COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

December 12, 2022

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

Attached is the Accountable Care Collaborative annual report for FY 2021–22. As required by the legislation, this report provides information on program enrollment, program performance, program costs and value, access to services for members in rural and frontier counties, efforts to coordinate with Long-Term Services and Supports, information on advisory committees and other stakeholder engagement, future areas of program development and efforts to reduce waste and inefficiencies through the Accountable Care Collaborative. It also provides information about how the program supported the Department's strategic pillars during FY 2021–22.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7796.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 Accountable Care Collaborative Implementation Report

Cc: Senator Joann Ginal, Vice Chair, Senate Health and Human Services Committee
Senator Janet Buckner, Senate Health and Human Services Committee
Senator Sonya Jaquez Lewis, Senate Health and Human Services Committee
Senator Barbara Kirkmeyer, Senate Health and Human Services Committee
Senator Cleave Simpson, Senate Health and Human Services Committee
Senator Jim Smallwood, Senate Health and Human Services Committee
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Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 12, 2022

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health & Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

Enclosed please find a legislative report to the House Public & Behavioral Health & Human Services Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

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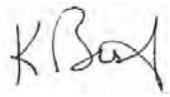

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 Accountable Care Collaborative Implementation Report

Cc: Representative Emily Sirota, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
Representative Ron Hanks, House Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, House Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, House Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, House Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, House Public & Behavioral Health & Human Services Committee
Representative Dave Williams, House Public & Behavioral Health & Human Services Committee
Representative Mary Young, House Public & Behavioral Health & Human Services Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 12, 2022

The Honorable Senator Zenzinger, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Sentor Zenzinger:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative.

Pursuant to section 25.5-5-419, C.R.S., on or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the Joint Budget Committee, the Public Health Care and Human Services Committee of the House of Representatives, and the Health and Human Services Committee of the Senate, or any successor committees, concerning the implementation of the Accountable Care Collaborative.

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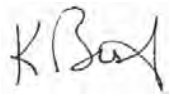

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 Accountable Care Collaborative Implementation Report

Cc: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Straayer, Budget Analyst, Office of State Planning and Budgeting
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Accountable Care Collaborative FY 2021-22

In compliance with Section 25.5-5-419, C.R.S.

December 1, 2022

Submitted to:

Joint Budget Committee, Public Health Care 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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COLORADO
Department of Health Care Policy & Financing

Executive Summary

In this report, the Department of Health Care Policy and Financing (the Department) summarizes the work of the Accountable Care Collaborative (ACC) from July 2021 to June 2022. Here are some of the highlights of this report.

Key Elements of the ACC

The ACC is the core vehicle that the Department employs to deliver and manage care to covered Health First Colorado (Colorado's Medicaid program) members. Specifically, the ACC is a unique hybrid of managed fee-for-service physical health care, managed care for behavioral health, member support, and care coordination. It is designed to be immersed in and responsive to the needs of each geographic region. The ACC helps the Department fulfill its mission, which is: *To improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* The ACC also supports the advancement of the Department's strategic pillars, the most relevant of which include: Member Health, Care Access, Operational Excellence and Customer Service, and Health First Colorado Value.

In FY 2021–22, the average monthly enrollment in the ACC was 1,489,511. Enrollment continues to increase since the COVID-19 pandemic began in 2020, when the COVID-induced economic downturn fueled significant job losses, and the related loss of employer-sponsored health coverage. The federal continuous coverage requirements for Medicaid also prohibited disenrollment of members during the Public Health Emergency (PHE), further propelling enrollment growth.

The ACC represents the majority of Medicaid expenditures, totaling $10.2B in FY 2021-22. This includes $8,378,725,778 in fee-for-service payments, $1,589,525,530 in capitated payments including behavioral health, $187,680,197 in administrative payments including care coordination, and $64,344,628 in earned incentive payments. From July 2021 to June 2022, the Medicaid cost per member per month (PMPM) year-over-year claim trend increase is 2.2%, while risk-adjusted trend is 4.0%. The year over year claim trend measured by total expenditures is 13.2%, which reflects the significant membership growth of 10.8%.

A critical component of the ACC is the Regional Accountable Entities (RAEs). The RAEs' primary focus is to: contract with Primary Care Medical Providers (PCMPs); manage the behavioral health capitation; coordinate care for all populations; manage administration, data and information; facilitate member access to care and support; and respond to unique department directives. The RAEs are furthering the

Department objectives in each of these areas while pursuing opportunities and advances in each area.

ACC Accomplishments and Advances

To achieve the Department's objectives to control Medicaid costs and improve member health, the Department developed a Population Management Framework to (a) address the health care needs of populations with complex and high-cost conditions and (b) prevent disease progression of conditions impacting the Medicaid population. A key strategy to this Framework is working with the RAEs to create and advance programs, which meet Department requirements, to improve member health, and better control costs on identified conditions commonly impacting the Medicaid population. These conditions include: maternity, diabetes, hypertension, congestive heart failure/coronary artery disease, chronic obstructive pulmonary disease, anxiety, depression, and chronic pain. All RAEs developed and implemented such programs. An opportunity is to standardize program measures on engagement, health improvement impact, and savings going forward.

To achieve cost control and quality improvement outcomes, and in addition to the program advances noted above, the Department implemented several, unique cost containment strategies impacting the ACC reporting period. This included continuing and expanding access to telemedicine, especially for behavioral health; expanding access to behavioral health providers; Hospital Transformation Program (HTP), which improves the quality and affordability of hospital care provided to members by tying value-based hospital payments to cost control and quality-based initiatives; the Prescriber Tool release of its Opioid Module (Jan 1, 2021) and its Affordability Module (June 1, 2021); and the emerging primary care alternative payment models that tie payment to member health outcomes.

ACC and RAE program performance is assessed through Key Performance Indicators (KPIs), Behavioral Health Incentive Program Indicators, and Performance Pool incentive measures. Health care utilization continued to recover this fiscal year as the state emerged from the initial pandemic while continuing to cope with COVID waves and health care workforce challenges. As a result of these volatile market factors, RAEs were able to reach some KPI targets (such as emergency department use where lower utilization is desired) but not others (such as well-child visits). Some RAEs were also able to meet their targets in prenatal engagement, dental visits, and well-child visits.

