Accountable Care Collaborative FY 2023-24

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

Dec. 2, 2024

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

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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 2023–24 (July 2023 through June 2024). Per Senate Bill 24-135, this report now combines the requirements in both Sections 25.5-419, C.R.S. and 25.5-415, C.R.S. in order to streamline HCPF's reporting about the ACC.

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 2023-24, Health First Colorado enrollment in the ACC averaged 1,274,668 members.

The ACC was 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 managed 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 today, referred to as ACC Phase II, has been in effect since July 1, 2018, and was developed based on substantial stakeholder engagement. HCPF is currently creating the next generation of the ACC, referred to as Phase III, which will go into effect July 1, 2025. It will build on what is working well, while also making improvements to modernize and address opportunities.

This fiscal year marked 12 years since HCPF launched the ACC. This year's accomplishments demonstrate fidelity to the original goals of the ACC as well as the model's ability to evolve and adapt to a dynamic health care market and changing consumer, provider, stakeholder, fiscal and federal demands. This summary provides an overview of some of the accomplishments from this year.

Program Performance

HCPF uses several health quality performance indicators to measure ACC program support for member health. According to the most recent data, the reported timeliness of prenatal care performance rate across all RAEs increased by an average

of nearly 6% from January to June 2023 to July to December 2023. All RAEs met their targets for engagement in postpartum care, for the percentage of members receiving contraception postpartum, child and adolescent well visits and well-child visits for children 15 to 30 months old. Additionally, all RAEs met their targets for behavioral health engagement for people releasing from state prisons, and for engagement in outpatient treatment for members with substance use disorder (SUD). Most RAEs also earned incentive funds for the percentage of members with complex needs who received extended care coordination.

Performance for the MCOs is assessed differently than for the RAEs. Each MCO has its own set of quality metrics and goals specific to their membership and aligned with the goals of the ACC. For calendar year 2023 (the most recently available data), Rocky Mountain Health Plans PRIME met their goals for initiation and engagement of alcohol and other drug dependence treatment, prenatal and postpartum care, behavioral health engagement and diabetes control. Denver Health Medicaid Choice met their goals for well-child care, prenatal and postpartum care and behavioral health engagement.

Member Health Initiatives

Improving member health is, and always will be, a key goal of the ACC. In FY 2023-24, HCPF and the MCEs continued to evolve population management strategies used within the ACC to better manage conditions in their regions and control costs. All MCEs provided dedicated condition management programs or partnered with community organizations or other local agencies, either through grant funding or other agreements, to support pregnant and postpartum members and members with diabetes. Finally, complex care coordination is an essential part of the ACC population management strategy that provides more specialized support to members with complex needs. All MCEs had strategies to identify and outreach these members.

MCEs partnered with HCPF on efforts to address health disparities through dedicated health equity plans and support members' health-related social needs. Notably, MCEs worked closely with HCPF to support members experiencing homelessness through the Statewide Supportive Housing Expansion pilot. As of June 2024, 695 Health First Colorado members were enrolled and receiving wraparound services, with one MCE successfully referring 72 members with complex needs and a history of homelessness to this pilot. MCEs also collaborated with HCPF and other state agencies to improve immunization rates, support transitions for people who are reentering the community from prisons and jails and improve services for children and youth.

Care Access

Access to care and services is a key priority of the ACC. In FY 2023-24, the ACC added over 1,000 contracted behavioral health practitioners, including licensed psychologists

and licensed behavioral health clinicians. RAEs worked to address gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care by dispersing a total of $1.7 million American Rescue Plan Act funds to increase access to high intensity outpatient services. HCPF also partnered with the RAEs on the design and ongoing implementation of several new provider types, including Comprehensive and Essential Safety Net Providers, behavioral health secure transportation, mobile crisis response and support professionals like community health workers, peers and qualified behavioral health assistants. Additionally, HCPF implemented Colorado Medicaid eConsult which allows primary care medical providers to submit clinical questions to specialty providers without making a referral.

MCEs partnered with HCPF to support members throughout the COVID-19 public health emergency (PHE). The unique structure of the ACC allowed HCPF to adjust to the rapid increase in Health First Colorado members, reflected in ACC enrollment. This represented about 500,000 additional ACC members from 2020 to 2023, due to federal continuous coverage enrollment rules. With the end of the PHE in May 2023, the ACC took the lead in helping members and providers understand the need to renew or transition to other forms of coverage, such as employer-sponsored insurance or Medicare. As of May 2024, HCPF and the MCEs outreached more than two million times via text, email, mailings and phone calls, reaching about 630,000 Colorado households, to provide education about renewing their coverage.

Operational Excellence and Customer Service

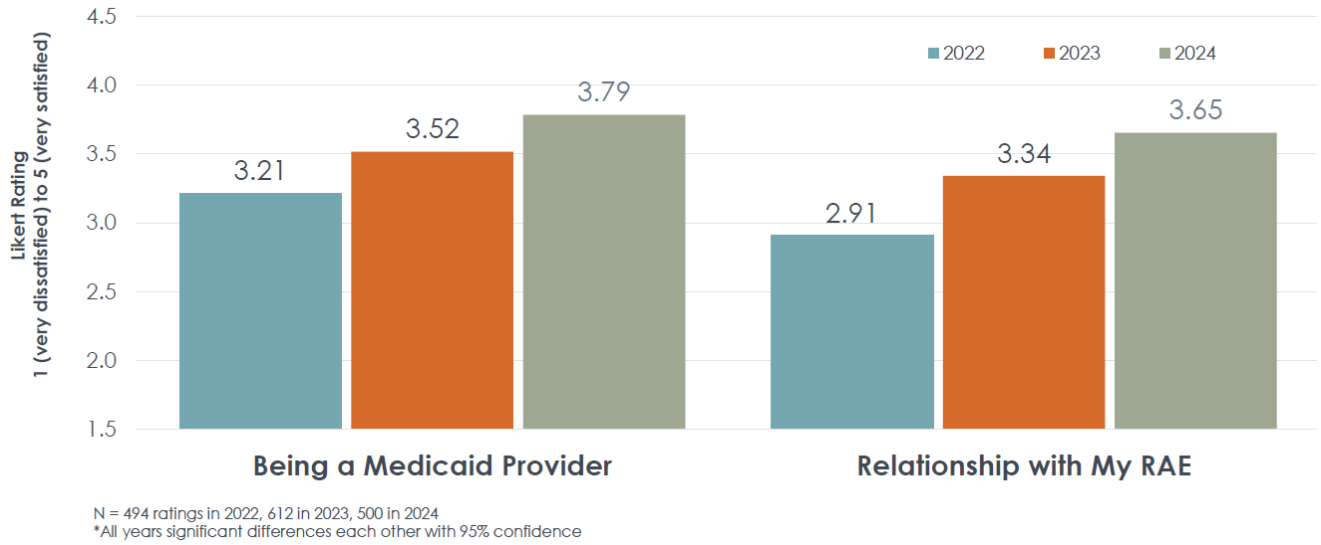
An important role for health plans and payers is to facilitate a good experience for members and providers, so they can navigate the system and spend more time focused on health and well-being.

From a member perspective, all MCEs answered calls in an average of less than 50 seconds. In the 2024 Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey about the RAEs, most members reported the ability to get needed care (79.3% for adult care and 81.2% for children) and receive care quickly (80.5% for adults and 85.1% for children). For all MCEs, most members reported satisfaction with care coordination (at least 80.7% for adults and 73.2% for children) and satisfaction with their medical provider's communications (at least 90.9% for adults and 92% for children). Across all MCEs, the majority of members were satisfied with the customer service they received (at least 88.7% for adults and 84.2% for children). Many of these ratings show improvement from the past fiscal year.

MCEs worked to improve provider experience by continuing to make enrollment and claims processing more efficient. In the last month of the reporting period, the

percentage of adjudicated claims paid within 30 days across all MCEs was at or above 99.2%. 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. HCPF and the RAEs also worked hard to improve the experience of the independent provider network (IPN), which includes providers not associated with larger systems like hospitals, residential settings, etc. Since 2022, HCPF has conducted annual surveys to measure provider satisfaction and experience with both HCPF and the RAEs. Results from the most recent survey found significant improvements in HCPF and RAE ratings across all measures between 2022 and 2024. No average ratings decreased from any year. IPN satisfaction consistently improved in two key domains: satisfaction with being a Medicaid provider and satisfaction with their relationship with the RAEs.

Figure 1. Overall Satisfaction Ratings Across All RAEs from 2022 to 2024



Value

HCPF strives to efficiently administer Health First Colorado and retains only 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. MCEs play an important 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 855 practices successfully participated in the first year of the Prescriber Tool APM, and 100% of the $1.15 million saved was distributed among all participating providers. Additionally, in FY 2023-24, more than 240 primary care locations participated in APM 2. These strategies help HCPF to better manage rising

health care costs to protect access to Medicaid coverage, benefits and provider reimbursements, while driving improvements in quality and health equity.

Priorities for FY 2024-25

In FY 2024-25, HCPF and the RAEs will continue to participate in a number of multi-year activities, many of which began this fiscal year, aimed at building improved services for the future. These ongoing efforts include:

- Designing and planning for the implementation of ACC Phase III, which will begin on July 1, 2025. Phase III is a critical part of efforts to improve care quality, service, equity and affordability. HCPF posted the formal request for proposal for the RAEs from May to July 2024 and issued an intent to award four contractors in September 2024. HCPF will work closely with the newly awarded RAEs to ensure a seamless transition that avoids disruption of services for members and providers alike.
- Collaborating and aligning with the Behavioral Health Administration to improve the behavioral health system in Colorado. This includes alignment between RAEs and Behavioral Health Administrative Service Organizations as appropriate, expanding access for priority populations like children and youth with complex needs, reducing administrative burden, improving quality reporting and rate transparency and addressing health-related social needs.
- Increasing coverage and benefits for members. In April 2024, HCPF submitted one of two amendments to the current 1115 SUD Waiver to the Centers for Medicare and Medicaid Services. This amendment allows for reimbursement for acute inpatient and residential stays in institutes for mental disease in specific instances, extends continuous Medicaid coverage for children to age three and adults leaving incarceration, and allows pre-release services for adults and youth transitioning from correctional facilities. HCPF submitted a second amendment to the 1115 SUD Waiver in August 2024 to address health-related social needs by allowing coverage for certain supportive housing and nutrition services.
- Continuing support for members' health-related social needs. This includes collaboration with Colorado's Office of eHealth Innovation to develop the Social Health Information Exchange platform. Additionally, HCPF continues to work on several feasibility studies, as directed by House Bills 24-1322 and 23-1300, to assess the ability of seeking federal authorization to cover a wide array of health-related social needs from housing and nutrition to interpersonal violence and climate-related needs.
- Designing Medicaid look-alike programs in compliance with House Bill 22-1289. This includes certain populations who would be eligible for Health First Colorado and CHP+ if not for their documentation status. MCEs will work with

HCPF to identify barriers and develop solutions for successful implementation of the program.

