$1,334,350,545	$0	$1,323,858,226	$275,580	($38,671)
	RF	$120,397,970	$0	$120,397,970	$0	$0
	FF	$7,016,809,544	$0	$7,110,231,724	($1,487,022)	$535,812

Line Item Information	Fund	FY 2024-25 Initial Appropriation	FY 2024-25 Supplemental Request	FY 2025-26 Base Request	FY 2025-26 Change Request	FY 2026-27 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	**Total**	**$39,323,047**	**$0**	**$32,318,791**	**$2,100,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,318,306	$0	$11,685,822	$649,635	$0
	CF	$3,462,102	$0	$2,393,155	$400,365	$0
	RF	$81,000	$0	$81,000	$0	$0
	FF	$21,461,639	$0	$18,158,814	$1,050,000	$0
01. Executive Director's Office, (B) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$107,008,840**	**$0**	**$101,557,279**	**$950,000**	**$250,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,031,794	$0	$15,928,015	$59,850	$15,750
	CF	$9,382,159	$0	$9,357,543	$49,400	$13,000
	RF	$12,204	$0	$12,204	$0	$0
	FF	$79,582,683	$0	$76,259,517	$840,750	$221,250
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$11,931,356,051**	**$0**	**$12,009,671,603**	**($5,515,730)**	**$1,023,591**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,573,779,779	$0	$3,561,445,916	($1,963,773)	$760,700
	CF	$1,321,506,284	$0	$1,312,107,528	($174,185)	($51,671)
	RF	$120,304,766	$0	$120,304,766	$0	$0
	FF	$6,915,765,222	$0	$7,015,813,393	($3,377,772)	$314,562

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Governor Jared Polis
FY 2025-26 Funding Request

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
November 1, 2024

Department Priority: R-06
ACC Phase III

Summary of Funding Change for FY 2025-26

Fund Type	FY 2025-26 Base Request	FY 2025-26 Incremental Request	FY 2026-27 Incremental Request
Total Funds	$12,143,547,673	($2,465,730)	$1,273,591
General Fund	$3,589,059,753	($1,254,288)	$776,450
Cash Funds	$1,323,858,226	$275,580	($38,671)
Reappropriated Funds	$120,397,970	$0	$0
Federal Funds	$7,110,231,724	($1,487,022)	$535,812
FTE	0.0	0.0	0.0

Summary of Request

Problem or Opportunity: The Accountable Care Collaborative (ACC) is Colorado's Medicaid care delivery system responsible for the administration of behavioral health benefits and the cost-effective coordination of Medicaid services. The ACC leverages the best features of Accountable Care Organizations (ACOs) and capitated managed care to support members in navigating a complex health system, while providing financial, care coordination, and other supports to providers. State Procurement Code requires the re-procurement of vendors every five to seven years. Current contracts conclude on June 30, 2025. ACC Phase III is designed to increase accountability and transparency; enhance care and case management; support providers; and leverage advances in technologies.

Proposed Solution: The Department requests to increase the administrative per-member-per-month (PMPM) payment to Regional Accountable Entities (RAEs), implement member incentive programs, centralize the credentialing process, increase survey sampling, expand the western slope Managed Care Organization (MCO), repurpose R6 funding to improve support for rural, small, and pediatric providers, and provide access to the Office of Community Living (OCL) Care and Case Management (CCM) system for RAEs.

Fiscal Impact of Solution: The Department requests a reduction of $2.5 million total funds, including $1.3 million General Fund in FY 2025-26. The Department requests an increase of $1.3 million total funds, including $0.8 million General Fund in FY 2026-27. This includes offsetting savings.

Requires Legislation	Equity Impacts	Revenue Impacts	Impacts Another Department?	Statutory Authority
No	Positive	No	No	25.5-5-402 and 406.1

Background and Opportunity

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) is the primary physical and behavioral health care delivery system for over 1.2 million Colorado Medicaid members. The Department created the ACC in 2011 to address its mission to improve health care access and outcomes for Colorado Medicaid members while demonstrating sound stewardship of financial resources. The ACC was designed with a long-term vision in mind and the understanding that to meet members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system. Phase I of the ACC established Regional Care Coordination Organizations (RCCOs) that were designed to work alongside the existing Behavioral Health Organizations (BHOs) to support members' physical health. Beginning in July 2018, Phase II of the ACC established the Regional Accountable Entities (RAEs), which combined the responsibilities of the RCCOs and BHOs under one entity to promote an integrated, whole-person approach to member's physical and behavioral health. The primary goals for Phase II have been to realize greater care coordination for members and cost savings for the State. As the core Medicaid delivery system, RAEs are contractually obligated to:

- **Provide a regionally responsive approach and oversight to care** particularly for members with chronic and complex health care conditions with needs that span multiple agencies and jurisdictions, as well as those transitioning from inpatient to lower levels of care. As regional organizations, RAEs are expected to understand the nuances among populations in the geographic area they cover to create cohesive provider and community support networks that deliver coordinated, whole-person care that improves health outcomes.
- **Administer the Capitated Behavioral Health Benefit** by maintaining a network of behavioral health clinicians and providing or arranging for the delivery of medically necessary mental health and substance use disorder services by utilizing a community-based continuum of care that adapts to a member's changing needs and provides appropriate access to care.
- **Contract with and support a network of Primary Care Medical Providers (PCMPs)** to serve as medical homes for members, providing whole-person, coordinated, and culturally competent care. RAEs also provide training and practice transformation support to providers to ensure the delivery of comprehensive, cost-effective, quality care that improves the member and provider experience. Additionally, RAEs are required to pass through 33% of their administrative PMPM payment to their provider network.
- **Manage overall administration, data and information, and member access to care and support** by leveraging technology and establishing the infrastructure, tools, and

resources that enable the timely and cost-effective delivery of health care services and supports that improve member outcomes

The RAEs often provide critical services and supports to Members in times of crisis. As an example, a care coordinator was able to help connect a member with appropriate mental health services and other supports after the individual lost everything in the Marshall Fires and then lost their job shortly after, leading the individual to contemplate suicide. Together, the care coordinator and service providers were able to assist the individual to engage with a therapist regularly, secure a new job, and find new housing. This individual's experience is a microcosm of the whole-person care that the RAEs are able to facilitate and that the Department aims to expand and improve with this next iteration of the ACC.

Over the past 18 months, the Department engaged with more than 5,700 attendees across 135 stakeholder meetings to design the next iteration of the ACC. The Department's stakeholder process was divided into three phases. The Vision Stage allowed for a broad understanding of how stakeholders believed the overall program could be improved. The Concept Stage created space to understand whether the policies and programs that were proposed in the prior stage were meeting the needs of the community. The Draft Contract Stage was an opportunity to refine the contractual requirements for RAEs in Phase III. The feedback and experiences of stakeholders collected throughout this process have been summarized into three feedback reports, which can be found on the Department's website.[1] Subject matter experts within the Department carefully reviewed the feedback received and recommended changes for inclusion in the final Request for Proposal. The Department continues to reference the feedback received throughout this process to identify additional opportunities to improve the ACC.