The Performance Pool program is funded with money not earned by the RAEs for KPI performance and is often used to respond flexibly to timely needs and priorities. FY

2021–22 was the first year the Department incentivized performance for the following Performance Pool metrics: Extended Care Coordination, Premature Birth Rate, Behavioral Health Engagement for Members Releasing from State Prisons, Risk-Adjusted PMPM, Asthma Medication Ratio, Antidepressant Medication Management, and Contraceptive Care for Postpartum Women. The initial Performance Pool results will not be available until early calendar year 2023 as the Department and RAEs finish processing claims and other data collection efforts necessary to assess performance.

Significant RAE advances were made in the area of Social Determinants of Health programming. This will continue to be a major focus going forward with innovations currently underway by the Department in collaboration with the Office of eHealth Innovation (OeHI).

Key customer service metrics for members and providers are listed below and reflect the Department's continued focus on this important area:

- HCPF Member Call Center Average Speed of Answer: 40 seconds
- Gainwell Provider Call Center Average Speed of Answer:
    - 4.5 minutes (July '21 – June '22)
    - 1 minute (last 12 months)
    - 30 seconds (last six months)
- Gainwell Medical Claim Processing Average Turnaround Time: 3.5 days
- RAE Member and Provider Call Centers Average Speed of Answer: 20 seconds
- RAE Behavioral Health Claims Payment Turnaround Time:
    - Percentage Paid or Adjudicated within 30 days: >99%
    - Average turnaround time: < 10 days

To further understand **the member experience**, the Health Services Advisory Group, Inc. (HSAG) administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey. Ratings varied across RAEs for each factor. However, most members reported being able to get needed care (80.9% for adult care and 80.2% for children) and get care quickly (78.9% for adults and 84.9% for children). They also reported satisfaction with care coordination (79.7% for adults and 82.3% for children) and how well their doctors communicate with them (91.3% for adults and 93.6% for children). HSAG recommended that the RAEs continue to expand options for after-hours care and explore additional ways such as focus groups to understand member experience.

About 25% of Medicaid-enrolled physicians, physician assistants, and osteopaths did not see a member, defined as not submitting a claim last year. Until this challenge is addressed, RAEs will struggle to ensure proper specialist access under the ACC. The

Department is refining this analysis with the goal of meeting with hospital systems, which have purchased most of the specialists in the state, to discuss this concerning finding.

The ACC achieved a number of behavioral health accomplishments despite the existing systemic challenges and solutions not yet implemented to address the opportunities across the state's behavioral health system:

- Between April 1, 2021 and March 31, 2022, 18.4% of Medicaid ACC members accessed services for mental health and substance use disorder (SUD) through the capitated behavioral health benefit or through primary care settings.
- In addition to coverage for residential, crisis, and outpatient substance use and mental health treatment, the capitated benefit structure supports the RAEs in covering and coordinating a variety of support services to help members avoid unnecessary inpatient care and remain in the community. Through the capitated benefit, members can access alternative community-based services ("B3") services, authorized through a federal 1915(b)3 waiver. These services are especially important for members with serious mental illness and co-occurring needs and includes prevention/early intervention, clubhouses/drop-in centers, vocational services, intensive case management, assertive community treatment, mental health residential treatment, respite care, and recovery services/peer support. B3 services also help members connect with peers, develop life skills, and prevent isolation.
- All members have access to short-term behavioral health services – up to six visits through integrated primary care. Nearly 70% of members (12,230) who used the short-term behavioral health benefit in FY 2021–22 had not accessed behavioral health through the capitated benefit in the previous year. Research on the populations accessing integrated care suggests that these services may be an effective strategy to close behavioral health disparities – a key goal for the Department.
- From January to December 2021, 33 providers at 58 locations offered the newly covered substance use residential services to 8,844 unique memberswho received 16,486 episodes of care.
- From July 1, 2021 to June 30, 2022, the Department exceeded its goal to add 950 new providers to the ACC with the addition of 1,150 providers to the behavioral health network.

Improving the System Through Strategic Investments and Programs

The ACC will benefit from three Department workstreams intended to improve access, quality outcomes, and affordability in the following areas: Rural Colorado

Investments, Behavioral Health Investments, and Home & Community Based Services (HCBS) Investments.

To advance rural community care access, health outcomes and affordability the Department is managing the following workstreams:

- $10 million equally split to fund increases in access and affordability initiatives focused on rural hospitals and their rural health clinics

- $12 million per year, totaling $60 million over five years, through the Rural Assistance Fund – a component of the Hospital Transformation Program to help rural hospitals transform for the future

- $17 million to connect rural providers to the Health Information Exchange, in collaboration with the Office of eHealth Information (OeHI) as well as additional funding for rural hospitals and physician groups in the FY 2023-24 budget to maintain this connection

The Behavioral Health system in Colorado is in the process of transformation to address significant challenges in access propelled by an insufficient number of providers and a lack of network participation across Medicaid and commercial plans among providers; challenges within the safety net; lack of cultural competencies which propel health disparities, and more. *The ability of the RAEs to meet the behavioral health demands of members, the Department and stakeholders is severely impaired due to systemic challenges and will improve in direct correlation to the transformative behavioral health initiatives as they are implemented.* In addition to these ACC-specific efforts, the Department has been working across state agencies and with stakeholders for the past three years to develop a statewide plan and implement transformative changes. This includes:

- Creation of the Behavioral Health Blueprint for Transformation as envisioned by the 2019 Behavioral Health Task Force and influenced by a needs assessment including the review of over 100 state behavioral health reports, a call to increase accountability and update oversight processes and standards that were previously in place, and feedback from thousands of stakeholders.

- Between FY 2018-19 and FY 2023-24 the Department, representing the state's largest payer of behavioral health services, collaborated with the Joint Budget Committee and the General Assembly to increase investments into Medicaid behavioral health by more than $500 million (as submitted in the Governor's budget and as of the writing of this report) supporting expanded access to quality care for all members.

- The allocation of $450 million in ARPA-allocated investments through recommendations from the 2021 Behavioral Health Transformational Task Force.

- The identification and allocation of another $115 million in Medicaid-specific behavioral health grants and programs funded by the HCBS ARPA transformational initiatives.