- Continuing key activities in advancing innovation to improve quality, access and affordability. HCPF is working to ensure that members and providers can easily access information through the Find-a-Doctor tool, so they can make the most informed decision about where to access or refer care. HCPF also aims to broaden the scope of Colorado Medicaid eConsult in the next fiscal year by enabling specialists to submit eConsults to other specialists.

Introduction: The Accountable Care Collaborative

Updates to this Report

Previously, there have been two annual legislative reports for the Accountable Care Collaborative (ACC). The first report, required by Section 25.5-5-419, C.R.S. focused on the role of the Regional Accountable Entities (RAEs) and overall ACC performance. The second report, required by Section 25.5-415, C.R.S. focused on the performance of the state's two fully capitated managed care plans for physical health. With the passing of Senate Bill 24-135, these two reports are combined beginning this year.

Regional Accountable Entities and Managed Care Organizations

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 deliver programs in response to geographic community 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 seven regions. Figure 2 shows the ACC Phase II region map with the following contractors that serve as RAEs for each region: 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.

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 administrative 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 administrative PMPM payment is the same for every region and is not used to reimburse primary care claims; PCMPs bill HCPF directly, fee-for-service, for most physical health care claims.

In implementing HCPF's capitated behavioral health benefit, each RAE contracts with a statewide network of behavioral health providers that provide mental health 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 (C.R.S. 25.5-5-415) is operated as part of the Region 1 RAE contract. Denver Health Medicaid Choice (DHMC), authorized through C.R.S 25.5-5-402 delivers physical health care in the Denver metro region and subcontracts with the RAE in Region 5 to administer the capitated behavioral health benefit. Both are designed to maximize the integration of behavioral health and physical health services for enrolled members. In this report, the term managed care entities (MCEs) will be used when discussing activities or responsibilities completed by both the RAEs and MCOs.

Figure 2. Accountable Care Collaborative Phase II Regional Map

RAEs play an important role in addressing emergencies and challenges that arise in their region. Regional flexibility helped the RAEs 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. RAEs 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. After several mass shootings between 2018 and 2022, and the Marshall fire in December 2021, the RAEs mobilized to rapidly identify and respond to community needs, coordinated services for affected Health First Colorado members, and often developed community response plans to streamline responses to future tragedies.

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 to opt out if they wish. Each MCO has an enrollment cap; as of June 30, 2024, 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, referred to as continuous Medicaid eligibility. From March 2020 through May 2023, ACC enrollment increased by more than 500,000 members. With the end of the PHE in May 2023, continuous Medicaid eligibility also ended, meaning individuals had to complete renewal paperwork to retain coverage or, if they were no longer eligible for Health First Colorado, secure alternative health coverage. From May 2023 through April 2024, enrollment rapidly decreased by nearly the same amount, returning to pre-pandemic levels. In FY 2023-24, Health First Colorado enrollment averaged 1,274,668 members compared to 1,594,258 in FY 2022-23. For reference, the average enrollment in FY 2018-19, the last full fiscal year before the pandemic, was 1,200,082.[1]

Table 1. ACC Enrollment by program throughout and after the PHE

Population	March 2020	April 2023	June 2024
RAE Enrollment	972,464	1,457,721	923,289
MCO Enrollment	116,668	166,813	101,356
TOTAL	**1,089,132**	**1,624,534**	**1,024,645**

[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.

Member Health Quality Performance Indicators

HCPF uses several sets of health quality performance indicators to measure ACC program support for member health. These include Key Performance Indicators (KPIs), Performance Pool incentive measures and Behavioral Health Incentive Program (BHIP) indicators. HCPF withholds a portion of the RAE administrative 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 2023-24. MCOs have separate metrics and incentives and are not eligible for KPI, BHIP or performance pool funds.

HCPF works with each RAE individually to set annual performance targets for indicators based on previous performance, changing priorities and other factors. HCPF intentionally sets high standards for achievement of performance metrics, 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.

It is important to note that the COVID-19 pandemic dramatically affected the outcomes of the quality performance indicators for the RAEs. Initially, the pandemic disrupted health care utilization patterns, while continuous Medicaid eligibility changed the overall population acuity, both of which impacted performance outcomes. Because HCPF sets baselines and performance targets using utilization information from previous years, the pandemic continues to impact performance goals and payouts. Accordingly, many of the performance targets in FY 2023-24 were difficult to set and in hindsight, difficult to achieve, as they reflected pre-pandemic goals. HCPF continues to work with RAEs and stakeholders to set more appropriate post-pandemic goals for performance metrics that also align better with current RAE resources.

As HCPF learned from previous phases of the ACC, it is clear that the nation's – and Colorado's – health care affordability, access, equity and quality challenges are complex, especially for low-income Coloradans and individuals with disabilities. To address those complexities and achieve shared goals going forward under ACC Phase III, RAEs and providers need improvements in technology, programs and payment methodologies. Additionally, strategies to improve quality outcomes and reduce health disparities, such as value-based payments and member incentives, need to be more focused and aligned.

There are numerous advances and opportunities required of the RAEs in ACC Phase III. To fully effectuate those advances, ACC Phase III will require an increase in administrative funding to RAEs to enable them to execute directives from HCPF that address capability gaps and achieve program goals. That increase will be offset by improved quality outcomes and affordability savings, resulting from ACC Phase III modernizations and advances.

Key Performance Indicators

KPIs provide insight into physical and medical health care utilization. RAEs can earn a part or all of the 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 from April 2023 to March 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 Visits (per 1000 members per year)
1 (RMHP)	18.7%	49.1%	64.9%	69.1%	48.6%	59.7%	58.8%	539.7
2 (NHP)	17.2%	50.9%	56.9%	62.2%	39.1%	61.5%	62.2%	649.4
3 (CoA)	25.6%	50.9%	61.3%	65.1%	48.0%	64.7%	61.1%	586.9
4 (HCI)	19.3%	48.7%	59.6%	64.8%	41.5%	64.2%	57.9%	520.6
5 (CoA)	23.5%	54.6%	64.0%	68.5%	53.5%	73.2%	65.1%	636.8
6 (CCHA)	16.6%	50.7%	59.4%	63.3%	47.2%	62.3%	65.5%	510.8
7 (CCHA)	32.3%	50.5%	60.4%	62.1%	40.5%	59.1%	57.4%	666.0

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

Table 3. Risk-adjusted PMPM by RAE from April 2023 to March 2024 (compared to ACC average risk-adjusted PMPM of $544.50)

RAE	Risk-adjusted PMPM
1 (RMHP)	$515.04
2 (NHP)	$460.65
3 (CoA)	$587.69
4 (HCI)	$490.91
5 (CoA)	$552.77
6 (CCHA)	$547.24
7 (CCHA)	$571.18

Key:
Green = Met target

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. The reported results are from FY 2022–23 rather than FY 2023–24 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, Performance Pool funds were used to incentivize RAE planning and work related to eConsult utilization and the PHE unwind. RAEs submitted implementation plans in May 2024 and will be reporting on the impact of this work in early FY 2024-25.

Table 4. Performance pool measures by RAE, FY 2022–23

RAE	Extended care coordination	Premature birth rate	Behavioral health engagement for people releasing from prison*	Asthma medica-tion ratio	Antidepressant medication management: acute and continuation	Contraception postpartum
1 (RMHP)	86.1%	9.0%	31.6%	50.8%	69.1% 46.9%	39.0%
2 (NHP)	89.6%	8.3%	31.6%	46.2%	69.4% 43.3%	40.9%
3 (CoA)	25.2%	10.3%	31.6%	47.4%	69.5% 46.6%	38.2%
4 (HCI)	56.4%	12.7%	31.6%	41.9%	64.0% 39.8%	47.7%
5 (CoA)	36.4%	10.0%	31.6%	46.5%	63.9% 42.1%	43.8%
6 (CCHA)	55.7%	10.1%	31.6%	50.8%	69.6% 47.8%	36.2%
7 (CCHA)	55.9%	11.8%	31.6%	50.3%	66.8% 45.6%	36.5%

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 Indicators

The BHIP indicators 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 2023–24 were for the RAEs' performance during FY 2022–23. Definitions for each BHIP indicator can be found in Appendix C.

Table 5. BHIP performance by RAE, FY 2022-23

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	Follow-up within 30 days of positive depression screen	BH assessment for children in foster care
1 (RMHP)	55.8%	56.2%	37.9%	67.2%	14.9%
2 (NHP)	59.5%	51.1%	35.7%	83.8%	14.4%
3 (CoA)	52.2%	47.4%	28.1%	43.3%	9.9%
4 (HCI)	58.8%	69.6%	36.0%	37.8%	36.6%
5 (CoA)	50.6%	47.0%	29.5%	49.3%	25.6%
6 (CCHA)	51.6%	60.8%	34.2%	55.7%	13.3%
7 (CCHA)	56.1%	33.9%	32.2%	59.7%	15.7%

Key:
Green = Met target

MCO Medical Loss Ratio Metrics

Performance for the MCOs is assessed differently than for the RAEs. Each MCO has its own set of quality metrics specific to their membership and aligned with the goals of the ACC. While RAE performance towards quality metrics 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 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% is retaining 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 have a certain MLR floor; they are given the opportunity to 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 2023 rather than FY 2023–24 due to the time it takes for the data to be collected and processed.