ACC Phase III has been designed to achieve the following goals: improve quality care for members, close health disparities and promote health equity for members, improve care access for members, improve the member and provider service experience, and manage costs to protect member coverage, benefits and provider reimbursements. To accomplish these goals, the RAEs will have enhanced responsibilities to:

- Broaden their network to ensure members have greater access to highly credentialed providers and specialists.
- Follow a tiered approach to care coordination where members in tier three (about 4-6% of members) receive complex care management, members in tier two (generally those with chronic conditions) receive condition management, and all other members are a part of tier one and receive preventive health promotion.
- Collaborate with Community-Based Organizations (CBOs) to reach members who would otherwise be difficult to reach. This may include financial arrangements with CBOs to support care coordination in settings where members are most comfortable.
- Support transitions of care for members being discharged from an inpatient or residential setting, including ensuring members are supported in accessing appropriate follow-up services within a timely manner.
- Promptly address and resolve provider complaints.
- Support implementation of and train providers to use the Social Health Information Exchange (SHIE) and other state and Department-supported tools and resources.

[1] https://hcpf.colorado.gov/accphaseIII

- Provide additional resources and training to providers, in particular funding investments in shared infrastructure and services across rural hospitals and rural clinics.

A guiding principle for ACC Phase III has been to improve support for providers by simplifying Department systems and operations. Primary care providers currently have opportunities to participate and receive quality-based payments through the ACC and through the Department's Alternative Payment Models for Primary Care (APM). This includes the approved APM 1, APM 2, and Pediatric APM. This structure has created confusion for providers and has resulted in multiple, duplicative approaches to measuring and paying a provider for achieving quality targets. In Phase III, the Department is integrating aspects of each of the mentioned Alternative Payment Models with the ACC under a comprehensive primary care payment framework, where the Department is measuring and paying for quality once in order to reduce administrative burden for PCMPs. This means that in APM 1 and APM 2 provider rates will no longer be changed based on quality scores and the Pediatric APM will be combined into the ACC quality structure.

The Department will continue to pay primary care providers directly for the delivery of Medicaid covered services, while the RAEs will pay primary care providers all payments not directly tied to the delivery of Medicaid covered services, such as payments for achieving quality performance targets. This means that the prospective payment from APM 2 will remain available and paid by the Department for adult, family medicine, and pediatric providers. The chronic condition shared savings available to adult primary care providers in APM 2 will no longer be paid by the Department and will be paid directly to the RAES to distribute to practices within their networks for improving the care that members with chronic conditions receive.

Reducing the administrative burden experienced by providers with the existing multi-pronged payment system between the Department and the RAEs, along with multi-payer alignment, will simplify the quality and incentive structure, garnering greater provider participation and will help improve quality and reduce costs. The practice support and technology resources that the RAEs will offer and use with providers is critical to primary care providers' ability to succeed in improving quality performance and lowering costs. Therefore, this new RAE-based incentive payment structure will empower and enable the RAEs and practices, especially small, rural, and pediatric rural practices to realize the full potential of value-based payments.

The RAEs serve an important role assisting providers in building innovative programs that improve quality care for members. For example, one RAE leverages a Center of Excellence designation to provide increased payment, that can include a lump sum payment, to providers who meet a combination of evidence-based practices and quality performance standards. This payment combined with assistance from the RAE's experts in practice support allows providers to implement solutions that can improve performance and address more challenging barriers to care delivery. This is the type of innovation and leverage that will become increasingly possible and accessible if the RAE-based incentive payment structure could be realized.

Member Incentive Programs

One of the novel ways in which ACC Phase III is designed to improve member health is through member incentive programs. A member incentive program supports healthy member behaviors

around core program areas. These incentives reward members for engaging with the state's Medicaid program in ways that assist providers, RAEs, and the Department in achieving shared equity, outcome and affordability goals. When leveraged with evidence-based programming and targeted at barriers identified by members, member incentives can improve health care engagement and outcomes.

Centralizing the Credentialing Process

Another innovation of ACC Phase III is to centralize the credentialing process for behavioral health providers. Currently, behavioral health providers are credentialed separately by each RAE, which means that many providers must go through the credentialing process with up to five different organizations in order to provide behavioral health services to members statewide. By centralizing this process, ACC Phase III will improve the provider experience and maximize the network of statewide behavioral health providers.

CAHPS Survey

The Center for Medicare and Medicaid Services (CMS) requires states and their managed care contractors to administer healthcare consumer and patient satisfaction surveys via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.[2] This program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of service. One hundred responses per question per RAE are needed in order to draw statistically meaningful conclusions. Currently, the response rate for nearly every question and for nearly every RAE falls below the 100-response threshold. The degree to which the response rate falls below the target varies by question and by RAE. Response rates have been falling for several years despite various interventions by the Department and the survey administration contractor. The decline is not unique to Colorado. The Department and contractor have studied the response rates and believe the decline to be largely attributable to survey fatigue. Consumers are inundated with satisfaction surveys as the push for data-driven corporate decision making has led many companies to invest in direct-to-consumer satisfaction survey mechanisms, like text, email, and phone calls. The Department believes that the response rate will remain stable at 4-7% and that by increasing the overall sample size, enough responses will be gathered for statistically sound conclusions to be made. These statistically sound conclusions would allow the Department to work with the RAEs to focus on the aspects of care that can be meaningfully improved, thus allowing for a better member experience and ultimately a healthier population.

Western Slope MCO Expansion

The Western Slope Managed Care Organization (MCO) was created as part of the payment reform and innovation pilot program authorized through C.R.S. § 25.5-5-415. When this program began at the start of ACC Phase II, the current contractor opted to start by covering only adults and children with disabilities in six counties in Western Colorado. The program has expanded to

[2] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

now cover adults and children with disabilities in nine different counties. However, this current bifurcated system is known to cause confusion and access to care issues. These issues arise when a family is enrolled in two different programs, one for the adults and another for the non-disabled children. The Western Slope MCO is now at a point where it can be expanded to include coverage for all children and adults in the nine-county service area.

RAE Support for Rural Providers

A critical role of the RAEs is to provide administrative payments to primary care providers for the non-billable services associated with serving as a medical home for Medicaid members. The RAE's administrative payments cover a wide variety of activities such as costs for outreaching members for compliance with evidence-based treatment plans, person-centered approaches to develop individual care plans, ensuring member access to services, and improving referral management. Many providers, particularly small, independent, pediatric, and rural providers, rely on these payments to maintain access for Medicaid members and to help offset the costs frequently associated with meeting the needs of Medicaid members with complex health and health-related social needs. For Phase III, the Department has placed additional responsibilities on the RAEs that support small independent providers and rural practices, including Rural Health Clinics. These new responsibilities will complement the Department's implementation of SB 22-200, which established a rural provider stimulus grant program and SB 23-298, which aims to improve healthcare access in rural or frontier counties by excepting hospitals with fewer than 50 beds from certain antitrust requirements. The RAEs are required to provide shared resources, condition management programming, and analytics at no cost to these providers and are encouraged to fund investments in needed and shared infrastructure and services across rural hospitals and rural clinics that may include care coordination models, software, technology upgrades, and assistance connecting to, maintaining, and utilizing state health information technologies, particularly the state Health Information Exchanges. The Department also seeks to achieve this by repurposing the 16% rate increase that was approved in the FY 2022-23 R6 "Supporting PCMP Transition with Value Based Payments". This repurposing would allow the funding that had been appropriated as a rate increase intended to incentivize provider participation in the APM, to instead be used to support APM readiness activities at small, rural, pediatric and other high-needs primary care medical providers that were unable to participate in the APM initially. These types of high-needs primary care medical providers were unable to initially participate in the APM because they have smaller overall budgets than the larger practices. Because of the magnitude of revenue difference, these practices were unable to tolerate the risk of variable payments based on quality criteria.