- Implementation of $35 million in ARPA-funded grants to advance the integration of behavioral health into primary care, as authorized by House Bill 22-1302.

- The passage of 20 behavioral health transformation bills during the 2022 Legislative Session, including the historic creation of the Behavioral Health Administration (BHA). These bills can be found in Appendix A.

- The Department is also working with the BHA, local communities, safety net providers, advocates, members and families on several workstreams that help to improve overall access, quality, transparency, and equity in the state behavioral health system. These efforts include: modernization of safety net provider and service definitions; revising, amending, or repealing regulations for behavioral health safety net providers; creating a Universal Contract; improved transparency and standards for safety net cost reports; streamlined processes for cross department oversight and administration; development of alternative and value-based payment models in Medicaid; investing in expanding safety net system; and decreasing the administrative burden to providers.

- The Department is also in process of applying for a $1 million planning grant in coordination with the Behavioral Health Administration, to assess Colorado's ability to participate in Certified Community Behavioral Health Clinic (CCBHC) model, with the possibility of applying at the end for a four-year demonstration grant. The planning year will include a thorough review of the benefits, opportunities, and challenges of the managed care model as it related to supporting a comprehensive behavioral health safety net.

The Department was awarded more than $500M in American Rescue Plan Act (ARPA) dollars to transform Home and Community Based Services (HCBS) to better serve individuals with disabilities. These individuals are also served by the ACC. In collaboration with stakeholders, the Department identified 63 projects to transform the industry currently in process, along with the funding of significant increases to

frontline worker wages. All 63 HCBS ARPA transformational initiatives are currently underway.

The following are the ACC priorities for FY 2022-23:

- Advancing Health Equity and Social Determinants of Health supports
- Advancing Innovations that improve access, equity and affordability, such as: eConsults, Prescriber Tool adoption and Social Determinants of Health Phase II module, Colorado Providers of Distinction work (implementing cost and quality indicators)
- Increasing care access with a special focus in the areas of behavioral health, specialty care and care in rural communities
- Implementing the American Rescue Plan Act (ARPA) projects in behavioral health and home and community-based service
- Collaborating with the Behavioral Health Administration (BHA) to achieve shared behavioral health systemic transformative goals
- Advancing CMS's directive to achieve 50% of payments within a value-based payment model by 2025
- Working with stakeholders to complete the design of ACC 3.0, which will be effective July 1, 2025.

I. Report Brief

Accountable Care Collaborative Overview

In Colorado, the Department of Health Care Policy & Financing (HCPF) is both "the coverage provider" and "the administrator" of the Medicaid program, called Health First Colorado. The ACC is a core vehicle, which the Department employs, to deliver and manage care to covered members. Specifically, the ACC is a unique hybrid of managed fee-for-service physical health care, managed care for behavioral health, member support, and care coordination. It is designed to be immersed in, and responsive to, the needs of each region.

The ACC supports the strategic pillars of the Department of Health Care Policy and Financing and its Medicaid program, the most relevant of which include: Member Health, Care Access, Operational Excellence and Customer Service, and Health First Colorado Value. During this fiscal year, the ACC continued to respond to the COVID-19 pandemic and its challenges, including increased enrollment, COVID surges, and increased demand for behavioral health care. As it is designed, the ACC responded to both statewide concerns and regional needs during this period, demonstrating one of its most valued features.

At the heart of the ACC are Regional Accountable Entities (RAEs), which manage care in each of the seven regions of the state. The RAEs contract with Primary Care Medical Providers (PCMPs) that serve as medical homes for members, administer the capitated behavioral health benefit, manage and coordinate care to achieve Department goals, address the unique needs of special populations, and respond to unique threats and opportunities at the direction of the Department (e.g., COVID vaccinations, Marshall Fire response, Prescriber Tool provider uptake).

Most full-benefit Medicaid members are enrolled in the ACC. In FY 2021–22, the average monthly enrollment in the ACC was 1,489,511. Enrollment has continued to increase since the COVID-19 pandemic began in 2020, when the COVID induced economic downturn fueled significant job losses across the nation, and with that the loss of employer-sponsored coverage. Concurrently, all Medicaid programs were required by the federal government to maintain continuous health care coverage for all members once covered, regardless of changes in their eligibility status, in exchange for state acceptance of the additional 6.2 points of FMAP dollars. These additional funds provided a critical influx of monies to the Colorado General Fund (over $1B over 10 quarters) above what was needed to cover the increase in program enrollees. This continuous coverage requirement will expire at the end of the public health emergency, which has not yet been announced, but is predicted to take place in calendar year 2023.

Member Health

The ACC is central to the Department's strategic pillar to improve member health outcomes, which includes a focus on reducing health disparities. It pursues this shared goal in the following ways.

Program Performance

The ACC tracks performance with three types of measures: Key Performance Indicators (KPIs), Behavioral Health Incentive Program Indicators, and Performance Pool incentive measures. KPIs included the following in FY 2021–22:

- Emergency Department Visits
- Behavioral Health Engagement
- Prenatal Engagement
- Dental Visits
- Child and Adolescent Well Visits

Health care utilization continued to recover this fiscal year as the state emerged from the initial pandemic lockdown but continued to cope with COVID waves and health care workforce challenges. As a result, RAEs were able to reach some KPI targets and not others. Despite these COVID induced challenges, some RAEs were able to meet their targets in prenatal engagement, dental visits, and well-child visits.

RAEs are eligible to earn up to 5% of their annual behavioral health capitation payment for reaching targets in the following behavioral health measures:

- Engagement in Outpatient Substance Use Disorder (SUD) Treatment
- Follow-up within Seven Days after an Inpatient Hospital Discharge for a Mental Health Condition
- Follow-up within Seven Days after an Emergency Department Visit for SUD
- Follow-up after a Positive Depression Screen
- Behavioral Health Screening or Assessment for Foster Care Children

Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year, so funds distributed to the RAEs this year were for performance in FY 2020–21. All RAEs met the targets for engagement in outpatient SUD treatment. Five of the seven RAEs met targets for behavioral health screening for foster care children, and three of the RAEs met targets for follow-up after a positive depression screen. None of the RAEs met targets for follow-up within seven days after inpatient hospital discharge for a mental health condition or follow-up within seven days of an ED visit for SUD.