RMHP PRIME's MLR floor began at 89%, 4% above the federally required standard of 85%. PRIME had the opportunity to lower its MLR floor by 1% per metric, for a total of 4%.

Table 6. RMHP PRIME Performance on MLR Metrics, 2023

RMHP MLR Metric	Performance	RMHP Goal for Performance Period	Goal Met?
Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 59.6% Engagement: 16.8%	Initiation: 30.1% Engagement: 9.1%	Yes Yes
Metric 2: Prenatal and Postpartum Care: Prenatal Care (NQF1517)	Prenatal Care: 90.83%	Prenatal Care: 60.1%	Yes
Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Postpartum Care: 90.39%	Postpartum Care: 37%	Yes
Metric 3: Behavioral Health Engagement Rate for Members Experiencing Housing Instability	20.33%	Improve performance by 10%	Yes
Metric 4: Diabetes HbA1c Poor Control <9.0%	18.26%	67.1%	Yes

DHMC's MLR began at 89%, 4 percentage points above the federally required standard of 85%. DHMC had the opportunity to lower the MLR by 1% per metric, for a total of 4%.

Table 7. DHMC Performance on MLR Metrics, 2023

DHMC MLR Metric	Performance	DHMC Goal for the Performance Period	Goal Met?
Metric 1: Well-Child Care			
First 15 Months	58.62%	57%	Yes
15-30 Months	64.19%	59.4%	Yes
3-21 Years	46.6%	43.4%	Yes
Metric 2:Prenatal and Postpartum Care: Prenatal Care (NQF1517)	Prenatal Care: 86.37%	Prenatal Care: 84.1%	Yes
Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Postpartum Care: 82.48%	Postpartum Care: 69.7%	Yes
Metric 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 41.71%	Initiation: 43.5%	No

DHMC MLR Metric	Performance	DHMC Goal for the Performance Period	Goal Met?
Metric 4: Housing & Health 1) BH Engagement rate for MCO/CCH Members 2) Housing and Health Deliverable	37.87%	Improve performance by 10%	Yes

Member Health Initiatives

HCPF uses a population management framework to promote wellness, prevent disease progression and provide additional resources to support Health First Colorado members with complex and chronic 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 keep members healthier, thereby reducing the total cost of care. 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, congestive heart failure/coronary artery disease, chronic obstructive pulmonary disease, anxiety, depression and chronic pain.

The sections that follow provide further information on the ACC's focus areas for member health: diabetes, maternity, complex conditions, health equity, health-related social needs (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. Examples of MCE programs to support members with diabetes include:

- DHMC: Supported approximately half of DHMC members with diabetes through a care management program.
- RAE 1 (RMHP) and RMHP PRIME: Partnered with LetsGetChecked, an in-home lab testing resource that provides testing options for members with identified gaps in diabetic health.
- RAE 2 (NHP): Provided grant funding for five community partners in the region to support diabetes management.
- RAE 3/5 (CoA): Utilized a high-risk pregnancy registry targeting members more likely to experience poor outcomes, such as pregnant members with co-occurring conditions like hypertension and diabetes. CoA also offered access to

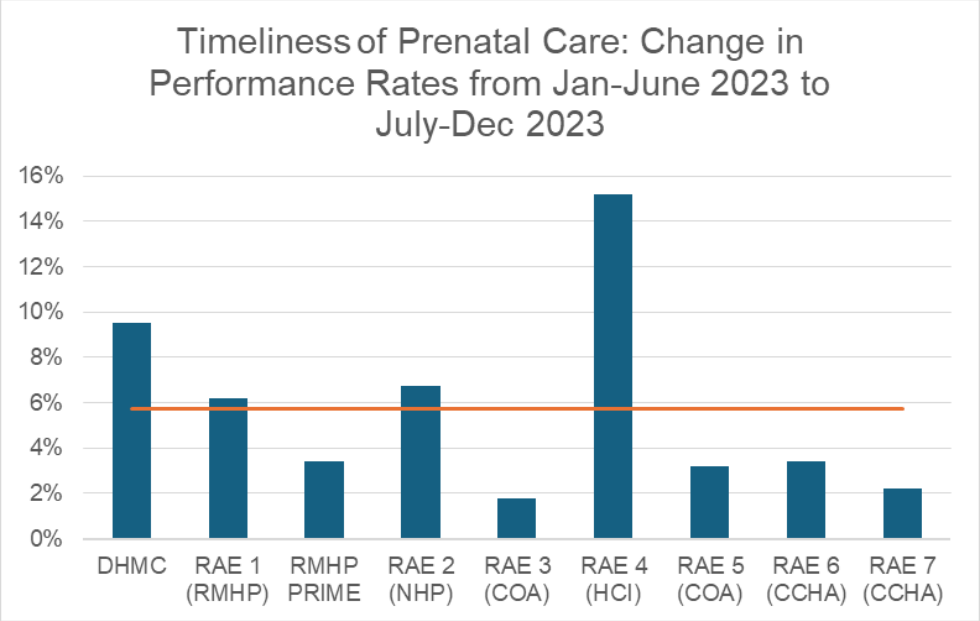
a digital condition management platform that provides education, tools and blood pressure cuffs to allow members to manage their diabetes at home.

- RAE 4 (HCI): Used the Care4Life text messaging-based virtual coach program for broad outreach, providing education and diabetes-specific patient self-management tips for healthy management of diabetes.
- RAE 6/7 (CCHA): Worked with county health departments to refer members to their Diabetes Self-Management Education and Support classes. CCHA provided 3,829 healthy meals to 95 members with diabetes in both regions during FY 2023-24.

Maternity

Maternal health continues to be a priority for HCPF and the ACC. The MCEs report their performance for several Centers for Medicare and Medicaid Services (CMS) core maternity metrics biannually. One example is timeliness of prenatal care, which is measured by the percentage of deliveries that received a prenatal care visit during the first trimester or within 42 days of enrollment in the ACC. According to the most recent available data, the reported timeliness of prenatal care performance rate across all MCEs increased by an average of nearly 6% from January to June 2023 to July to December 2023. This shows great success of the MCEs in managing the prenatal care needs of their members. Figure 3 illustrates the performance rates for the most recent two reporting periods across all MCEs.

Figure 3. Change in Performance for Timeliness of Prenatal Care



Below are highlights from the MCEs' maternity programs in FY 2023-24:

- DHMC: Connected with sister agency Denver Public Health to improve care coordination and referrals to their Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) teams.
- RAE 1 (RMHP) and RMHP PRIME: Partnered with and provided funding for The Willow Collective, which provides multiple levels of support to members during pregnancy and through early childhood. Services focus on pregnancy-related depression and other behavioral health concerns.
- RAE 2 (NHP): Supported the Weld County Nurse-Family Partnership, serving members during pregnancy and continuing until the child reaches age two.
- RAE 3/5 (CoA): Partnered with Mama Bird Doula Services and Kente Village Resource Center to support pregnant members of color.
- RAE 4 (HCI): Provided individualized, one-on-one support for high-risk moms through a care management program. HCI also incentivized members to keep up with prenatal and postpartum checkups in addition to well-child visits after the baby is born through the Health Rewards program.
- RAE 6/7 (CCHA): Partnered with Project Angel Heart to expand a medically tailored meal program to high-risk maternity members. CCHA also awarded $50,000 to Elephant Circle to support training ten new doulas in the Colorado Springs area, as well as providing 15 families with doula services at no charge.

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 provides more specialized support to members with complex care needs. Complex care coordination aims to improve health outcomes, reduce health care costs and increase independence for members with the greatest needs. Below are some highlights from the MCEs' strategies to support members with complex conditions:

- DHMC: Identified members with complex care needs through intake assessments, internal and external referrals, and a risk stratification tool that uses cost, risk factors, conditions and social determinant of health indicators to generate outreach lists. Data-driven dashboards are being used to further track and evaluate outcomes for vulnerable populations, such as members with special health care needs and members in foster care.
- RAE 1 (RMHP) and RMHP PRIME: Optimized the identification criteria of complex members and focused on face-to-face outreach attempts, increasing

the number of high-need members engaged in complex care coordination. A standardized referral process is being piloted that can be applied across community agencies to reduce duplication and administrative burden.

- RAE 2 (NHP): Ensured that priority populations received complex care management needed to improve health outcomes. Members are prioritized based upon condition comorbidity, new diagnoses, those struggling with a condition that is "poorly controlled", as indicated by recent emergency department visits or hospital admissions, medication adherence rates and missed key indicators.
- RAE 3/5 (CoA): Prioritized outreach to high-risk members due for renewal following the PHE unwind to ensure complex members stayed connected to appropriate services and resources. CoA also implemented a high-needs pediatric team, including nine full-time specialized care managers, which aims to streamline care, strengthen relationships with agency partners and allow for focused interventions for high-needs pediatric members.
- RAE 4 (HCI): Enhanced care coordination delivery and ensured continued local community and resource connection through Care Navigation and Care Management programs to improve the self-management support and transitional care management needed to maintain the health of their most complex members. HCI also ensured continued adherence to complex member outreach and care plan creation through the development and communication of monthly care coordination entity scorecards.
- RAE 6/7 (CCHA): Applied strategies to improve the coordination of health care services, communication among care teams and collaboration to prevent duplication across the health neighborhood and community while ensuring that members can access appropriate medical services, resources and community programs. CCHA's care coordination teams participated in regular complex case reviews with case management agencies, PCMPs, health/hospital systems, behavioral health providers, SUD facilities and community partners when applicable to address barriers and find solutions to meet member needs.

Health Equity

Health equity continues to be a key priority for HCPF as outlined in the HCPF Health Equity Plan. MCEs are an important partner in the commitment to meaningfully address and eliminate health disparities. In FY 2023-24, MCEs submitted their individual health equity plans, which illustrate robust strategies to improve quality of care for their regions in the following focus areas: maternity and perinatal health, behavioral health and prevention. These plans identify the impact of current work, priority populations and strategies to reduce disparities. HCPF continues to send each MCE member-level data files, by indicator, with demographic fields (age, county, disability, gender, language and race/ethnicity) that can be used to identify priority

populations. Each MCE will choose its own priority populations for each indicator and calculate results for each priority population based on the needs of their region.