RAE Access to Care and Case Management System

The Care and Case Management (CCM) system consolidates functions that currently exist across the Benefit Utilization (BUS) and Determination of Developmental Disability (DDDWeb) systems, which currently serve as the bifurcated care coordination tool for members with complex needs who qualify for waiver services and long-term supports. The CCM also adds enhancements and functionalities to the BUS and DDDWeb systems it is replacing. When all phases of implementation have been completed the CCM functionality will include:

- New Assessment and Person-Centered Support Plan
- Other functions of case management, such as:
    - Log note entry

    - Critical Incident Reporting (CIRS)
    - Other Reports
- Allows for automated outputs to aid in support planning
- Interfaces with the Bridge, CBMS and PEAKPro

The CCM is still in development, and the current system build does not include RAE access. Case management agencies (CMAs) do have access. Allowing both the RAEs and the CMAs access to the CCM system will improve the coordination of services for the state's most complex members. The ability of RAEs and CMAs to share data is a critical success factor for managing the care of complex members who receive care and service coordination from a variety of professionals, many of which do not work for the same agency. Data sharing, which will be facilitated by the CCM, expedites collaboration, communication and coordination and ultimately improves the experience and outcomes of members.

Proposed Solution and Anticipated Outcomes

The Department requests a reduction of $2,465,730 total funds, including $1,254,288 General Fund in Fiscal Year 2025-26. The Department requests an increase of $1,273,591 total funds, including $776,450 General Fund in FY 2026-27. These funds will be used to increase the Administrative Per Member Per Month payment for the RAEs, implement member incentive programs, centralize the credentialing process for behavioral health providers, expand the Western Slope MCO to include all children, improve RAEs' ability to support rural providers, and provide access to the OCL Care and Case Management system for the RAEs.

The Department is committed to advancing the Governor's Wildly Important Goals. In doing so, the Department acknowledges that to administer a successful medical assistance program, various cost pressures must be balanced. Those cost pressures include the cost of services, the utilization and availability of services, and the administrative cost of the program. Typically, Medicaid pays the lowest rates of all payers, so reducing the service costs or provider reimbursements carries significant concerns over provider network adequacy and provider revenue constraints. Therefore, the Department believes that moving the needle on utilization patterns and administration are more direct and beneficial ways to reduce the total cost of the program. ACC Phase III is designed to improve population health outcomes and thereby reduce the need for more, and potentially more costly, services and to provide substitution services that are more efficient and effective at achieving the desired health outcomes.

Administrative PMPM Increase

The Department is requesting to increase the administrative PMPM each RAE receives. This increased PMPM will improve population health outcomes by funding the RAEs expanded care coordination and condition management responsibilities, as well as allow RAEs to support non-billable services such as practice transformation. This expansion will help members receive the care they need to manage their complex and chronic conditions. Additionally, each RAE will receive an individualized PMPM amount based on the respective population sizes and costs of operation. As regional organizations, RAEs are expected to understand the nuances among populations in the geographic area they cover to create cohesive provider and community support networks that deliver coordinated, whole-person care that improves health outcomes. The requested Admin PMPM amounts are:

- Region 1: $21.29 ($4.53 PMPM increase)
- Region 2: $23.49 ($6.73 PMPM increase)
- Region 3: $18.73 ($1.97 PMPM increase)
- Region 4: $17.83 ($1.07 PMPM increase)

In addition to funding targeted opportunities for enhanced condition management, increasing the administrative PMPM payments for the RAEs will enable increased care management during transitions of care for members discharging from inpatient and residential settings. Studies have shown that this focus of care management during transitions of care leads to significantly reduced total Medicaid costs by ensuring members are receiving the appropriate follow-up care to reduce future readmissions.

If the request to increase this payment to the RAEs is not funded, the Department will have two options: 1) significantly scale back the program requirements, including reducing care management support for members with chronic conditions and transitions of care support; this could result in costs associated with deferred health screenings and oversight, while also foregoing the savings associated with averted hospital readmissions or 2) refuse to fully fund the new RAE contractual obligations, which means RAEs likely will not be able to provide the same level of support for members. Both options would result in worse population health outcomes and unrealized hospital readmission savings as evidenced by the savings assumptions notated below related to the transitions of care support RAEs would be required to provide based on the new ACC III contract. Many of the programmatic changes for Phase III were driven by input from stakeholders. Members, providers, and other stakeholders would likely react with frustration at not having the concerns they voiced during the engagement process addressed. Additionally, because RAEs are contractually required to pass through a minimum of 33% of the administrative PMPM payments to their provider network, providers would receive less funding from their RAE if the PMPM increase is not funded. Lastly, if this component is not funded, the additional focused care management support that RAEs would be providing to members with chronic conditions would be unfunded and unrealized. This would mean that improvements in overall health outcomes and avoidable costs for this population would also be unrealized.

Member Incentive Programs

The Department requests to implement member incentive programs to support healthy member behaviors around core program areas. These incentives activate members in their own care in ways that assist providers, RAEs, and the Department in achieving shared equity, outcome and affordability goals. When leveraged within evidence-based programming and targeted at barriers identified by members, for members, patient incentives can improve health care engagement. Initial incentives would focus on three key areas:

- Baby and Me Tobacco Free (BMTF), a national program that provides diaper vouchers to pregnant and postpartum individuals who participate in a tobacco cessation program and test negative for nicotine
- Contingency Management (CM), which provides motivational incentives to promote treatment adherence for individuals with substance use disorders
- Early-Entry-to-Care Incentives (EETC) which provides incentives to pregnant people to engage in Medicaid prenatal programs (education, high risk screening and case management supports if determined high risk) in the first trimester of pregnancy.

If this request is not funded, the Department would be unable to require RAEs to implement member incentive programs. This would also mean that the Department would have less means of addressing the maternal health challenges identified above.

Centralizing the Credentialing Process

The Department requests to centralize the credentialing process for behavioral health providers. Currently, behavioral health providers must credential with each individual RAE in order to provide behavioral health services to members statewide. After significant stakeholder engagement with the independent behavioral health provider network, it was found that this current credentialing process is a barrier to providers enrolling with Medicaid and ultimately accepting Medicaid patients. A centralized process will allow for more equal participation among different sized practices, especially for those in the Independent Provider Network, and will reduce administrative burden for providers so that they can focus on caring for members. This solution will allow for a centralized credentialing process to be built within existing technology infrastructure such that qualified providers would only need to be credentialed once to provide care to any member in the state. If this request is not funded, the Department would be unable to pursue this solution. The Department, RAEs, and providers would need to continue with the administratively burdensome process whereby behavioral health providers must credential with each RAE.

CAHPS Survey

The Department requests funding to increase sampling for the federally required CAHPS surveys to enhance the Department's ability to understand and improve member experience of care. To draw meaningful conclusions from the data the Department receives, or make national comparisons, a minimum of 100 responses per question is required. Current response rates are well below that. To meet that threshold, the Department's surveying contractor has recommended a 40% oversample for both the adult and child surveys. This oversample would lead to an additional 2,160 adult surveys (for a total of 7,560) and 2,640 child surveys (for a total of 16,600) distributed to members. The ability to draw statistically significant conclusions from the data to understand member experience will allow the Department to better identify and remove barriers to accessing the health care services that members need. If this request is not funded, the Department would continue to see sample sizes and response rates at low levels and potentially continue to decrease. This would continue to render this federally required survey less clinically meaningful.

Western Slope MCO Expansion

The Department requests to expand the Western Slope MCO to include coverage for all children. This solution will streamline the administration of the program and create efficiencies by integrating this population into an existing managed care structure. Moreover, eliminating the current bifurcated system can help improve access to care and member experience, while reducing confusion for members and providers alike. If this request is not funded, the members enrolled in this MCO would continue with a bifurcated system where children and their parents may be enrolled in different programs, leading to confusion and challenges accessing care.