In FY 2021–22, the Performance Pool funds were used to incentivize performance on the following indicators:

- Extended Care Coordination
- Premature Birth Rate
- Behavioral Health Engagement for Members Releasing from State Prisons
- Risk-Adjusted Per Member Per Month (PMPM) Payment
- Asthma Medication Ratio
- Antidepressant Medication
- Contraceptive Care for Postpartum Women

The Department also used Performance Pool funds to incentivize RAE planning and work related to four key issues: COVID-19, the prescriber tool, e-health and the public health emergency unwind. RAEs submitted FY 2022–23 plans for all four issues.

Member Health during COVID-19

RAEs played a critical role in identifying and reaching out to unvaccinated members and priority populations while collaborating with providers and community-based organizations to increase Medicaid vaccination rates for COVID-19. As of May 2022, 49.9% of Medicaid and CHP+ members ages 5 and older were partially or fully vaccinated for COVID-19. The vaccination rates may be related to a slow rollout of FDA approval for children, but are consistent with national averages. The ACC also met goals for disparity reduction, ensuring that vaccination rates between white members and members of color were within three percentage points. At 50.6%, the COVID-19 vaccination rate for members of color was higher than the rate for white members (45.9%).

RAEs worked to close the COVID-19 equity gap through data collection and analysis, provider outreach on vaccinations, increased provider reimbursement for vaccination, free at-home COVID tests, transportation to vaccination sites, and partnerships with Long-Term Services and Supports and community leaders to increase vaccination rates.

Maternal Health Equity

Maternal and infant health outcomes are among the most important indicators of the health of the state and nation. Providing prenatal care for more than 40% of births in the state each year, the Department is focused on improving health outcomes for parents and newborns. Long-standing systemic racism has had a deleterious effect on pregnant people of color and created a disparity in maternal health outcomes. In the last decade, behavioral health has become the leading cause of maternal mortality, surpassing postpartum hemorrhage and eclampsia deaths.

The ACC has been using a broad array of initiatives to improve maternal health, from special programs for pregnant and postpartum people to new payment models that incentivize better maternal health outcomes. All RAEs meet the requirement to have a program in place to support pregnant and postpartum members that meets criteria established by the Department.

Social Determinants of Health

A focus on the social determinants of health has been a part of the vision for the ACC from its inception. RAEs are uniquely positioned to make the connection between health care and nonmedical drivers of health and wellbeing. The Department and the ACC worked on the following initiatives this year:

- The Department participated in the work being done through the Colorado Blueprint to End Hunger.
- RAEs gave more than $24 million in community investment grants to support organizations helping members with their nonmedical needs.
- The Department collaborated with the Department of Corrections, the Colorado Judicial Branch, and counties to serve members releasing from prison, on probation, or in county jails.
- The Department ensured that Residential Child Care Facilities (RCCFs) complied with the federal Family First Preventions Services Act of 2018 (FFPSA) and created statewide utilization management guidelines for children and youth as mandated by these regulations.
- A joint Department/CDHS workgroup created a referral form so that county child welfare staff with high-needs youth can request additional support for needs that are unmet due to gaps in services or systematic barriers.
- RAEs addressed the needs of members experiencing homelessness through Housing First programs, placement in temporary shelters and permanent housing, and care coordination services.
- Completion of a Request for Proposal that will enable Phase II of the Prescriber Tools —which will enable health care providers to prescribe programs, not just pills — to get at the root of health care. This innovation will advance prevention goals like enabling a provider to prescribe Medicaid's prenatal supports program or a diabetes support program while advancing our SDoH vision by enabling providers to prescribe food supports like SNAP or WIC for pregnant people.

Care Access

One of the strategic pillars of the Department and the ACC is to improve member access to affordable, quality care. The ACC pursues the advancement of this pillar in the following ways:

Specialist Access

On specialist access, the Department has more recently analyzed network provider utilization by specialty and hospital ownership to identify where we have opportunities. This analysis shows that about 25% of our enrolled providers did not see a member, defined as not submitting a claim, last year. This is consistent with commercial coverage, where a recent GAO study found that 21% of psychiatrists were not accepting new patients. We are now refining this analysis in order to meet with hospital systems, as they have purchased most of the specialists in the state, to discuss this concerning finding. These meetings will take place in calendar year 2023. We are specifically interested in the behaviors of not-for-profit hospitals, which may be enrolling their owned specialists but not accepting appointments with Medicaid members. A lack of available specialist appointments for Medicaid members by referring Medicaid PCMPs is one of the top concerns of Federally Qualified Health Centers (FQHCs).

Behavioral Health

Between April 1, 2021 and March 31, 2022,**18.4% of members accessed services for mental health and SUD** through the capitated behavioral health benefit or through primary care settings. The capitated behavioral health benefit includes outpatient, inpatient, wraparound services, crisis, residential and emergency services for mental health and substance use disorders. The capitated benefit structure allows RAEs to identify needs and coordinate a variety of support services to help members avoid unnecessary inpatient care and remain in the community. Under the capitated benefit, members can access alternative community-based services "B3" services. These services are especially important for members with serious mental illness and include prevention/early intervention, clubhouses/drop-in centers, vocational services, intensive case management, assertive community treatment, mental health residential treatment, respite care, and recovery services/peer support. B3 services also help members connect with peers, develop life skills, and prevent isolation. Without a managed care program that includes a capitated benefit, the Department would not be able to provide some of these services and would not be able to maintain such a comprehensive set of behavioral health benefits.

Members also can receive short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's PCMP site. Nearly 70% of members (12,230) who used the short-term behavioral health benefit in FY 2021–22 had not accessed behavioral health through the capitated benefit in the previous

year, suggesting that this benefit may be expanding access to behavioral health care. In addition, there were disparities in the utilization of capitated behavioral health services by race and ethnicity, but not in rates of short-term behavioral health, indicating that these services may be an effective strategy to closes behavioral health disparities – a key goal for the Department.

This fiscal year was the first full year of the expansion of theSUDbenefit to cover the entire continuum of SUD care, including residential treatment and withdrawal management. In the first calendar year of the expanded benefit (January 1 to December 31, 2021), 33 providers at 58 locations offered covered residential services to 8,844 unique members who received 16,486 episodes of care.