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[2]. 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. Below are highlights of work done during FY 2023–24 to address the HRSNs of members.

1. *Colorado Blueprint to End Hunger*

ACC program staff and the RAEs collaborated with other state departments, local governments and community groups as part of the Colorado Blueprint to End Hunger. Priorities for this work included ensuring eligible Health First Colorado members are enrolled in programs such as SNAP and WIC and improving coordination between RAEs and agencies providing food security resources. HCPF also received recommendations from the Blueprint to End Hunger for ACC Phase III and worked to incorporate suggestions into the request for proposal, while accounting for data sharing and resource limitations of sister agencies. While Blueprint to End Hunger has made changes to its administrative structure, HCPF and the RAEs are committed to supporting this transition and continuing collaboration.

2. *Senate Bill 23-174: Access to Certain Behavioral Health Services*

In FY 2023-24, HCPF implemented the "174 Coverage Policy" in accordance with the requirements outlined in Senate Bill 23-174. This policy allows members under the age of 21 without a covered diagnosis to access a limited set of behavioral health services. The legislation detailed service categories that must be covered, and HCPF engaged stakeholders to identify the specific service codes to be included. A key purpose behind this policy was to address social determinants of health, so HCPF has created a list of codes providers can use that account for these environmental factors that impact member health. Additional information about the 18 services covered under this policy can be found on the coverage policy webpage. This coverage policy took effect July 1, 2024.

[2] 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

3. Statewide Supportive Housing Expansion Pilot

Permanent Supportive Housing (PSH) is an intervention that combines housing and wraparound services for individuals with a disability, including those whose disability is related to a behavioral health diagnosis and a history of homelessness. In December 2022, HCPF launched the Statewide Supportive Housing Expansion (SWSHE) pilot project with the Colorado Department of Local Affairs, through funding made available by Section 9817 of the American Rescue Plan Act (ARPA). The pilot identified members with a history of homelessness who met defined diagnosis and service utilization criteria, and provided them with pre-tenancy and tenancy supportive services including housing navigation, case management and peer support. These were in addition to clinical behavioral health services such as therapy and SUD treatment.

As of June 2024, 695 Health First Colorado members were enrolled in the pilot and receiving wraparound services. Of these, 317 had been previously homeless but were able to secure a housing voucher prior to the pilot, and 378 secured housing as part of the program. One MCE successfully referred 72 members with complex needs and a history of homelessness to PSH during the pilot. The SWSHE pilot ended Sept. 30, 2024, and is under evaluation by the Urban Institute to study its impact on Medicaid utilization.

4. Community Investment Grants

RAEs have the option to fund local community organizations, public health departments, health care providers and others for innovative projects that support health and address barriers to care through community investment grants. RAE grants support health neighborhoods and communities to improve the overall quality of care, health, wellness and outcomes for members while reducing expenditures.

In FY 2023-24, all RAEs provided community investment grants to more than 287 recipients throughout Colorado totaling approximately $20 million. RAE-funded projects focused on maternal, infant, and early childhood mental health, providers and members affected by the end of the PHE, members with developmental and other disabilities, unhoused members or those experiencing housing instability, LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+) youth, and the building of a comprehensive Wellness Center Complex in Rio Grande Hospital that will be used to improve the holistic health of the Del Norte community.

Justice-Involved Members

Individuals returning to the community after incarceration have many needs, including access to health coverage and continuity of care. Post-incarceration care is especially important because people releasing from the justice system have a disproportionately high rate of serious mental illness (SMI), SUD, infectious diseases

and chronic health conditions. To better support this population, HCPF established the Criminal and Juvenile Justice Collaborative, a standing group of key stakeholders including the RAEs, in FY 2023-24. This group meets monthly to provide HCPF with ongoing feedback and ensure robust stakeholder participation in criminal justice projects. This partnership will allow HCPF to comprehensively identify ways in which reentry and pre-release services may help individuals succeed upon returning to their communities.

HCPF continues to host monthly meetings to manage and improve data-sharing agreements between the Department of Corrections, Colorado Judicial Branch and the RAEs to address the health needs of those releasing from state prisons. The percentage of members receiving behavioral health services within 14 days of release continues to improve; this engagement rate stood at 10% in January 2020 and increased to 35% through December 2023.

As an example of the care RAEs provide to justice-involved members, HCI (RAE 4) contracted with Clean Enterprises to provide education programming around health, financial stability, business education, literacy and employment to members in various correctional facilities in the state. By the end of the grant, Clean Enterprises will have engaged with over 300 individuals and provided additional master mentorship programs to 30 to 50 individuals.

Services for Children and Youth

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

MCEs often partner with local and state government agencies and community organizations to address issues in their region that affect children and youth. For example, in 2023, RAE 6/7 (CCHA) partnered with the Boys and Girls Club of the High Rockies to foster resiliency skills for youth in the rural communities of Region 7 by integrating behavioral health services into club activities. The goal of the program is to prevent youth suicide by providing mental health services and access to care for both youth members and their families in the community.

Below are examples of collaborative initiatives in FY 2023-24 related to children and youth that involved HCPF and the MCEs.

1. *Statewide Efforts to Improve Services for Children and Youth*

HCPF is working to develop a robust implementation plan to improve the delivery of intensive behavioral health services (IBHS) to children enrolled in Health First Colorado over the next five years. The goal is to create a delivery model for culturally relevant, family centered, child-driven intensive behavioral health services and supports in the most integrated, least restrictive setting. IBHS will include services such as intensive care coordination, intensive in-home and community services, and mobile crisis intervention and stabilization services. HCPF is continuing to align the improvements in ACC Phase III with the implementation plan and will work closely with stakeholders in the coming months.

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

HCPF continued to facilitate the HCPF, RAEs, CDHS and counties (HRCC) Forum for child welfare issues. The HRCC Forum's work this fiscal year included:

- Incorporating staff from BHA into the work of the HRCC Forum.
- Monthly workgroup meetings focused on how to use data to assess the effectiveness of the ACC for youth involved in the child welfare system. The workgroup developed a request for ongoing reporting and HCPF's data team is in the process of gathering and sharing the data.
- Biweekly meetings to assess challenges and make recommendations to the independent assessment process. The workgroup brought together HRCC Forum participants and other statewide organizations for an in-depth analysis of problems and opportunities with the independent assessment process. Recommendations and next steps are expected by the end of 2024.
- Updates and resource-sharing for HCPF projects such as the Senate Bill 19-195 funding pilot, the universal referral document pilot, the IBHS implementation plan, and ACC Phase III.

Collaboration to Improve Health First Colorado Immunization Rates

The ARPA project, Medicaid Member Immunization Effort, funded two term-limited positions at HCPF to increase COVID-19 vaccination rates for Health First Colorado members. These positions supported the MCEs and local providers to close disparities in vaccination rates between priority populations including pediatric members and their families, Black, Indigenous, and People of Color (BIPOC) communities, and homebound members. Additionally, the Colorado Department of Public Health and Environment (CDPHE), HCPF and the MCEs collaborated on the coordination of vaccine activities, providing technical assistance and training, making local connections to resources, removing barriers, and sharing best practices and data between regions and providers. HCPF staff partnered with CDPHE to provide expertise and education to support pharmacy participation in the Vaccines For Children program, helping

expand vaccine access for children enrolled in Health First Colorado living in rural and frontier regions.

The MCEs report on immunization outreach activities and partnerships made with providers and community-based organizations. In FY 2023-24, DHMC partnered with the Denver Housing Authority and Harm Reduction Center to provide immunization education. CoA (RAE 3) partnered with Adelante Community Development to support the continuation of COVID-19 vaccine outreach within the community, focused primarily on reaching Spanish-speaking populations by holding vaccine clinics at the local flea market once a week since July 2023. HCPF is continuing to collaborate closely with the MCEs and CDPHE on the ongoing monitoring of vaccine activities and well-child visit rates for members.

Care Access

PHE Unwind

HCPF and the MCEs worked closely to plan for the eventual end of the PHE and the corresponding elimination of continuous Medicaid eligibility. These efforts, referred to as "Keep Coloradans Covered," included outreach and communication strategies to inform members and providers about potential coverage changes, upcoming renewal dates and member and provider responsibilities. When the federal government officially notified Colorado that the PHE would end in May 2023, HCPF and the MCEs immediately implemented these communications strategies and began messaging members and providers.

In FY 2023-24, MCEs were key partners in the effort to raise awareness about the end of continuous Medicaid eligibility and outreach members about completing their benefit renewals. As of May 2024, HCPF and the MCEs made more than two million texts, emails, mailings and phone calls, reaching about 630,000 Colorado households, to provide education about renewing their coverage. Households were outreached an average of four times if they hadn't yet renewed. This outreach was in addition to a collaborative campaign between HCPF and the RAEs to raise awareness of the need for Health First Colorado and CHP+ households to renew their coverage and update their contact information. RAEs worked within their communities to focus on hard-to-reach populations and tailored outreach based on member communication preferences and in multiple languages.

While the PHE Unwind ended in April 2024, the work continues. MCE partners will continue their coordinated outreach efforts to support member renewals, focusing on members who have not yet taken action on their renewals and high-risk members, for whom an interruption in coverage could pose serious health risks.

Implementation of Colorado Medicaid eConsult

eConsult platforms allow PCMPs to submit clinical questions to specialty providers without having to make a referral. This allows PCMPs to leverage specialist expertise when they cannot provide needed specialty care during an appointment. On Feb. 1, 2024, HCPF and Safety Net Connect (SNC) launched Colorado Medicaid eConsult. After extensive stakeholder engagement with providers, HCPF also began reimbursing PCMPs for the use of approved third-party eConsult platforms.

One of the primary goals of Colorado Medicaid eConsult is 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 14 pediatric specialties available, Colorado Medicaid eConsult expands the range of electronic medical expertise accessible to members across the state.

From February to June 2024, there have been a total of 31 eConsults, with only four leading to a referral for a face-to-face appointment with a specialist. In FY 2023-24, 135 PCMPs out of Regions 2, 3, 4, 5, 6 and 7 were enrolled and trained to use the platform. With RAE support, SNC continues to engage with PCMPs to introduce and explain the benefits of the eConsult program and guide practice sites through enrollment and onboarding. RAEs were also provided incentive dollars that had to be utilized by Sept. 30, 2024 to support provider adoption and utilization of Colorado Medicaid eConsult.