RAE Support for Small, Rural, and Pediatric Providers

To align with the comprehensive payment framework for ACC Phase III, the Department is requesting to repurpose the 16% rate increase that was approved in the FY 2022-23 R6, "Supporting PCMP Transition with Value Based Payments," and have this money paid by the RAEs rather than the Department. This funding would instead be used to support value-based payment readiness and advancement for small, rural, pediatric, and other high-needs primary care medical providers who have lower overall budgets, and thus have a thin margin that cannot currently tolerate the risk in variable payments based on quality criteria. Under ACC Phase III, RAEs will be expected to provide practice transformation support for PCMPs participating in APMs, and this repurposed request will enable the RAEs to achieve both the key goals of the ACC. Utilizing the funds to specifically target practices who need additional support beyond the current ACC revenue streams will incentivize uptake and meaningful participation in a value-based payment model, while providing the necessary investment for practices who would not otherwise be ready to do so. The Department has performed extensive stakeholder engagement with primary care medical practices and other stakeholder partners, which is available in the FY 2024-25 Legislative Report on Department APMs in line with statute 25.5-4-401.2(2)(a)(II-III). The Department believes that repurposing these funds will help to improve Medicaid member access to care by helping practices at risk of closure to continue seeing Medicaid patients.

RAE Access to Care and Case Management System

The Department is requesting to provide RAEs access to the OCL Care and Case Management (CCM) system to improve the ability for RAEs and Case Management Agencies (CMAs) to easily review the status of shared members, gain a greater understanding of the care and provider history, and identify next steps to coordinate care. It is essential for organizations that have shared responsibilities in providing care management activities to have access to the same information about their shared members. According to stakeholder engagement, all key stakeholders agreed that RAE access to the CCM system will significantly improve the integration of the care coordinated by RAEs and CMAs. Members receiving services from CMAs are often the most complex members. Improving the coordination between RAEs and CMAs will help ensure that members receive more efficient and coordinated care. If this request is not funded, RAEs and CMAs would continue to operate in separate systems, leading to uncoordinated care for members with the most complex conditions.

Department Wildly Important Goals

The RAEs have been key partners in supporting many of the Department and Shared Agency WIGs. Additionally, the expanded contract requirements for the RAEs in ACC Phase III are closely aligned with the advancement of these WIGs. Increasing the administrative PMPM, implementing member incentive programs, increasing survey participation, centralizing the credentialing process, expanding the Western Slope MCO, and integrating the CCM into the RAEs, will advance the WIGs in the following ways:

23-24 Department WIGs

1: Keep Coloradans Covered through renewal and transition outreach

RAEs have been a key partner in our effort to outreach and educate members about completing their renewal applications now that continuous Medicaid eligibility has ended. RAEs will continue to be required to reach out to and assist members scheduled for renewal in submitting necessary renewal forms.

2: Pharmacy Cost Savings by supporting Prescriber Tool enrollment

In FY22-23 RAEs helped promote prescriber tool use by identifying PCMPs who could use the tool, incentivizing use with administrative funding and troubleshooting by practice support teams. In Phase III, RAEs will have increased requirements to provide practice transformation support, including by supporting the adoption of department tools, like the Prescriber Tool. The prescriber tool is a multifunctional platform accessible to prescribers through most electronic health record (EHR) systems. It provides patient-specific benefit and cost information to prescribers at the point of care and eases administrative burden and rework for prescribers while improving service to patients.

23-24 Shared Agency WIGs

1: Saving Coloradans Money on Health Care by increasing the number of the Primary Care Provider sites participating in APM2

RAEs have been critical to the success of APMs as they are responsible for supporting providers in participating and meeting quality improvement goals. In Phase III, RAEs will have increased requirements to provide practice transformation support, including by supporting providers in participating in value-based payment arrangements.

4: Statewide Supportive Housing Expansion Pilot

In FY22-23, RAEs worked with the Continuum of Care programs within their regions to help ensure members with behavioral health diagnoses and other chronic conditions have been appropriately prioritized and connected to appropriate programs during the Statewide Supportive Housing Expansion (SWSHE) pilot program. While this pilot program will end prior to the start of ACC Phase III, addressing member's health-related social needs is a high priority. Additional requirements have been added to the RAE contracts around collaborating with local organizations to support members experiencing housing insecurity. Housing insecurity often leads to significant, negative, long-term health outcomes and the need for costly medical care. By making this a high priority requirement for the RAEs the Department believes that utilization of certain high-cost services may be averted. This additional responsibility is supported by the increased PMPM.

Supporting Evidence and Evidence Designation

Evidence Summary

Program Objective	Admin PMPM • improve quality care for members, • close health disparities and promote health equity for members,

	• improve care access for members,
	• improve the member and provider service experience and
	• manage costs to protect member coverage, benefits and provider reimbursements.
	
	Member Incentive Programs
	• Baby and Me Tobacco Free
	  ○ Reduce number of pregnant people who smoke during pregnancy, resulting in healthier outcomes for newborns
	• Case Management
	  ○ Reduce number of newborns who are exposed to substances during pregnancy
	• Early Entry to Care
	  ○ Provide support to pregnant people who otherwise would not receive adequate care and support

Outputs being measured	Admin PMPM • Transitions of Care ○ Number of hospital readmissions after an inpatient stay Member Incentive Programs • Number of people enrolled in programs

Outcomes being measured	Admin PMPM
	• Follow-up care received after inpatient hospital stays
	
	Member Incentive Programs
	• BMTF
	  ○ Number of pregnant people who smoke during pregnancy
	• CM
	  ○ Number of pregnant people who use substances during pregnancy
	• EETC
	  ○ Number of pregnant people receiving adequate care during pregnancy

Evidence Designation with Brief Justification	Admin PMPM
	• Transitions of Care – Promising
	  ○ The evidence used to evaluate savings for this program uses a reference group that is not perfectly aligned to Colorado's Medicaid program but provides a sufficient comparison for the purposes of this budget request.[3] The research does provide evidence of improved outcomes over time and uses a strong comparison group.
	• Transitions of Care for Children – Evidence Informed
	  ○ The evidence used to evaluate savings for the children's population describes a significant and favorable association between length of primary care and hospital readmissions.[4]

[3] North Carolina Medicaid Transitions of Care
[4] Pediatric Inpatient Readmissions in an Accountable Care Organization

	Member Incentive Programs • BMTF - Promising ○ The evidence used to evaluate savings for this program uses two reference groups with statistically significant outcomes that support the idea that this program will result in savings for the Department.[5]

The first piece of evidence presented in this request is the article *Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions* published by Health Affairs.[3] This article describes an observational study in which North Carolina Medicaid members were categorized into two groups, based on whether they received transitional care or usual care services. After a five-year study period, it was determined that those in the transitional care group had readmission rates 20 percent lower than those in the usual care group, which, through their analysis, was shown to be a statistically significant reduction. Due to the lack of a randomized controlled study, this evidence does not qualify for an evidence informed designation. However, given the comparison between the transitional care group and the usual care group that demonstrated statistically significant, favorable outcomes in favor of the transitional group, this evidence earns the designation of promising.

The second piece of evidence presented in this request is the article *Pediatric Inpatient Readmissions in an Accountable Care Organization* published by the Journal of Pediatrics.[4] This study uses Medicaid claims data for approximately 30,000 children to assess the difference in admission rates depending on the level of care received. It was found that more primary care services were associated with fewer hospital readmissions as well as a reduction in readmissions costs. While this is an observational study and not a randomized controlled study, there is a strong, significant association found between amount primary care and hospital readmissions, indicating this study earns a designation of evidence informed.