Despite workforce challenges, the RAEs have increased the total number of contracted behavioral health practitioners. The Department set a goal to add 950 newly enrolled behavioral health providers, including licensed psychologists and licensed behavioral health clinicians, from July 1, 2021 to June 30, 2022. As of July 19, 2022, the Department exceeded its goal (to add 950 providers) with the addition of 1,150 providers, representing a 10.6% net increase in providers. Practitioners were added in every quarter of 2021 in all regions.

Reimbursement rates also help fuel provider network participation. In this spirit, the Department has collaborated with the Joint Budget Committee and the General Assembly to increase investments into Medicaid Behavioral Health by more than $500 million between FY 2018/19 and FY 2023/24 (as submitted in the Governor's budget and as of the writing of this report).

Coordinating with Long-Term Services and Supports

Most members access the Long-Term Services and Supports (LTSS) system through the 24 Single Entry Points (SEPs) and 20 Community Centered Boards (CCBs) in the state. RAEs coordinate with SEPs and CCBs in different ways. Some have a dedicated staff member who works to coordinate with the SEPs and CCBs in the region. Other RAEs train their care coordinators, especially those who focus on members with complex conditions, to work collaboratively with SEPs and CCBs and review complex cases together. In future ACC designs, there is an opportunity to improve the coordination and collaboration between SEPs, CCBs and RAEs to the betterment of member service and health outcomes.

Access to Care in Rural and Frontier Counties

Colorado is a geographically diverse state with five of the seven RAE regions servicing members residing in rural or frontier counties; only Region 3 (Adams, Arapahoe, Douglas, and Elbert) and Region 5 (Denver County) do not. Access to all types of care

is limited in rural and frontier areas, especially for behavioral health and medical specialty services. RAEs are improving access to care through telehealth, transportation services, mobile health clinics, and enhanced payments to providers who serve members in rural and frontier areas.

Operational Excellence and Customer Service

One important role of the ACC is to help members, providers, and partners to navigate Medicaid and the health care system in general.

This year, Health Services Advisory Group, Inc. (HSAG) administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, rather than the Patient-Centered Medical Home Survey that has been used in past years, to comply with a federal data collection requirement. The survey looked at factors such as getting needed care, getting care quickly, provider communication, health plan customer service, and coordination of care. Ratings varied across RAEs for each factor, but most members reported being able to get needed care (80.9% for adult care and 80.2% for children) and get care quickly (78.9% for adults and 84.9% for children). They also reported satisfaction with care coordination (79.7% for adults and 82.3% for children) and how well their doctors communicate with them (91.3% for adults and 93.6% for children). HSAG recommended that the RAEs continue to expand options for after-hours care and explore additional ways to understand member experience, such as focus groups.

The Medicaid Operations Office created dashboards to track member call center service, provider call center service, provider claim payment turnaround time, and customer service by RAE, such as call response time and claim payment turnaround time. Those findings for the period July 1, 2021 through June 30, 2022 can be found below.

- HCPF Member Call Center Average Speed of Answer: 40 seconds

- Gainwell Provider Call Center Average Speed of Answer:
    - 4.5 minutes (July 2021 – June 2022)
    - 1 minute (last 12 months)
    - 30 seconds (last 6 months)

- Gainwell Medical Claim Processing Average Turnaround Time: 3.5 days
- RAE Member and Provider Call Centers Average Speed of Answer: 20 seconds
- RAE Behavioral Health Claims Payment Turnaround Time
    - % Paid or Adjudicated w/in 30 days: >99%

- Average turnaround time: < 10 days.

As managed care entities for behavioral health, RAEs are responsible for ensuring a good provider experience. The Department continued to work with independent behavioral health providers to facilitate their participation as Medicaid providers, increase member access and improve provider satisfaction. All the RAEs increased reimbursement rates for behavioral health providers, leveraging the continued increase in funding provided by the Department and the Joint Budget Committee (Behavioral Health funding is up more than $500 million between FY 2018-19 and as submitted for FY 2023-24). RAEs have also worked with PCMPs and community providers to remove barriers so they can do their work and serve members.

The volume of services provided by the Independent Provider Network (IPN) has increased by 24% over the SFY 2021 time period. The weighted average reimbursement rate for Independent Providers increased by 6.9% year over year between SFY 2020 and SFY 2021. Practice transformation teams have helped PCMPs expand the services offered, identify billing and data collection issues, and solve problems with medical assistant staff turnover.

In FY 2021-22, the ACC offered members and stakeholders several ways to participate in decision-making and offer feedback. The Program Improvement Advisory Committee (PIAC) continued its work in support and follow-up after members access the Colorado behavioral health crisis service system, and coordination of services for members with justice system involvement eligible for coverage. In addition, the PIAC made recommendations for improving data collection practices to assess equity in depression screenings that the Department's data section is working to implement.

Each RAE has a regional performance advisory committee. These regional committees focus on issues such as care coordination efforts, member support services, RAE performance review, and policies for distributing pay-for-performance dollars. RAEs also have member advisory councils that focus on understanding the member's perspective to inform policy, program decisions, and communications.

Health First Colorado Value

The ACC is designed to support the Department's strategic pillars, one of which is Medicaid Cost Control. This pillar is also part of the Department's mission. The ACC cost control design and its related innovations are a critical part of protecting member benefits, broad access to Medicaid and provider reimbursements. The effectiveness of ACC cost control can be evaluated by reviewing the overall Medicaid claim cost trend, which is measured in several ways. From July 2021 to June 2022, the

Medicaid PMPM trend is 2.2%, while risk-adjusted trend is 4.0%. Paid trend is 13.2%, which reflects the significant membership growth of 10.8%. The ACC was also part of a comprehensive Medicaid cost control strategy that controlled Medicaid trend during the PHE such that HCPF was able to return $1.2 billion of the additional 6.2 points of Federal Medical Assistance Percentage received during the PHE over the 10 quarters since the PHE began, after covering claims from the hundreds of thousands of additionally eligible Coloradans.