Behavioral Health Transformation

Access to behavioral health care is essential for a person's health and well-being. Providing needed behavioral health care is a challenge nationally and a particular challenge for Medicaid programs, which cover more people with SMI and SUD than commercial insurance, and deliver care in large geographic areas with both urban and rural populations. Behavioral health system transformation is necessary to address these challenges and meet community needs. As the largest payer of behavioral health services in the state, Medicaid policies and payment strategies directly impact Health First Colorado members, but also drive and influence change across Colorado. Examples of behavioral transformation work in FY 2023-24 include:

- Collaboration with BHA on the design of Behavioral Health Administrative Service Organizations (BHASO), which will consolidate SUD treatment and crisis services and include services offered by comprehensive community behavioral health centers. Although RAEs and BHASOs are similar, there are differences between populations served and function. The shared goals are to improve services to Coloradans, improve coordination and efficiencies across the system

and create consistency for providers while reducing administrative burden. BHASOs will be implemented by July 2025.

- Funding short-term grants to further integrate behavioral health services in primary care settings. To date, there have been 140 total sites expanding or newly implementing integrated behavioral health. RAE practice transformation teams will continue to support integrated sites.
- Surveying the current landscape in Colorado related to care of Health First Colorado members with SMI and serious emotional disturbance (SED) at facilities subject to the federal Institutes for Mental Disease (IMD) exclusion. This project explored ways to mitigate current IMD risk and determine ways providers could expand access to step-down services to facilitate discharge as early as clinically appropriate, as well as potentially preventing admission into higher levels of care. As a result of this research, HCPF developed a new Behavioral Health Campus Policy and launched a regular IMD Forum to address barriers to care at IMD facilities and identify resources to strengthen state partnerships among stakeholders, including the RAEs, providers and BHA.
- Creating at least 125 residential beds for adults with complex behavioral health needs that may be served by a long-term supportive environment as mandated by House Bill 22-1303. The priority of admission to these homes will be patients discharging from the two Colorado State Mental Health Hospitals in Pueblo and Fort Logan. There are two levels of Mental Health Transitional Living home support services. Level 1 homes are funded through Home and Community Based Services waivers. RAEs will contract with Level 2 homes, which will provide individuals with additional structured behavioral health intervention and support within the setting of the home itself.

Behavioral Health Safety Net

Another key aspect of behavioral health system reform has been the expansion of the behavioral health safety net, with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. HCPF and BHA engaged in a multi-pronged effort to provide education, training and technical assistance to providers and other stakeholders on behavioral health safety net system updates, including:

- The creation of new safety net provider types, Comprehensive and Essential Providers. These providers serve priority populations and comply with the safety net no refusal requirements, ensuring that priority populations receive access to the care that they need to achieve whole-person health. Both provider types went live in July 2024 and will contract with RAEs in order to provide behavioral health services to Health First Colorado members.

- The development of new payment methodologies for safety net providers. RAEs will reimburse Comprehensive Providers using a Prospective Payment System (PPS) that pays providers a standard daily rate for any qualifying service provided to a member, regardless of what or how many specific services were rendered on a single date of service. Additionally, RAEs must also offer the Comprehensive Providers in their region a value-based payment arrangement for meeting measurable outcomes that improve member access to quality care. Essential Providers will receive minimum reimbursement rates for selected essential services. More information about the Comprehensive Provider PPS and the Essential Fee Schedule can be found in the July 2024 State Behavioral Health Services Billing Manual.
- The design of Universal Contract Provisions. Two state laws (House Bill 22-1278 and House Bill 22-1302) require HCPF and BHA to develop Universal Contract Provisions that will define expectations for state-contracted behavioral health providers. This will standardize contract expectations around data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission and billing for procedures. HCPF and BHA sought stakeholder feedback on the initial draft during the summer and fall of 2023. The final provisions are expected to be included in ACC Phase III.

Behavioral Health Crisis Services

In FY 2023-24, HCPF collaborated across state agencies to implement new benefits that support individuals in behavioral health crises.

1. *Behavioral Health Secure Transportation Benefit*

Traditionally, urgent behavioral health transportation has been provided by law enforcement or emergency medical services, which can be stigmatizing or traumatizing to the individual in crisis. Utilizing this high level of care can also be costly to the system and may lead to unnecessary interaction with law enforcement. Due to the nature of emergency medical transportation, members must often go to the emergency department prior to being routed to a behavioral health treatment facility. In FY 2023-24, HCPF implemented a new benefit, Behavioral Health Secure Transportation, to help get members in a behavioral health crisis to the best place for treatment in a less traumatizing manner. Through April 2024, 12 providers have enrolled to provide this benefit which has led to 3,308 trips for Health First Colorado members.

2. *Mobile Crisis Response*

In FY 2023-24, HCPF and BHA worked to implement the Mobile Crisis Response benefit which funds standardized services across the state for members. The updated benefit allows teams to provide a trauma-informed, community-based crisis response at any

time to anyone in Colorado experiencing a behavioral health crisis in a wide variety of community-based settings, regardless of age, insurance status, residency or prior utilization. HCPF reimburses for members only, while BHA covers costs for all others. These services can be accessed through 988 or the Colorado Crisis Line, which connects people directly to behavioral health professionals as a trauma-informed alternative to calling police or going to an emergency room. This program was designed to reduce unnecessary hospital visits and arrests. Providers are required to connect members to post-crisis health care and community support services.

HCPF provided $1.75 million ARPA funds to agencies through an interagency agreement with BHA to help providers adjust to these updated standards. The providers supported staff in completing the BHA OwnPath Crisis Professional Curriculum, increased their capacity for 24/7 response, purchased equipment and harm reduction tools and improved technology. Funds were also being used to create more culturally responsive and person-centered equitable access to Mobile Crisis Response services in Colorado. Through April 2024, 16 of HCPF enrolled Mobile Crisis Response providers answered 490 community calls for service.

3. *Crisis Hotline Support*

The Colorado Crisis Line, or 988, provides immediate, anonymous, confidential emergency telephone support to anyone in need of assistance, information or referrals regarding a behavioral health crisis. In alignment with Senate Bill 21-154 and the Colorado 988 implementation plan, HCPF transitioned from the administrative funding support provided by the RAEs to encounter billing for members.

Medication-Assisted Treatment/Opioid Treatment Program

Medication-assisted treatment (MAT) refers to the use of medication together with other therapies to treat SUD. Any provider credentialed to prescribe MAT is permitted to do so under the fee-for-service model and does not need to contract with a RAE to receive reimbursement. Opioid treatment programs (OTPs) are licensed by BHA in accordance with federal standards. OTPs are the only type of provider that are permitted to prescribe, dispense and administer methadone in an outpatient setting.

New federal guidelines have reduced barriers and improved access to MAT by allowing buprenorphine to be prescribed through telehealth without an in-person visit. The regulations also allow providers more flexibility to offer take-home doses of methadone. Effective July 1, 2024, HCPF allows buprenorphine doses greater than 24mg based on provider attestation through the Prescriber Tool. HCPF is also extending the approval time period from six months to 12 months.

Behavioral Health Provider Network Expansion

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.

Expanded access to behavioral health care depends on increasing the number of providers who can deliver services. In regions where providers are limited due to national workforce shortages, RAEs 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 2023-24, the ACC added over 1,000 contracted behavioral health practitioners, including licensed psychologists and licensed behavioral health clinicians. All regions increased the number of contracted practitioners since last year.

Table 8. Number of MCE-contracted behavioral health practitioners from June 2023 to June 2024

MCE	Behavioral Health Practitioners as of June 2023	Behavioral Health Practitioners as of June 2024
DHMC	8,302	9,059
1 (RMHP)	4,064	5,631
2 (NHP)	3,480	4,504
3 (CoA)	8,300	9,062
4 (HCI)	3,480	4,506
5 (CoA)	8,302	9,059
6 (CCHA)	7,421	9,193
7 (CCHA)	7,421	9,193

Note: The following RAEs share a network: DHMC and RAE 5, RAEs 2 and 4, RAEs 3 and 5, and RAEs 6 and 7.

1. *Behavioral Health Network Adequacy Analysis*

In FY 2023-24, HCPF worked with a contractor to better assess access to behavioral health providers. In Phase I of this project, the contractor helped identify "phantom providers" that were enrolled with HCPF and contracted with the RAEs, but not

actively billing for services. In Phase II of this project, the contractor will identify network system gaps and offer recommendations to address them.

2. SUD Network Expansion

Through a combination of additional locations and services available across the continuum, statewide the SUD residential service providers enrolled in Health First Colorado increased by 18 during FY 2023-24. However, there is still important work to be done to increase access to adolescent residential service providers. Effective July 2023, payments have been increased for adolescent SUD residential providers in hopes of increasing provider participation in offering these services. In 2023, more than 10,000 members received residential and hospital SUD treatment services, a 23% increase in the number of members served. Initial authorization denials for residential services have continued to decrease through the third year of the 1115 waiver demonstration to about 5%.

3. High Intensity Outpatient Services

In FY 2023-24, RAEs worked to address gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care. Each RAE was contracted to disperse a total of $1.7 million ARPA funds to increase access to high intensity outpatient services through capacity building efforts. These services include expanding availability of high intensity services for children, youth, and young adults, members of the LGBTQIA+ community and adults at high risk of institutionalization. Many providers in each region opted to apply funding to expand their treatment centers, purchase company vehicles to aid with transportation for members, address workforce challenges to increase the availability of services for those at risk of institutionalization and provide staff training and certification to offer a greater array of evidence-based high intensity therapeutic interventions and services.

In FY 2023-24, the Joint Budget Committee approved the R7 Behavioral Health Continuum budget request which authorized the expansion of SUD coverage to include American Society of Addiction Medicine 2.5 Partial Hospitalization Programs. Partial hospitalization programs provide 20 hours or more of clinically intensive programming each week to support patients who are living with an SUD condition and an unstable medical and/or psychiatric condition in need of daily monitoring and management in a structured outpatient setting. Coverage for these services began July 1, 2024, thereby completing coverage for the full continuum of SUD services.