The third piece of evidence presented in this request is the article *Impact of an Incentive-based Prenatal Smoking Cessation Program for Low-income Women in Colorado* published by Public Health Nursing.[5] In this study, approximately 2,000 women were enrolled in a Baby & Me Tobacco Free (BMTF) program, and their birth outcomes were compared to two comparison groups, both consisting of women who smoked during pregnancy. In comparison to both groups, participants in the BMTF program were shown to have a lower risk of preterm birth and fewer NICU admissions, resulting in health care savings in both cases. While this was not a randomized controlled study, there were two strong comparison groups that demonstrated a significant and favorable outcome in favor the positive outcomes exhibited in the BMTF group, giving this study a designation of promising.

Promoting Equitable Outcomes

Administrative PMPM Increase

In an increasingly complex health care environment, care coordination is an essential function in supporting care access, members' navigation across multiple agencies to address their medical, behavioral and social needs and to improve their quality of life. Where health care service providers are often focused on a single aspect of a member's care, care coordinators have the time to build trust and stronger relationships so that they can provide the holistic

[5] Impact of an Incentive-Based Prenatal Smoking Cessation Program for Low-Income Women in Colorado

support a member may need. They further have the ability to leverage data and insights to connect members with appropriate health improvement programs and supports for health-related social needs to achieve ACC goals of improving member health, closing disparities and driving Medicaid affordability.

The Center for Health Care Strategies explains that simply outreaching members in need of care coordination by traditional risk stratifications or utilization will inherently lead to inequities.[6] Therefore, specific requirements have been added to the contracts for RAEs to collaborate with community-based organizations (and other agencies serving shared members) to increase equitable access to care coordination, case management, health improvement programs, and health-related social need supports.

Member Incentive Programs

The initial member incentives included in this request are maternity-focused due to the continued maternal health equity challenges across the state.

Most Medicaid members (76.0%) received prenatal care in the first trimester, but there are large disparities. Native Hawaiian Other Pacific Islander (57.7%), Black/African American (70.2%), and American Indian Alaska Native (70.6%) parents had lower rates than other race/ethnicity groups. Early-entry-to-care (EETC) in the prenatal period improves valuable outcomes. EETC provides member incentives to pregnant people to engage in Medicaid prenatal programs (education, high risk screening and case management supports if determined high risk), in the first trimester of pregnancy.

In Colorado, drug overdose is the second leading cause of death among pregnant and postpartum people and is the leading contributor to the increase in maternal mortality. The Contingency Management program provides motivational incentives to promote treatment adherence for individuals with substance use disorders.

Tobacco use is a significant contributor to preterm birth and hypertension which increases the likelihood of obstetric complications (in the top three leading causes of maternal mortality). Baby and Me Tobacco Free provides diaper vouchers to pregnant and postpartum individuals who participate in a tobacco cessation program and test negative for nicotine. This is a national program that is primarily delivered by counties across the country.

In order to effectively implement these programs, the Department would complete extensive member and advocacy engagement to identify barriers to starting and maintaining evidence based care to ensure that incentives target the specific barriers, since data shows that incentives that are directly tied to removing barriers are the most effective.

CAHPS Survey

Increasing the survey sampling will ensure the Department has appropriate sample sizes to make meaningful comparisons across diverse populations to understand disparities in member experience of care.

[6] The Center for Health Care Strategies

Western Slope MCO Expansion

Including all children in this MCO will help improve access and outcomes for members and create a better experience of care for members and providers alike.

RAE Access to Care and Case Management System

Members that receive home and community-based services through CMAs are those living with long-term disabilities and other chronic illnesses. Providing RAE access to this system will create a more efficient process for providing comprehensive and coordinated care to complex members receiving services through both agencies thus improving accessibility of services and potentially improving their overall outcomes.

Assumptions and Calculations

Administrative PMPM Increase

The Department's actuarial contractor estimated the increase to the administrative PMPM payments to account for increased licensure requirements, care coordination and condition management requirements, transitions of care requirements, provider communication and complaint resolution requirements, social health information exchange adoption requirements and other practice transformation requirements. Due to varying member months between RAEs and varying amounts needed to fund each RAEs fixed costs, PMPMs will vary between RAEs.

The Department multiplied the newly estimated rates by the respective forecasted number of member months for each RAE. The number of member months assumed for each RAE comes from the Department's February 2024 caseload forecast.[7] The amount requested is the difference between this new cost and the forecasted cost of ACC's administrative PMPM expenditure.

Additionally, there are some savings that can be reasonably expected due to the implementation of Transitions of Care requirements. These requirements are a function of the increase in the Administrative PMPMs. The Department used data from North Carolina's Medicaid program to estimate savings, given that they have implemented similar interventions. The savings realized by the North Carolina Medicaid program as a result of novel interventions in transitions of care is compelling and potentially applicable to new interventions present in the ACC Phase III contract.[3] However, the two situations are not perfectly aligned, meaning that some of the interventions contemplated in the North Carolina experience have already been implemented via ACC Phase II. Additionally, some of the interventions implemented in North Carolina will not be implemented in ACC Phase III. Therefore, the Department chose to significantly dampen the savings expectations associated with the novel transitions of care interventions in the ACC Phase III contract. The savings calculations are estimates based on Department data. The Department pulled data to mirror the population measured in the North Carolina study (inpatient discharge in the previous 12-month period, excluding certain Diagnosis Related Group (DRG) codes associated with childbirth, burn, trauma care, etc.). The Department then calculated the rate of hospital readmission and the average cost of an inpatient hospital stay (excluding non-qualifying DRG codes). Rather than applying a 20% reduction to hospital readmissions as was found to occur in North Carolina, the

[7] HCPF February 2024 Forecast

Department estimates the cumulative effect of the new interventions present in the ACC Phase III contract will yield an approximate 10% reduction in hospital readmissions.

The Department believes this savings estimate of approximately $34 million to be meaningful and realistic for two primary reasons. First, given that the RAEs are tasked with targeting the most at-risk members and members with complex conditions for the Transitions of Care initiative, it is reasonable to assume a large amount of savings will be associated with this intervention because it is often the most complex members driving the upper end of hospital readmission spending. Second, in addition to transitions of care, the ACC Phase III contract also requires the RAEs to make improvements to their care management programs. The intention of this change is to help members receive the best and most appropriate care available. The Department assumes there will be savings associated with these improvements and given the close relationship between transitions of care and care management, a portion of the above savings estimate could be reasonably attributable to care management.

An additional $471,237 is estimated to be saved due to the implementation of Transitions of Care for children. The literature supporting these savings focuses heavily on hospital stays and readmissions, as well as high-cost services and encounters. The ability of a Transitions of Care or Care Coordination organization is to mitigate or avert hospital readmissions is the primary cost savings intervention. This intervention is complicated when looking at children's populations because a high percentage of children hospital stays and readmissions are preplanned (over half), thus a care coordination or transition of care style of intervention is less likely to lower costs or avert hospital readmissions for this population. However, research suggests there are still a number of children's hospital readmissions that could be averted by a transition of care and care coordination intervention.

The ACC Phase III infrastructure aims to bolster the resources and capabilities of some of the most rural and isolated providers in the state, thereby allowing them to coordinate care and manage the transitions of care for more residents of the state. The Department assumes that the members who reside in some of the most rural and isolated corners of the state are those least likely to currently receive these types of coordination services. The Department believes that this targeted investment can have a meaningful impact on the hospital readmission cost trend. Given that children's populations on the western slope and eastern plains would be going from an environment in which very little care coordination currently exists to one where some of the most isolated and vulnerable rural PCMPs would now have additional resources and support, the Department believes the interventions contemplated in ACC Phase III would have a meaningful effect on children's hospital readmission rates, thus yielding savings.