The primary drivers of this trend growth were an increase in fee-for-service reimbursement rates approved by the Joint Budget Committee and the General Assembly; an increase in utilization of services, which the pandemic suppressed the previous year; and an increase in behavioral health capitation payments due to the addition of inpatient/residential SUD benefits as well as behavioral health rate reimbursement increases. Program costs include administrative costs, incentive payments, and all expenses for benefits and services provided during FY 2021–22, including capitation and fee-for-service payments.

One of the original goals of the ACC was to avoid inefficient care such as non-emergent emergency department visits and avoidable inpatient hospitalizations by having members engage more effectively with their PCMPs. The Department evaluated the impact of PCMP engagement on costs with the hypothesis that members who engaged with their PCMP would have lower than expected costs due to the medical home function performed by the PCMP. Engagement was defined as having at least one visit with any PCMP during either FY 2020-21 or FY 2021-22. The Department compared the expected per member cost in FY 2021-22 to their observed cost. The Department can estimate the expected annual costs for members using an assigned risk score produced by IBM that considers a member's diagnoses, eligibility category, and demographics. The analysis found that members who engaged with a PCMP in either FY 2020-21 or FY 2021-22 were less costly than expected. The Department avoided up to $189 million in costs for members who engaged with a PCMP.

In addition to primary care member alignment and focus, to achieve these Medicaid Cost Control outcomes, the ACC also implemented several cost containment strategies impacting the year: continuing and expanding access to telemedicine, especially for behavioral health; expanding access to behavioral health providers; the Hospital Transformation Program (HTP)[1], which improves the quality and affordability of hospital care provided to members by tying value-based hospital payments to cost control and quality-based initiatives; the Prescriber Tool release of its Opioid Module

[1] https://hcpf.colorado.gov/colorado-hospital-transformation-program

(Jan 1, 2021) and its Affordability Module (June 1, 2021); the emerging primary care alternative payment models that tie payment to health outcomes.

- Implemented in October 2021, the HTP requires that all Colorado hospitals identify and implement initiatives and meet performance measure benchmarks that improve quality (which also helps close disparities), and drive affordability (6 measures for small hospitals (<26 beds), 8 measures for mid-sized hospitals (26-90 beds), and 10 measures for large hospitals (91+beds)). Given that hospital costs represent the largest percentage of the Medicaid health care dollar, HTP is one of the most important and collaborative initiatives underway in the state to the betterment of both Medicaid and health care affordability for All Coloradans.

- In meeting the requirements of the HTP, hospitals in the state are currently working to implement 636 different initiatives.

- As of the quarter ending June 30, 2022:

    - 99% of these interventions are reported to be on target to meet their first planning and implementation milestones

    - 1,479 interim activities completed across all hospital interventions

    - Over 700 unique Community Health and Neighborhood Engagement (CHNE) activities have been completed

        - 548 consultations with key stakeholders

        - 101 community advisory meetings

        - 53 public engagement meetings

- Baseline data for the HTP will be collected in January 2023, and the first year of performance against benchmarks will begin October 2023.

- Prescriber Tool evolution and adoption have been and will continue to be an important focus of the ACC. The Opioid Risk Module by OpiSafe, was released in January of 2021. For prescribers using the Opisafe platform, the average morphine milligram equivalent per opioid prescription decreased by about 16% in the first year. The second module, the affordability module, was released in a soft launch in June 2021, with most of the year spent working with hospitals and PCMPs to implement the tool. The tool has achieved over $3.4 million in

cost savings in its first full fiscal year. This module provides alternatives to doctors during the prescribing process, enabling providers to more easily prescribe from the Medicaid preferred drug list. This lowers prescription drug costs and improves member outcomes. Currently, 9,870 providers (40%+ of Medicaid prescribers) are using the tool.

Expanding access to behavioral health providers enables members to seek and obtain care, improving their ability to keep behavioral health issues from escalating. The Medicaid behavioral health network has continued to increase in size – with the addition of 1,150 providers, there was a 10.6% net increase in the total number of Medicaid providers. Telehealth, which has been instrumental to improving member access to behavioral health has also been a significant part of achieving this goal, with over 50% of eligible behavioral health services provided through telehealth (as of June 30, 2021).

Priorities for FY 2022-23

The following are the ACC priorities for FY 2022–23:

- **Advancing Health Equity and Social Determinants of Health**. The Department outlined its health equity priorities in the recently published Health Equity Plan, including COVID-19 vaccination rates, maternal health, behavioral health access, and prevention to address equity and unconscious bias. Effective July 1, 2022, health equity plans are required in all RAE contracts and due to the Department on July 31, 2023.

- **Advancing Innovations like the Prescriber Tool (above), Colorado Providers of Distinction and eConsults**

    - **Providers of Distinction.** Members will be able to make informed decisions on where to access care by providing them with up-to-date information on the quality of care and patient experience at hospitals and other facilities through the Find-A-Doctor tool on the Health First Colorado website. PCMPs will also be able to use this information to refer patients to providers with a proven track record of better outcomes for Medicaid members. The effective employment of these emerging cost and quality indicators is a critical strategy to reduce disparities, improve outcomes and drive affordability.

    - **eConsults** facilitate e-communications between a Medicaid PCMP and a specialist to expand care at the PCMP site. This reduces specialist appointment no-shows, improves access to specialists, and equips PCMPs

to provide better care. If a specialist visit is appropriate, eConsult helps PCMPs make informed referral decisions with the emerging Providers of Distinction cost and quality indicators. The Department expects to select an eConsult vendor to operate the statewide platform by the end of 2022 and implement it in the summer or fall of 2023.

- CMS has directed the Department and other Medicaid programs across the nation to have at least 50% of payments in a **Value-Based Payment** structure by 2025. The Department has multiple pathways in process to achieve that goal, in the following areas: the Hospital Transformation Program, Primary Care, Primary Care, Maternity Care, Prescription Drugs (with manufacturers), use of the Prescriber Tool, specialty care (Providers of Distinction outcomes), Nursing Homes, PACE Providers and more – many of which are directly tied to the ACC.

- **Behavioral Health Transformation & Partnership with the Behavioral Health Administration**. The ACC will continue to collaborate with the new BHA created by House Bill 22-1278. The Department is partnering closely with the BHA to ensure that its new policies and initiatives are compliant with federal guidelines and align with other initiatives. The ACC will continue to work with the BHA to continuously identify areas for improvement and to successfully implement the BHA's vision for a people-first behavioral health system.