4. Support Professionals

HCPF continues to seek new opportunities to improve access to care for members. One such strategy is to cover services provided by support professionals, individuals that assist in a member's care by providing outreach, education or other forms of

social support. Examples include the implementation of community health workers consistent with Senate Bill 23-002 (HCPF is seeking CMS approval to reimburse for these services starting July 2025), increasing access to Peer Services through the ARPA project Peer Support Grants for Housing Stability and through the ten Recovery Support Service Organizations in the state, and, in compliance with Senate Bill 22-181, covering services provided by Qualified Behavioral Health Assistants.

Autism Spectrum Disorder Coverage

Effective January 2024, HCPF added autism spectrum disorder (ASD) as covered diagnoses under the Capitated Behavioral Health Benefit for psychotherapy services only for members under 21. Through extensive stakeholder engagement, HCPF received feedback that behavioral health providers serving members with ASD were being denied payment based on administrative standards that require a primary diagnosis when submitting a claim. When an individual is diagnosed with ASD and other behavioral health conditions, it can be challenging to determine the primary condition driving the need for treatment. However, when this diagnosis was not covered by the RAEs, it created barriers to accessing psychotherapy services for members with ASD. The intention of this policy is to remove any barrier for a member with ASD and a co-occurring behavioral health diagnosis from being denied appropriate psychotherapy. This does not change Pediatric Behavioral Therapies, which is not a RAE-covered service and is still billed to HCPF.

Long-Term Services and Supports Care Coordination

1. *ARPA 5.04 Care/Case Management Best Practices*

HCPF continued using ARPA funds to increase and improve communication, collaboration and cross-agency coordination for members receiving care coordination from a RAE and case management agency. Best practices identified last fiscal year were used this year to connect core competencies with roles and responsibilities, create a future systems map, inform rule and contract language, and plan for cross-agency communication and systems integration strategies, training and future sustainability.

2. *Members At-Risk of Institutionalization*

The ACC is coordinating with other offices at HCPF to ensure alignment with the U.S. Department of Justice agreement for members at-risk of institutionalization. ACC Phase III requires future RAEs to comply with the requirements of the agreement and to outreach members identified as at-risk of institutionalization. The final details have not been settled, but HCPF anticipates that this work will be similar to existing workflows to outreach members who receive denials for private duty nursing.

Telehealth

HCPF continues to track and monitor telehealth utilization with an emphasis on behavioral health services. As of the latest month of available data from FY 2023-24 (March 2024), tele-behavioral health visits were conducted, on average, in 38% of all eligible behavioral health visits. There has been a marginal and steady decline in tele-behavioral health utilization over time. For reference, tele-behavioral health utilization was at its highest in April 2020 when the PHE began, with 67% of all eligible behavioral health visits being conducted via telehealth. Nonetheless, with more than a third of behavioral health visits still taking place with telehealth, this form of access to care remains an important option to members and providers. Utilization of tele-behavioral health in FY 2023-24 did not vary substantially among RAEs, though RAE 1 (RMHP) members had the lowest utilization at 32% and members in RAEs 2 (NHP) and 6 (CCHA) both had the highest utilization at 42%. Psychotherapy services remain the most common behavioral health service to be provided by telehealth.

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

The ACC 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. The 2024 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 the ACC should continue building provider networks and address provider barriers to ensure access to care.

Table 9. MCE Performance on CAHPS Surveys

MCE	Ability to get needed care	Ability to get care quickly	Satisfaction with care coordination	Satisfaction with their doctor's communication	Satisfaction with MCE customer service
RAE Aggregate	Adults: 79.3% Children: 81.23%	Adults: 80.5% Children: 85.1%	Adults: 83.3% Children: 80.1%	Adults: 93.2% Children: 93.9%	Adults: 88.7% Children: 88.5%
DHMC	Adults: 75.2% Children: 74.5%	Adults: 71.5% Children: 79.2%	Adults: 90.2% Children: 73.2%	Adults: 93.5% Children: 92%	Adults: 90.2% Children: 84.2%
RMHP PRIME*	Adults: 85.2%	Adults: 79.3%	Adults: 80.7%	Adults: 90.9%	Adults: 92.9%

*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 measure experience is through the responsiveness of the MCE call center. In FY 2023-24, the average speed of answer for all MCE member call centers was less than 50 seconds.

Table 10. Member call center data by MCE, FY 2023-24

MCE	Average member monthly call volume	Member response times (avg speed of answer)	Member call abandonment rate
DHMC	2,008	47 seconds	2.02%
1 (RMHP)/RMHP PRIME	3,692	13 seconds	0.43%
2 (NHP)	446	11 seconds	0.29%
3 (CoA)	1,742	19 seconds	0.5%
4 (HCI)	446	11 seconds	0.29%
5 (CoA)	1,742	19 seconds	0.5%
6 (CCHA)	2,111	13 seconds	1.94%
7 (CCHA)	1,070	15 seconds	1.99%

Provider experience

A positive provider experience depends on several factors, including smooth enrollment/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. Performance on provider service requirements by MCE, June 2024

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	99.4%	100%	100%
1 (RMHP)/RMHP PRIME	99.8%	100%	100%
2 (NHP)	99.7%	100%	100%
3 (CoA)	99.2%	100%	100%
4 (HCI)	99.9%	100%	100%
5 (CoA)	99.4%	100%	100%
6 (CCHA)	99.6%	100%	100%
7 (CCHA)	99.6%	100%	100%

A provider's experience is better when they can get help and answers to questions in a timely manner. Table 12 shows provider call center response data for FY 2023-24.

Table 12. Provider call center data by MCE, FY 2023-24

MCE	Average provider monthly call volume	Provider response times (avg. speed of answer)	Provider call abandonment rate
DHMC	860	4 minutes 21 seconds	11.6%*
1 (RMHP)/RMHP PRIME	3,569	17 seconds	.41%
2 (NHP)	371	12 seconds	.5%
3 (CoA)	1,807	22 seconds	1.04%
4 (HCI)	379	12 seconds	.49%
5 (CoA)	1,807	22 seconds	1.04%
6 (CCHA)	1,191	22 seconds	.66%
7 (CCHA)	1,191	22 seconds	.66%

*Since this reporting began, DHMC's call abandonment rate has fluctuated from 2% to as high as 41% in July 2023. In Spring 2024, DHMC implemented new processes, training and staffing and has seen substantial improvements in their call abandonment rates (2% in June 2024).

Engagement with the Independent Provider Network

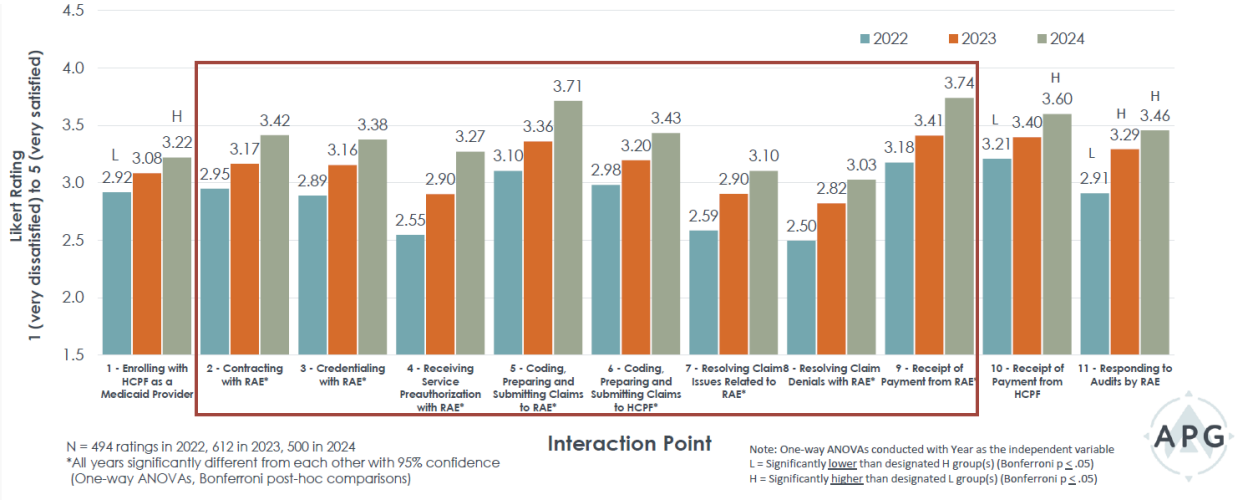
As a result of the 18-month initiative with a third-party independent contractor, Arrow Performance Group (APG), HCPF created the Behavioral Health Independent Provider Network (IPN) Collaborative to offer providers not associated with larger systems (hospitals, residential settings, community centers, etc.) a space to engage and monitor issues specifically impacting the IPN. This meeting reports on communication efforts, behavioral health policies, billing/coding, rates, legislative updates and updates from the ongoing IPN working group.

The IPN working group's focus is to move forward the 21 recommendations that came out of the APG's effort to identify improvements to the Medicaid behavioral health landscape. This work has resulted in meaningful change and improvements for the IPN that includes expanding covered clinical diagnoses, identifying a billing policy for extended clinical encounters for evidence-based practices as well as dyadic interventions, simplifying the State Behavioral Health Services Billing manual by removing unnecessary modifiers, creating a Third-Party Liability resource and establishing a single RAE outpatient behavioral health audit tool, among other improvements.

Each MCE has worked to improve their relationship with and the experience of the IPN. One MCE has improved their process to proactively outreach providers to resolve billing issues, implemented system updates for easier navigation and improved their forums for engaging providers and the educational resources available to them. Another MCE streamlined their credentialing and contracting to create a more efficient process for providers, while also engaging extensively with providers to provide education, answer questions and ensure they have the resources needed to provide care to Health First Colorado members.

Since 2022, APG has conducted annual surveys to measure provider satisfaction and experiences both with HCPF and the RAEs. The survey measured general provider satisfaction and experiences around provider services, such as enrollment, contracting and credentialing, submitting prior authorization requests, submitting claims and resolving issues, receiving payments and responding to audits. Results from the most recent survey found significant improvements in HCPF and RAE ratings across all measures between 2022 and 2024, with no average ratings decreasing from any year.