The savings estimate for children is calculated by assuming a 25% reduction to the 145 current children's admissions in RAEs 1, 2 and 4. This would result in a reduction of 36 admissions, and with each readmission costing $1,300, the savings associated with this initiative would total $471,237. The research done by The Journal of Pediatrics found a 31% reduction, but that is dampened to 25% to account for cancer patients and neonates (also per the study).[8]

[8] Pediatric Inpatient Readmissions in an Accountable Care Organization

The children's portion of the savings estimate only takes into consideration admissions from RAEs serving rural communities, given that these communities are likely to see the most benefit from the improvements being made in ACC Phase III. However, additional savings may be realized statewide.

Member Incentive Programs

The first member incentive program outlined in this request is the Baby and Me Tabacco Free (BMTF) program, a national program that provides diaper vouchers to pregnant and postpartum individuals who participate in a tobacco cessation program and test negative for nicotine. According to BMTF research, the cost of this program is expected to be $781 per member.[9] The following assumptions were made to estimate the number of members expected to be enrolled in this program:

- According to the Colorado PRAMS report from 2021, 3.5% of women smoked during the last 3 months of their pregnancy.[10]
- Approximately 26,000 births were covered by Medicaid in 2020, prior to increased enrollment due to the Public Health Emergency.[11]
- According to research published by Preventative Medicine, it can be expected that approximately 30% of eligible women will participate in this program.[12]

Given these assumptions, it is estimated that 273 women will participate in the BMTF program. With this population estimate, combined with the $781 per member cost, this program is estimated to cost $213,213. Additionally, as detailed in the BMTF research, running this program can also be expected to lead to savings from other preventable medical costs, such as fewer NICU admissions and less complications during birth.[9] Given that there were two reference groups used in this study, each with different savings estimates, the average of the two savings rates has been used. Thus, the Department anticipates that for every $1 spent on this program, an estimated $5.26 will be saved. Based on this, the Department estimates savings of approximately $1.1 million.

The second member incentive program in this request is the Contingency Management (CM) program, which provides motivational incentives to promote treatment adherence for individuals with substance use disorders. The Contingency Management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a substance use disorder and as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

This program is estimated to cost no more than $500 per member. The following assumptions were made to estimate the number of members expected to be enrolled in this program:

[9] Impact of an Incentive-Based Prenatal Smoking Cessation Program for Low-Income Women in Colorado
[10] Colorado PRAMS report 2021
[11] Maternal Health and Equity Report, 2023
[12] Systematic Review on Use of Health Incentives in U.S. to Change Maternal Health Behavior (2021)

- According to the Maternal Health and Equity Report from 2023, 3.8% of newborns were substance-exposed or diagnosed with Neonatal Abstinence Syndrome.[11]
- Approximately 26,000 births were covered by Medicaid in 2020, prior to increased enrollment due to the Public Health Emergency.[11]
- According to research published by Preventative Medicine, it can be expected that approximately 30% of eligible women will participate in this program.[12]

Given these assumptions, it is estimated that 296 women will participate in the CM program. With this population estimate, combined with the $500 cost per member, this program is estimated to cost $148,200.

The final member incentive program is the Early-Entry-To-Care Incentives (EETC), which provides incentives to pregnant people to engage in Medicaid prenatal programs (education, high risk screening and case management supports if determined high risk) in the first trimester of pregnancy. The Department proposes a $50 voucher, or a product of equivalent value, to be the incentive for all participants.

The following assumptions were made to estimate the number of members expected to be enrolled in this program:

- According to the Colorado Health Information Dataset, 18% of women did not receive appropriate levels of care during their first trimester.[13]
- Approximately 26,000 births were covered by Medicaid in 2020, prior to increased enrollment due to the Public Health Emergency.[11]
- According to research published by Preventative Medicine, it can be expected that approximately 30% of eligible women will participate in this program.[12]

Given these assumptions, it is estimated that 1,404 women will participate in the EETC program. With this population estimate, combined with the $50 cost per participant, this program is estimated to cost $70,200.

There is a substantial body of research indicating that prenatal care and early entry into prenatal care for pregnant adults carries benefits for the individual and broader population health. However, it is not statistically sound to attempt to draw a straight line from the early entry to care incentive program considered in this request to reduced prenatal expenditures. Therefore, no savings have been estimated for the early entry to care program, but the Department assumes that there will be long-term savings realized and improvement in maternal healthcare outcomes.

Centralizing the Credentialing Process

According to an estimate from the Department's health information system contractor, this initiative is expected to take approximately 4500 hours of vendor time, which based on current hourly rates, the Department estimates to cost approximately $650,000 over the course of 54 weeks.

[13] Colorado Health Information Dataset

CAHPS Survey

Cost estimates are based on modeling which was completed by Department's survey administrator contractor.[14]

Western Slope MCO Expansion

The Department trended forward current Medicaid FFS rates for Medicaid children and the foster care population to account for an annual growth rate of 7.5%. The Department then added the state RAE administrative rate to each PMPM to account for the administrative burden the RAEs take on when managing and coordinating each member's services. These rates were multiplied by the respective member months for each population group, resulting in the $70 million that will be transferred from FFS to managed care rates.

The Department used the final calculated rates to generate the cost of switching over from FFS to Managed Care, due to a difference of rates. An additional 10% was added to account for administrative payments. Since the state administrative rate is already included in these rates, it was subtracted back out from the 10% administrative rate to generate the MCO specific administrative rate. This MCO specific administrative rate was multiplied by the member months to yield the $3 million in additional funds required to switch from FFS rates to Managed Care rates. The administrative rate represents the Department's payment for the following services that the MCO is contractually obligated to provide:

- Care coordination
- Operational expenses
- Credentialing and network development.
- Professional services for tax, legal, and audit matters.
- Member services for general support and grievance handling.
- Expenses for claims processing, reinsurance, and fraud prevention etc.
- Community benefit expenditures focused on improving public services.

RAE Access to Care and Case Management System

According to the relevant vendor estimate it is assumed that each license required for this initiative will cost approximately $2,500. With 100 licenses estimated by the Department, the licensing portion of this initiative is estimated to cost $250,000.[15]

Additionally, the MMIS contractor will require funding of approximately $50,000 to complete the changes required in the claims processing system.

[14] (2024). Colorado Department of Health Care Policy and Financing CAHPS Survey HSAG Proposal, 1-4.
[15] (2024). State of Colorado Contract, *AssureCare,* 2-117.