- **American Rescue Plan Projects**. The Department received federal funding to implement the state's American Rescue Plan Act (ARPA) funds for projects focused on improving access to home and community-based services (HCBS) and transforming the state's behavioral health system.

- **Increasing care access** with a special focus in the areas of behavioral health, specialty care and care in rural communities.

- **ACC Phase III**. The Department has begun to design the next iteration of the ACC, which will be effective July 1, 2025. The Department is actively partnering with sister agencies to leverage emerging advances across the industry and with stakeholders to design new policies and programs to ensure the ACC will achieve the shared goals of improving health equity, access, quality, member and provider experience, and cost management. The design will focus on protecting both provider reimbursements and member benefits, which is especially important during economic downturns.

The ACC was designed with a long-term vision aimed at transforming Colorado's health care delivery system to improve member health, serve the increasing number of Coloradans, and control costs for the state. The program continues to evolve in response to increasing pressures placed on an ever-changing health care system. The program has shown its ability to innovate to improve member outcomes and reduce health care costs, and it is poised to continue to do so in the future.

II. Details of the ACC, In Complement to the Above Brief

Accountable Care Collaborative Overview

As the core of the Colorado Medicaid program, the ACC is designed to bring coherence and leadership to a system that, before the program's inception in 2011, was characterized by fragmentation and inadequate support for both providers and members. The program is a unique hybrid of fee-for-service physical health care, managed care for behavioral health, and additional services to coordinate care.

The ACC model balances the efficiency of a single statewide program with the unique needs of Colorado's diverse regions to ensure geographic responsiveness as well as responsible management of the state's health care budget. It is designed to be responsive to the needs of members and providers in each region, while ensuring access, quality, equity, and cost control, intended to protect Medicaid benefits, program access and provider reimbursements. Its fundamental premise is that regional managers are in the best position to deliver the programs in response to the unique geographic community differences across the state. For this reason, the ACC does not use one central administrative organization, but instead has a RAE that manages care for each of the seven regions of the state. The program is authorized by Section 25.5-5 Part 4, C.R.S.

Figure 1. Regions and RAEs of the Accountable Care Collaborative

The Role of Regional Accountable Entities and Managed Care Organizations

Regional Accountable Entities

Each RAE works closely with the region's providers and members to meet the unique needs of the people who live and work in their region. In a health care environment that changes quickly and demands agility, the regional model allows the state to respond rapidly, test alternative payment model structures and other innovations, and scale them up or down as needed. The functions of the RAE are summarized below:

- **Contract with PCMPs**. RAEs contract with PCMPs to serve as medical homes for Medicaid members.[2] All members are attributed to a PCMP upon their enrollment into the program, and members can select a different PCMP at any time. The Department pays PCMPs fee-for-service for the health care they provide, and RAEs pay them a PMPM payment for medical home services. Each

[2] https://pcmh.ahrq.gov/page/5-key-functions-medical-home

RAE develops their own methodology for determining the amount of these payments, which vary significantly depending on factors such as member acuity, provider capabilities, member utilization of services, and other considerations. RAEs provide training and support and distribute the PMPM payments to incentivize the delivery of comprehensive, cost-effective, team-based, quality care.

- **Manage the behavioral health capitation**. Most behavioral health services provided to Medicaid members are provided under a capitated managed care plan to provide a comprehensive array of mental health and substance use disorder services while controlling costs. RAEs receive a PMPM payment to administer this benefit and contract with providers in their region to maintain a network. The RAE is accountable for ensuring the delivery of medically necessary mental health and SUD services with a community-based continuum of care that adapts to a member's changing needs over time.

- **Coordinate care for special populations**. The RAE coordinates care across a wide range of inpatient and outpatient providers. It collaborates with LTSS providers and connects with criminal justice, child welfare, and other state agencies to address complex member needs that span multiple agencies and jurisdictions. A critical function of each RAE is to create cohesive formal and informal provider networks that work together to provide coordinated, whole-person care.

- **Manage overall administration, data and information, and member access to care and support**. The RAE is responsible for ensuring timely and appropriate access to medically necessary services for all members. The RAE establishes the infrastructure, tools, and resources that enable providers to serve members with complex conditions, implement required Department programs (i.e.: prenatal care, complex case management, diabetes management and support) and make appropriate, timely, and coordinated specialty care referrals.

- **Respond to unique department directives**. RAEs carry out Department directives to control costs, improve quality or in response to market or community factors, such as COVID (e.g., vaccination access and uptake), address housing disruption due to the Marshall Fire, or increase update of the Prescriber Tool.

Managed Care Organizations

Most physical health care is delivered and billed as fee-for-service rather than as a capitated managed care benefit. However, two physical health managed care

capitation plans are used in the ACC: Rocky Mountain Health Plans (RMHP) Prime (C.R.S. 25.5-5-415) and Denver Health Medicaid Choice (C.R.S 25.5-5-402). RMHP Prime is operated as part of the Region 1 RAE contract. New state legislation passed in 2019 resulted in a state contract directly with Denver Health, which delivers physical health care and partners with the RAE in Region 5 to administer the behavioral health benefit. Both initiatives are designed to maximize the integration of behavioral health and physical health services for enrolled members.

Accountable Care Collaborative Enrollment FY 2021-22

Most full-benefit Medicaid members are enrolled in the ACC, so ACC enrollment reflects overall Medicaid enrollment. Enrollment has increased since the COVID-19 pandemic began in 2020 when the federal government temporarily required Medicaid programs to maintain health care coverage for all medical assistance programs regardless of changes in a member's eligibility status. The requirement will expire at the end of the declared PHE, which has not yet been set.