Figure 5. Satisfaction Ratings by Interaction Point Across All RAEs from 2022 to 2024



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.

The broad scope of the ACC is addressed via these forums. Priority topics in FY 2023-24 included ACC Phase III planning; RAE support for member revalidation after the end of continuous coverage; review of ACC performance metrics; planning related to 1115 waiver authority for continuous coverage, HRSNs and incarcerated members; and health equity work.

RAE Accountability

HCPF oversight of the RAE begins by ensuring contract requirements comply with extensive federal and state statutes and regulations. All RAE 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. In addition to many activities described in this report, like quality performance metrics, incentive payments to improve service quality and access and stakeholder committees, HCPF reviews comprehensive deliverables submitted by the RAEs 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 RAE contract performance. When RAEs are not meeting contract elements, they are placed on action monitoring plans or corrective action plans.

Additionally, HCPF has implemented innovative solutions to encourage greater accountability for the RAEs. In FY 2022-23, RAEs 3/5 (CoA) and RAE 1 (RMHP) migrated to new platforms for provider claims payment to improve functionality. To mitigate the risk of disruption, HCPF required enhanced service standards and financial accountability by requiring the diversion of funds to specific programs within their regions if those standards were not met. Overall, both organizations were able to successfully improve their systems for providers while limiting disruptions for members. This has served as the foundation for the accountability advancements in progress for ACC Phase III.

Health First Colorado Value

ACC Budget

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, enabling HCPF to better control cost trends and 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 2023 to June 2024, the per-member-per-month trend was 27.6%, while risk-adjusted trend was 10.1%. These increases are due to the demographic shift in Medicaid enrollment as HCPF completed redeterminations for members who had been locked into Medicaid

during the pandemic. The members who were subsequently disenrolled were less expensive than those who remained on Medicaid. In addition, the average acuity of the members who remained on Medicaid was higher than HCPF anticipated, resulting in higher overall costs per member. During the evaluation period, the approved across the board provider reimbursement increase, which has a direct impact on Medicaid cost trend, was 3%. 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 4.1%, which reflects an average monthly membership decline of 18.4% due to the PHE. The ACC was part of a comprehensive Medicaid cost control strategy that controlled these cost increases during the PHE. HCPF was able to draw down over $2 billion in additional federal funds from January 2020 through December 2023 through the COVID enhanced federal match available during that period, which resulted in a corresponding reduction in the need to use state funds for those costs.

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 administrative PMPM payment 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.

Table 13. FY 2023-24 Budget for the ACC

ACC Budget Category	FY 2023-24 Expenditures
Payments for Services	
Fee-for-service payments	$10,238,534,435
DHMC MCO capitation payments	$238,381,343
RMHP PRIME MCO capitation payments	$231,682,336
Behavioral health capitation payments	$1,025,543,919
Administrative and Incentive Payments	
Administrative PMPM payments	$170,284,620
KPI payments	$17,281,244
BHIP payments	$3,640,020
Performance pool payments	$28,603,582
TOTAL ACC EXPENDITURES	**$11,953,951,499**

MCO Cost of Care

The cost of care for members in capitated managed care plans include all costs for members' care, regardless of whether it is covered under the physical health capitation, behavioral health capitation or fee-for-service. The cost includes three elements: the physical health PMPM for members, the behavioral health PMPM for members and the cost of any services that are not covered by the PMPM (fee-for-service payments). The third category includes long-term services and supports, medical transportation, dental care, pharmacy 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. Due to the time it takes for the data to be collected and processed, cost of care data in Table 14 is for FY 2022-23.

Table 14. MCO Cost of Care, FY 2022-23

Cost	DHMC	RMHP PRIME
Physical Health Capitation: Total PMPM fees for medical care.	$298,289,918	$299,437,480
Behavioral Health Capitation: Total PMPM fees for mental health care and substance use treatment.	$74,574,173	$47,150,619
Fee-for-Service Payments: Payments for services not covered under the capitation (e.g., long-term services and supports, dental care, medical transportation).	$75,981,807	$67,988,306
Delivery Paid Amounts: Payments made to clinics that charge an encounter fee for care (e.g., FQHCs). These are unique to DHMC	$6,749,860	N/A

Cost	DHMC	RMHP PRIME
Total Cost of Care: The total cost of care (physical and behavioral health capitation payments and fee-for-service payments), while holding the MCO accountable for quality and population health outcomes.	$455,595,758	$414,576,406
Cost of Care PMPM: The amount of money paid or received monthly for each individual enrolled in the managed care plan.	$345 per member per month	$621 per member per month

Hospital Transformation Program

The Hospital Transformation Program (HTP) funds and supports incentive payments to improve health care access and outcomes. The goal of the HTP is to improve the quality of hospital care by tying provider fee-funded hospital payments to quality-based initiatives. Hospital-led projects will achieve benefits not just for members but all Coloradans and their employers, including improved patient outcomes, better delivery system performance, lower Medicaid costs, improved hospital readiness for value-based payments and increased collaboration between hospitals and other health partners. As part of HTP, all participating hospitals have been required to set up notification processes with their RAEs. In FY 2023-24, RAEs and hospitals also collaborated on the following to improve access to services for members, especially those in rural and frontier counties:

- The University of Colorado Hospital identified and tested process workflows for timely RAE communication to ensure a follow-up appointment with a clinician was made prior to discharge and notification to the RAE.
- Pagosa Springs Medical Center worked on a process for documentation tracking and reporting to support the completion of behavioral health screenings. This included collaboratively developing and implementing a discharge plan and notification process with the appropriate RAEs for eligible patients with a diagnosis of mental illness or SUD who have been discharged from the hospital or emergency department.
- Aspen Valley Hospital created an EHR solution to allow completion of the Edinburgh Depression Scale Screening for all identified pregnant and postpartum members. Positive screens for perinatal and postpartum depression and anxiety are sent to the RAE, ensuring information is being shared between the hospital and RAE and the appropriate next steps are taken.
- Wray Community District Hospital worked to implement a standardized referral to clinicians by amending the EHR to ensure that a follow-up appointment with a clinician is made prior to discharge and notification of the RAE will occur within one business day.

Prescriber Tool

Launched in 2021, the prescriber tool offers pharmacy benefit information at the point of care to improve prescription drug transparency and affordability, improve member access and decrease the administrative burden for providers. With the collaboration and support of RAEs, HCPF has effectively promoted the tool with care providers. Nearly half of all active Health First Colorado providers use at least one module of the Prescriber Tool.

In 2023, HCPF launched the Prescriber Tool alternative payment model (APM) with the intention of making providers part of the drug cost affordability solution. The tool consists of four modules: electronic prescribing (eRx), electronic prior authorization (ePA), real-time benefits inquiry (RTBI) and an opioid misuse risk module. A total of 855 practices successfully participated in the first year of the Prescriber Tool APM. One hundred percent of the $1.15 million pool of shared savings was distributed among all participating providers. RAEs helped the Prescriber Tool APM team reach practices with out-of-date contacts and continue to educate practices and providers on the benefits of the tool. In Program Year 2, HCPF will share 75% of the shared savings pool.

Alternative Payment Models

Value-based payments, sometimes referred to as APMs, are reimbursement methodologies that reward providers for achieving shared goals like improving affordability and patient outcomes. HCPF aims to have 50% of all Health First Colorado payments tied to value-based arrangements by 2025 and the majority of members in a care relationship with accountability for quality and total cost of care by 2030. MCE practice transformation teams provide education and support for providers participating in these programs. MCEs supported the development and implementation of the following APMs in FY 2023-24.

1. *APM 1*

APM 1 is a pay-for-performance model that modifies traditional primary care fee-for-service (FFS) to reward improved quality of care while containing costs. In FY 2023-24, HCPF collaborated with MCEs to promote APM 1 and ensure the program's success. According to the most current data available, nearly 87% of participating non-Federally Qualified Health Center (FQHC) PCMPs achieved or exceeded the quality threshold and were eligible for an enhanced rate. PCMPs that achieved the threshold either achieved HCPF goals or improved upon some or all their quality measures.

2. *APM 2*

APM 2 allows participating providers to receive some or all their revenue as prospective PMPM payments to provide stable revenue and room for increased investment in care improvement. Providers are also eligible to share in the savings

that result from improved chronic care management. Non-FQHC providers participating in APM 2 were eligible to receive 100% of the Medicare rates for services covered under the model starting in July 2023. FQHCs may participate in a modified version of the program that provides some flexibility to accommodate the federal payment requirements for FQHCs. More than 240 primary care locations participated, including both FQHCs and non-FQHC providers, exceeding participation targets for FY 2023-24.

APM 2 underwent an extensive evaluation in FY 2023-24 that encompassed all aspects of the current model, its interaction with APM 1 and overall alignment with the ACC. A "Design Review Team" (DRT), made up of a diverse group of primary care providers, advocates, and members, met bimonthly to evaluate the current state and future design elements. Additionally, HCPF reviewed the number of providers eligible for the chronic condition incentive payments; two providers achieved the minimum savings threshold of the 12 who met the quality requirements. HCPF expects the number of eligible providers to increase in subsequent program years as data-sharing tools improve.

3. *Payment Alternatives for Colorado Kids (PACK)*

PACK, which focuses on pediatric primary care, was in development this fiscal year in response to feedback from the pediatric stakeholder community that adult-focused quality and payment models do not meet the needs of pediatric primary care providers or recognize their unique outcomes. Throughout FY 2023-24, HCPF engaged with the DRT to solicit feedback on programmatic goals, quality measurement, target setting and program sustainability. HCPF plans to launch PACK in 2025 as part of ACC Phase III.

4. *Maternity APMs*

The Maternity Bundle is HCPF's first episode-based payment program, which aims to raise the quality and lower the cost of maternal care while advancing maternal health equity. It covers all prenatal, labor and delivery and postpartum care for pregnant and postpartum members. Providers participating in this voluntary program can receive incentive payments depending on their ability to manage the cost of each episode. There are currently nine participating providers that provide services for about 30% of all Health First Colorado births. HCPF is currently developing a new Maternity APM based on extensive stakeholder feedback to more effectively align quality objectives with payment structures, aiming for improved patient outcomes. The Maternity APM will prioritize minimizing disparities, honoring member preferences and autonomy and fostering positive birthing experiences and outcomes during the pregnancy journey.