Table 1.1
Summary by Line Item
FY 2025-26

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; General Professional Services and Special Projects	$2,100,000	0.0	$649,635	$400,365	$0	$1,050,000	50.00%	Summary by Initiative Table 2.1 Row J
B	(1) Executive Director's Office (B) Information Technology Contracts and Projects; Medicaid Management Information System	$950,000	0.0	$59,850	$49,400	$0	$840,750	88.50%	Summary by Initiative Table 2.1 Row D + Row G
C	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($5,515,730)	0.0	($1,963,773)	($174,185)	$0	($3,377,772)	Blended	Summary by Initiative Table 2.1 Row A + Row B + Row C + Row H + Row I
D	**Total Request**	**($2,465,730)**	**0.0**	**($1,254,288)**	**$275,580**	**$0**	**($1,487,022)**		Sum of Rows A through K

Table 1.2
Summary by Line Item
FY 2026-27

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0		
B	(1) Executive Director's Office (B) Information Technology Contracts and Projects; Medicaid Management Information System	$250,000	0.0	$15,750	$13,000	$0	$221,250	88.50%	Summary by Initiative Table 2.2 Row D + Row G
C	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$1,023,591	0.0	$760,700	($51,671)	$0	$314,562	Blended	Summary by Initiative Table 2.2 Row A + Row B + Row C + Row F + Row H + Row I
D	**Total Request**	**$1,273,591**	**0.0**	**$776,450**	**($38,671)**	**$0**	**$535,812**	**42.07%**	Sum of Rows A through K

Table 1.3
Summary by Line Item
FY 2027-28 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0		
B	(1) Executive Director's Office (B) Information Technology Contracts and Projects; Medicaid Management Information System	$250,000	0.0	$15,750	$13,000	$0	$221,250	88.50%	Summary by Initiative Table 2.3 Row D + Row G
C	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$1,573,493	0.0	$1,035,651	($51,671)	$0	$589,513	Blended	Summary by Initiative Table 2.3 Row A + Row B + Row C + Row E + Row F + Row H + Row I
D	**Total Request**	**$1,823,493**	**0.0**	**$1,051,401**	**($38,671)**	**$0**	**$810,763**	**44.46%**	Sum of Rows A through K

Table 2.1
Summary by Initiative
FY 2025-26

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Increase Administrative PMPM	$26,591,884	$0	$8,562,587	$1,063,675	$0	$16,965,622	63.80%	Table 3.1 Row C
B	Increase Withhold PMPM	$3,062,850	$0	$986,238	$122,514	$0	$1,954,098	63.80%	Table 3.2 Row C
C	Implementing Member Incentive Programs	$431,613	$0	$203,937	$0	$0	$227,676	52.75%	Table 4.1 Row S
D	Centralizing the Credentialing Process	$650,000	$0	$40,950	$33,800	$0	$575,250	88.50%	Table 4.2 Row C
E	Increasing Sampling for CAHPS Survey	$0	$0	$0	$0	$0	$0	50.00%	
F	Expanding Western Slope MCO to Include Children	$0	$0	$0	$0	$0	$0	50.00%	Table 4.4 Row E
G	Providing Access to the OCL Care and Case Management (CCM) System for RAEs	$300,000	$0	$18,900	$15,600	$0	$265,500	88.50%	Table 4.5 Row E
H	Transitions of Care Savings	($34,009,340)	$0	($10,951,007)	($1,360,374)	$0	($21,697,959)	63.80%	Table 5.1 Row D
I	Transitions of Care Savings - Children	($471,237)	$0	($235,619)	$0	$0	($235,618)	50.00%	Table 5.2 Row E
J	Incentive Program Savings - BMTF	($1,121,500)	$0	($529,909)	$0	$0	($591,591)	52.75%	Table 6.1 Row C
K	Enrollment Broker Mailer	$2,100,000	$0	$649,635	$400,365	$0	$1,050,000	50.00%	Vendor Estimate
L	**Total Request**	**($2,465,730)**	**$0**	**($1,254,288)**	**$275,580**	**$0**	**($1,487,022)**	**60.31%**	**Sum of Rows A through J**

Table 2.2
Summary by Initiative
FY 2026-27

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Increase Administrative PMPM	$26,591,884	$0	$8,562,587	$1,063,675	$0	$16,965,622	63.80%	Table 3.1 Row C
B	Increase Withhold PMPM	$6,125,701	$0	$1,972,476	$245,028	$0	$3,908,197	63.80%	Table 3.2 Row C
C	Implementing Incentive Program	$431,613	$0	$203,937	$0	$0	$227,676	52.75%	Table 4.1 Row S
D	Centralizing the Credentialing Process	$0	$0	$0	$0	$0	$0	88.50%	
E	Increasing Sampling for CAHPS Survey	$0	$0	$0	$0	$0	$0	50.00%	
F	Expanding Western Slope MCO to Include Children	$3,476,470	$0	$1,738,235	$0	$0	$1,738,235	50.00%	Table 4.4 Row E
G	Providing Access to the OCL Care and Case Management (CCM) System for RAEs	$250,000	$0	$15,750	$13,000	$0	$221,250	75.00%	Table 4.5 Row C
H	Transitions of Care Savings	($34,009,340)	$0	($10,951,007)	($1,360,374)	$0	($21,697,959)	63.80%	Table 5.1 Row D
I	Transitions of Care Savings - Children	($471,237)	$0	($235,619)	$0	$0	($235,618)	50.00%	Table 5.2 Row E
J	Incentive Program Savings	($1,121,500)	$0	($529,909)	$0	$0	($591,591)	52.75%	Table 6.1 Row C
K	Enrollment Broker Mailer	$0	$0	$0	$0	$0	$0	0.00%	
K		$0	$0	$0	$0	$0	$0		
L	**Total Request**	**$1,273,591**	**$0**	**$776,450**	**($38,671)**	**$0**	**$535,812**	**42.07%**	**Sum of Rows A through J**

Table 2.3
Summary by Initiative
FY 2027-28 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Increase Administrative PMPM	$26,591,884	$0	$8,562,587	$1,063,675	$0	$16,965,622	63.80%	Table 3.1 Row C
B	Increase Withhold PMPM	$6,125,701	$0	$1,972,476	$245,028	$0	$3,908,197	63.80%	Table 3.2 Row C
C	Implementing Incentive Program	$431,613	$0	$203,937	$0	$0	$227,676	52.75%	Table 4.1 Row S
D	Centralizing the Credentialing Process	$0	$0	$0	$0	$0	$0	88.50%	
E	Increasing Sampling for CAHPS Survey	$549,902	$0	$274,951	$0	$0	$274,951	50.00%	Table 4.3 Row I; Administrative contract, not service being rendered to individual members
F	Expanding Western Slope MCO to Include Children	$3,476,470	$0	$1,738,235	$0	$0	$1,738,235	50.00%	Table 4.4 Row E
G	Providing Access to the OCL Care and Case Management (CCM) System for RAEs	$250,000	$0	$15,750	$13,000	$0	$221,250	75.00%	Table 4.5 Row C
H	Transitions of Care Savings	($34,009,340)	$0	($10,951,007)	($1,360,374)	$0	($21,697,959)	63.80%	Table 5.1 Row D
I	Transitions of Care Savings - Children	($471,237)	$0	($235,619)	$0	$0	($235,618)	50.00%	Table 5.2 Row E
J	Incentive Program Savings	($1,121,500)	$0	($529,909)	$0	$0	($591,591)	52.75%	Table 6.1 Row C
K	Enrollment Broker Mailer	$0	$0	$0	$0	$0	$0	50.00%	
L	**Total Request**	**$1,823,493**	**$0**	**$1,051,401**	**($38,671)**	**$0**	**$810,763**	**44.46%**	**Sum of Rows A through J**

Table 3.1: ACC Phase 3.0 Admin PMPM Cost Comparison			
Row	**Item**	**Amount**	**Notes**
A	February 2024 S-1 Admin PMPM Forecast	$170,045,982	
B	ACC Phase III Admin PMPM Estimate	$196,637,866	
C	Total Change in Admin PMPM Cost Estimate	$26,591,884	

Table 3.2: ACC Phase 3.0 Withhold PMPM Cost Comparison

Row	Item	Amount	Notes
A	February 2024 S-1 Withhold PMPM Forecast	$59,420,255	
B	ACC Phase III Withhold PMPM Estimate	$65,545,955	
C	Total Change in Withhold PMPM Cost Estimate	$6,125,701	Amount will be halved for FY2025-26 due to 6 month delay in incentive payments

Table 3.3: ACC Phase 3.0 New Rates Summary				
Row	**RAE**	**Total PMPM Rate**	**Member Months**	**Total Expenditure**
A	RAE 1	$21.29	2,490,338	$53,019,301
B	RAE 2	$23.49	1881165.2	$44,188,570
C	RAE 3	$18.73	3,989,458	$74,722,546
D	RAE 4	$17.83	5,061,885	$90,253,405

Table 3.4: ACC Phase 3.0 New Rates Breakout								
Row	RAE	Admin PMPM Rate	Withhold PMPM Rate	Total PMPM Rate	Member Months	FY2025-26 Administrative Cost	FY2025-26 Withhold Cost	FY2025-26 Total Cost
A	RAE 1	$15.97	$5.32	$21.29	2,490,338	39,764,476	$13,254,825	$53,019,301
B	RAE 2	$17.62	$5.87	$23.49	1,881,165	33,141,427	$11,047,142	$44,188,570
C	RAE 3	$14.05	$4.68	$18.73	3,989,458	56,041,909	$18,680,636	$74,722,546
D	RAE 4	$13.37	$4.46	$17.83	5,061,885	67,690,054	$22,563,351	$90,253,405

Table 4.1: Incentive Program			
Row	**Item**	**Amount**	**Notes**
Baby and Me Tobacco Free			
A	Rate	$781.00	"Impact of an Incentive-Based Prenatal Smoking Cessation Program for Low-Income Women in Colorado"
B	Number of Mediciaid Births in 2020	26,000	2023 Maternal Health Equity Report
C	Percentage of Women Who Smoked During Last 3 Months of Pregnancy	3.5%	Colorado 2021 PRAMS Report: https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/2021TableauSummaryTables/2021PRAMSSummaryTables?%3Aembed=y&%3AisGuestRedirectFromVizportal=y
D	Uptake Rate	30%	Washio Y, Atreyapurapu S, Hayashi Y, Taylor S, Chang K, Ma T, Isaacs K. Systematic review on use of health incentives in U.S. to change maternal health behavior. Prev Med. 2021 Apr;145:106442. doi: 10.1016/j.ypmed.2021.106442. Epub 2021 Jan 27. PMID: 33515587; PMCID: PMC7956068.
E	Estimated Utilizers	273	Row B * Row C * Row D
F	BMTF Total	$213,213	Row A * Row E
Contingency Management			
G	Rate	$500	Department Estimate; Previously 550, updated 6/18
H	Number of Mediciaid Births in 2020	26,000	2023 Maternal Health Equity Report
I	Percentage of Newborns Who Were Substance Exposed	3.8%	2023 Maternal Health Equity Report
J	Uptake Rate	30%	Washio Y, Atreyapurapu S, Hayashi Y, Taylor S, Chang K, Ma T, Isaacs K. Systematic review on use of health incentives in U.S. to change maternal health behavior. Prev Med. 2021 Apr;145:106442. doi: 10.1016/j.ypmed.2021.106442. Epub 2021 Jan 27. PMID: 33515587; PMCID: PMC7956068.
K	Utilizers	296	Row H * Row I * Row J
L	CM Total	$148,200	Row G * Row K
Early Entry to Care			
M	Rate	$50	Department Estimate
N	Number of Mediciaid Births in 2020	26,000	2023 Maternal Health Equity Report
O	Percentage of Pregnant People Who Did Not Receive Adequate Care During First Trimester	18%	Colorado Health Information Dataset: https://cohealthviz.dphe.state.co.us/t/HealthInformaticsPublic/views/COHIDLiveBirthsDashboard/LiveBirthStatistics?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no
P	Uptake Rate	30%	Washio Y, Atreyapurapu S, Hayashi Y, Taylor S, Chang K, Ma T, Isaacs K. Systematic review on use of health incentives in U.S. to change maternal health behavior. Prev Med. 2021 Apr;145:106442. doi: 10.1016/j.ypmed.2021.106442. Epub 2021 Jan 27. PMID: 33515587; PMCID: PMC7956068.
Q	Utilizers	1,404	Row N * Row O * Row P
R	EETC Total	$70,200	Row M * Row Q
S	**Total**	**$431,613**	**Row F + Row L + Row R**

Table 4.2: Centralized Credentialing Process			
Row	**Item**	**Amount**	**Notes**
A	Rate	$144	Department Estimate
B	Hours	4,500	Gainwell estimate
C	**Total**	**$650,000**	**Row A * Row B**

Table 4.3: CAPHS Survey			
Row	**Item**	**Amount**	**Notes**
FY2025-26			
A	Adult Survey	$181,440	Vendor Estimate
B	Child Survey	$326,024	Vendor Estimate
C	**Total**	**$507,464**	**Row A + Row B**
FY2026-27			
D	Adult Survey	$188,561	Vendor Estimate
E	Child Survey	$338,756	Vendor Estimate
F	**Total**	**$527,317**	**Row D + Row E**
FY2027-28			
G	Adult Survey	$196,637	Vendor Estimate
H	Child Survey	$353,265	Vendor Estimate
I	**Total**	**$549,902**	**Row G + Row H**

Table 4.4: MCO Include Children			
Row	**Item**	**Amount**	**Notes**
A	Shift from FFS to Managed Care	$70,925,138	This represents a shift in funds, not included in total calculation
B	Cover overlapping payments during shift	$6,187,243	One-time shift, only included in FY25-26, ongoing negotiations with Rocky to ensure no double month payment; not included in calculation
C	Address difference in rate	$3,321,782	This is the admin load shift from RAE admin to account for active management of care by MCO
D	Additional actuary expenses	$154,688	To ensure actuarily sound managed care rates
E	**Total**	**$3,476,470**	**Row C + Row D**

Table 4.5: CCM System for RAEs			
Row	**Item**	**Amount**	**Notes**
A	Per license cost	$2,500	Vendor estimate
B	Number of licenses	100	Department estimate
C	Total license cost	$250,000	Row A * Row B
D	SCR cost	$50,000	Department Estimate; One-time cost in first year of implementation
E	**Total**	**$300,000**	**Row C + Row D**

Table 5.1: Transitions of Care Savings Calculation - Adults			
Row	**Item**	**Amount**	**Notes**
A	Number of readmissions	25,841	Department data
B	Average cost of readmission	$13,161	Department data
C	Savings reduction	10%	Jackson, C et al. (2013). Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. HealthAffairs.
D	**Estimated Savings**	**$34,009,340**	**Row A * Row B * Row C**

Table 5.2: Transitions of Care Savings Calculation - Children			
Row	**Item**	**Amount**	**Notes**
A	Number of readmissions	145	Department data; for RAEs 1,2 and 4
B	Reduction in readmissions	25%	Department data; for RAEs 1,2 and 4
C	Number of readmission reduction	36	Row A * Row B
D	Average cost of readmissions	$13,000	Department data; for RAEs 1,2 and 4
E	**Estimated Savings**	**$471,237**	**Row A * Row B * Row C**

Table 6.1: Incentive Program Savings - BMTF			
Row	**Item**	**Amount**	**Notes**
A	BMTF Expenditure	$213,213	
B	Savings rate	$5.26	Using average savings between two reference groups in BMTF study: Polinski, K et al. (2020). Impact of an Incentive-Based Prenatal Smoking Cessation Program for Low-Income Women in Colorado. National Library of Medicine.
C	**Estimated Savings**	**$1,121,500**	**Row A * Row B**