Preparing for ACC Phase III

Current RAE contracts will end on June 30, 2025. HCPF is in the process of designing the next iteration of the ACC, referred to as Phase III, which will begin 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.

Significant work was completed in FY 2023-24 to support the design and implementation of ACC Phase III. HCPF released both the ACC Phase III Concept Paper, which outlined the proposed program design and key changes and the ACC Phase III Draft Contract which outlined the proposed contract requirements for the RAEs. HCPF hosted approximately 70 stakeholder meetings with over 3,000 attendees over the course of the fiscal year to gather feedback on the proposed programs, policies and contract requirements outlined in these documents. From May to July 2024, HCPF posted the formal request for proposal for the RAEs. An evaluation committee of subject matter experts reviewed each proposal and HCPF issued an intent to award four contractors in September 2024.

HCPF is proposing several areas of change for ACC Phase III, including:

- A reduction in the number of regions from seven to four to ensure sustainable investment in regional infrastructure and better leverage efficiencies of the RAEs.
- An adjustment to how members are attributed to a PCMP.
- The provision of member incentives to support healthy behaviors in key program areas, like maternal health.
- An increased focus on health equity by requiring dedicated personnel, staff training and a regional committee.
- The alignment of payment models across markets through partnerships with the Center for Medicare and Medicaid Innovation's Making Care Primary, and the Colorado Division of Insurance to reduce administrative burden for providers.
- A PCMP structure that evolves from a Primary Care Medical Home to an Accountable Care Organization (ACO)-like model, which rewards outcomes not just actions.
- The continuation of provider and member tool innovation, like cost and quality indicators, eConsults and the Social Health Information Exchange.
- Improved processes for children and youth accessing behavioral health care services and the implementation of high-fidelity wraparound.
- Advances in care coordination and program accountability to improve quality, close disparities and drive affordability.

Proposed payment models will build on existing models. 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 HRSNs. Administrative payments will continue to be paid to the RAEs for 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. Alignment with alternative payment models will continue, as described in the Health First Colorado Value section of this report.

Priorities for FY 2024-25

ACC Phase III Implementation

In FY 2024-25, significant work will be completed, both in partnership with the newly selected vendors and throughout the department, to support the successful transition to a new phase of this program. As stakeholder involvement has been a priority in designing ACC Phase III, there will be continued opportunities for stakeholders to provide their input on the implementation of many of the new policies and programs.

Part of a successful transition to Phase III includes closing out the current contracts. HCPF will work closely with the newly awarded RAEs to ensure a seamless transition that avoids disruption of services for members and providers alike.

BHA Collaboration and Alignment

HCPF and BHA will continue to collaborate and align closely to improve the behavioral health system in Colorado. Both agencies worked closely to align the RAE regions for ACC Phase III with the BHASO regions. There will be ongoing collaboration to clarify and align roles and care coordination responsibilities as BHA continues to develop the BHASOs. HCPF and BHA will also continue to work together on universal contracting provisions and strengthening the behavioral health safety net. Additionally, HCPF and BHA are identifying opportunities for increased efficiency through joint review and sharing of available technologies used for data collection and analysis, claims processing, social programs, learning management systems and other initiatives to improve patient outcomes and equity, federal match dollars and other shared goals. Areas of focus include expanding access for children and youth with complex needs, reducing administrative burden, improving quality reporting and rate transparency, expanding access for priority populations and addressing HRSNs.

1115 Waiver Amendment

Under the current 1115 Waiver, Colorado offers a full continuum of SUD services to members including residential level of care and inpatient SUD services and allows for residential SUD facilities with more than 16 beds to receive reimbursement through Health First Colorado. On April 1, 2024, HCPF submitted an amendment to the current 1115 SUD Waiver to CMS. The amendment includes the following services:

- Reimbursement for acute inpatient and residential stays in IMDs for individuals diagnosed with a SMI or SED to cover up to 60 days, so long as providers maintain an average length of stay of 30 days or less.
- Extending continuous Medicaid and CHP+ coverage for children to age three, authorized by House Bill 23-1300.
- Extending 12 months of continuous Medicaid coverage for adults leaving incarceration from a Department of Corrections facility, authorized by House Bill 23-1300.
- Pre-release services for adults and youth transitioning from correctional facilities. Pre-release services would include a targeted benefit package for these individuals to include case management services, MAT for SUD, a 30-day supply of medications upon release and certain other supportive services.

If approved by CMS, this suite of coverage provisions and services will be implemented across the state, creating and strengthening connections between carceral settings, government agencies, health and social service entities, and many others — all collaborating to improve reentry into the community while maintaining their health and well-being.

On Nov. 14, 2024, Colorado received approval from CMS to extend Medicaid and CHP+ coverage eligibility for two groups of Coloradans, a change made possible by the amendment submitted on April 1, 2024. This policy will support continuous coverage up to 36 months for children from birth to age three who are eligible for Health First Colorado or CHP+. The second group this policy supports will be adults leaving a state prison, ensuring these individuals have 12 months of continuous Medicaid coverage eligibility regardless of any changes in income or other fluctuations. Both eligibility changes will be implemented on Jan. 1, 2026.

Authorized by House Bill 24-1322, HCPF submitted a second amendment to the 1115 SUD Waiver on Aug. 12, 2024, that would address HRSN. The proposed HRSN services included in the amendment are:

- Housing services including pre-tenancy and housing navigation services, tenancy sustaining services, rent/temporary housing for up to six months (including utilities) and one-time transition and moving costs.
- Nutrition services including meals or pantry stocking, medically-tailored meals and nutrition counseling/education.

Health-Related Social Needs

1. *Social Health Information Exchange*

HCPF will continue to collaborate with Colorado's Office of eHealth Innovation on the development of the Social Health Information Exchange (SHIE). This platform is being

designed to securely share social health information to enable case management agencies, RAEs, care coordinators, community health workers and health care providers to connect Health First Colorado members to programs. These will include state programs like SNAP and WIC, RAE programs like prenatal care or diabetes care and support or HRSN supports like community foodbanks, homeless shelters or housing vouchers. All of these programs are intended to improve whole-person care, access, equity, quality and affordability. The SHIE is being released in waves beginning in Fall 2024.

2. *HRSN Feasibility Study*

House Bill 24-1322, Medicaid Coverage Housing and Nutrition Services, was signed into law during the 2024 legislative session. This legislation directs HCPF to conduct a study of the feasibility of seeking federal authorization for Health First Colorado to cover a set of housing and nutrition services for members. This study was submitted to the Joint Budget Committee in November 2024. House Bill 24-1322 also allows HCPF to seek federal authorization for these services if adding them is determined to be budget neutral. This provision is what allowed HCPF to submit an 1115 waiver amendment for a subset of these services in August 2024.

HCPF is also working on a longer-term feasibility study of HRSNs as directed by House Bill 23-1300. This study differs from the aforementioned House Bill 24-1322 in that it is on a longer timeline and requires HCPF to study a broader set of services than just housing and nutrition. The study includes other HRSNs such as nonmedical transportation, interpersonal violence, climate-related needs and other social needs identified in the process of conducting the study. HCPF will launch external workgroups to inform this study in FY 2024-25 and will submit this study by January 2026.

HB22-1289 Implementation

In compliance with House Bill 22-1289, HCPF will continue its work to implement Medicaid look alike programs for populations who would be eligible for Health First Colorado and CHP+ if not for their documentation status, including pregnant people, postpartum people through 12 months and children up to age 18. MCEs will work with HCPF to identify barriers and develop solutions for successful implementation of the program.

Advancing innovations to improve quality, access and affordability

1. *Quality and Cost Trend Management*

In the next fiscal year, HCPF will continue work to improve quality and control cost trends to drive affordability, access and equity for all Health First Colorado members. As part of this effort, HCPF is developing new RAE dashboards that will display key

indicators that monitor utilization, quality and cost trends. These dashboards will help HCPF proactively monitor trends and identify areas for program improvement.

2. *Facility Cost and Quality Indicators*

HCPF will continue 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. HCPF is working to ensure that members and referrers can easily access this information through convenient online means, such as or similar to, the Find-a-Doctor tool. Stakeholder engagement began in 2024 and will continue in FY 2024–25 to support the evolution of this important work by improving quality outcomes, closing disparities and driving affordability to achieve the shared goals of protecting provider reimbursements, program access and member benefits.

3. *Quality of Care Process and Resolution*

HCPF is currently developing a new process for reporting quality of care grievances. To improve the reporting process for grievances and quality of care concerns, we have collaborated with various stakeholders and implemented a web intake form to ensure thorough investigations are completed to resolution. This initiative aims to provide HCPF with comprehensive oversight of member and provider complaints, and patient safety concerns to identify risks and trends to improve member safety.

4. *eConsult*

In the next fiscal year, HCPF aims to broaden the scope of Colorado Medicaid eConsult by enabling specialists to submit eConsults to other specialists. While the ordering and response process for eConsults will largely resemble the current model, roles will be expanded to accommodate more user types. HCPF plans to roll out this initiative in the subsequent fiscal year following stakeholder engagement and platform updates.

Appendices

Appendix A. Key Performance Indicator Definitions

The following eight KPIs were used in FY 2023-24:

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 RAE's 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

The performance pool measures for FY 2022-23 are described below:

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**: 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 2023–24 were for the RAEs' performance during FY 2022–23. 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 mental health condition**: Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health 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 mental health service within 30 days of screening positive for depression.
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. **Behavioral Health Engagement Rate for Members Experiencing Housing Instability.** The implementation and outcomes of a housing program and its strategies for Health First Colorado members enrolled in PRIME, based on a quarterly deliverable.
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. **Housing and Health**. This metric has two parts. 1) Denver Health must submit the results of quarterly surveys and measure the behavioral health engagement rate for members who receive services from the Colorado Coalition for the Homeless. 2) Health and Housing evaluation deliverable.