Table 1. Accountable Care Collaborative average enrollment by population, FY 2021-22

Population	Average Enrollment FY 2021-22	Percent of Total Enrollment
Children without disabilities	572,879	38.5%
Adults without disabilities, **eligible due to** the Affordable Care Act expansion	571,147	38.3%
Adults without disabilities, **eligible before** the Affordable Care Act expansion	251,468	16.9%
Children and adults with a disability, including Medicare-Medicaid members	94,017	6.3%
TOTAL	**1,489,511**	**100%**

III. Member Health

One of the Department's strategic pillars is to improve member health outcomes and reduce health disparities. In 2020, the Department updated its mission: *To improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.* To fully achieve the outcomes component and the equity component of the mission, the Department is applying a health equity lens across programs and initiatives, including the ACC, to eliminate avoidable differences in health outcomes.

This section focuses on ACC program performance in supporting member health in FY 2021–22 and the work the RAEs are doing to support member health.

ACC Program Performance

ACC program performance is assessed through KPIs, Behavioral Health Incentive Program Indicators, and Performance Pool incentive measures.

Key Performance Indicators

For the second phase of the ACC, the Department reduced the amount of guaranteed administrative fee payments to the RAEs by linking a greater proportion of reimbursement to performance on the KPIs. Four dollars and thirteen cents ($4.13) of the RAE's PMPM administrative fee is withheld for KPIs. The RAEs can earn quarterly KPI incentive payments equaling all or part of the $4.13 PMPM withhold by achieving certain performance levels on the KPIs identified by the Department. Below is a description of the KPIs used to measure and incentivize RAE performance in FY 2021–22:

1. **Emergency Department Visits**: Number of emergency department visits per 1,000 members per year, risk-adjusted to take into consideration the relative health of a RAE's population compared to that of other RAEs.
2. **Behavioral Health Engagement**: Percentage of members who receive at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit.
3. **Prenatal Engagement**: Percentage of members who have at least one prenatal visit within 40 weeks prior to the delivery and are Medicaid enrolled at least 30 days prior to the delivery.
4. **Dental Visits**: Percentage of members who receive at least one dental service (medical or dental claim).

5. **Child and Adolescent Well Visits**: Percentage of child and adolescent members who have the appropriate minimum number of well visits based on their age and according to HEDIS standards. (This is a composite measure that comprises two HEDIS measures, one for children 0 to 30 months, and one for children and adolescents aged 3 to 21 years.)

Table 2. KPI Performance by RAE, 12-month Performance Period from April 2021 to March 2022

RAE	ED (per 1000 members per year)	Behavioral Health Engagement	Prenatal Engagement	Dental Visits	Child & Adolescent Well Visits	Well-Child Visits: First 15 Months	Well-Child Visits: 15-30 Months
1	495.8	21.68%	56.80%	40.40%	40.71%	69.11%	64.66%
2	599.5	14.87%	64.23%	37.43%	33.73%	64.88%	53.87%
3	538.6	17.37%	62.81%	41.28%	43.01%	68.38%	60.64%
4	460.6	17.01%	67.54%	36.74%	36.71%	61.57%	56.41%
5	600.3	20.84%	72.71%	41.95%	49.55%	70.04%	63.95%
6	460.0	18.86%	60.00%	37.50%	40.77%	62.18%	56.48%
7	595.8	17.58%	64.05%	37.19%	34.62%	59.95%	56.18%

Key:
Green = The RAE met a 5% improvement over baseline
Yellow = The RAE met a 10% improvement over baseline or met the target for gap closure
White = Did not meet a minimum of 5% improvement over baseline

Health care utilization continued to recover this fiscal year as the state emerged from the initial pandemic lockdown but continued to cope with COVID waves, significantly increased enrollment numbers, and the health care workforce challenges. As a result, RAE performance varied widely with some KPI targets such as emergency department use, where lower utilization is desired, reached and others, such as well-child visits, not met. Despite this trend, some RAEs still met their targets in prenatal engagement, dental visits, and well-child visits.

Behavioral Health Incentive Program Indicators

RAEs are eligible to earn up to 5% of their annual behavioral health capitation payment for reaching performance metrics. These additional funds are authorized by

the Colorado General Assembly and the Centers for Medicare and Medicaid Services (CMS). Below is a description of the behavioral health incentive program indicators used to measure and incentivize RAE performance in behavioral health in FY 2021–22.

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.

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 2021–22 were for the RAEs' performance during FY 2020–21. Table 3 shows the percentage of members in each RAE who received the service described in each performance indicator. The Department intentionally set goals high with year-over-year improvement. While not all RAEs are meeting their incentives, the ACC overall and each individual RAE performed higher than the national average for Medicaid MCEs, where national data has been reported. The two, seven-day follow-up measures are modified HEDIS measures; RAEs have performed higher than the national average in all calculated performance years to date.

Table 3. Behavioral Health Incentive Program Performance by RAE, FY 2020-21

RAE	Outpatient SUD	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	47.90%	44.80%	32.46%	57.49%	16.39%
2	50.80%	50.07%	29.64%	87.09%	18.60%
3	45.09%	56.76%	30.50%	43.47%	15.41%
4	48.51%	70.43%	36.49%	50.19%	33.11%
5	36.65%	56.03%	35.25%	39.21%	28.57%
6	41.61%	64.51%	35.30%	47.48%	17.82%
7	54.10%	41.42%	32.75%	73.39%	23.29%

Key:
Green = Met target
White = Did not meet target

Performance Pool

The Performance Pool is funded with money not earned by the RAEs for KPI performance and is often used to respond flexibly to timely needs and priorities. FY 2021–22 was the first year the Department incentivized performance for the following Performance Pool metrics. The initial Performance Pool results will not be available until early calendar year 2023 as the Department and RAEs finish processing claims and other data collection efforts.

- **Extended Care Coordination**: Percentage of members with complex 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.

- **Premature Birth Rate**: Percentage of premature births (< 37 weeks) per total live births during the measurement period.

- **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. This was especially salient during the pandemic, as many low-risk individuals were released during COVID.

- **Risk-Adjusted PMPM:** This incentive looks at whether a RAE's risk-adjusted PMPM cost was less than the ACC average risk-adjusted PMPM or reduced from a set baseline. The metric was not finalized in FY21-22 but went into effect on July 1, 2022.

- **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.)

- **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 6 months).

- **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 3 to 60 days of delivery.

The Department also used Performance Pool funds to incentivize RAE planning and work related to four key issues: COVID-19, the prescriber tool, e-health and the PHE unwind. RAEs submitted plans for all four issues for implementation in FY 2022-23.

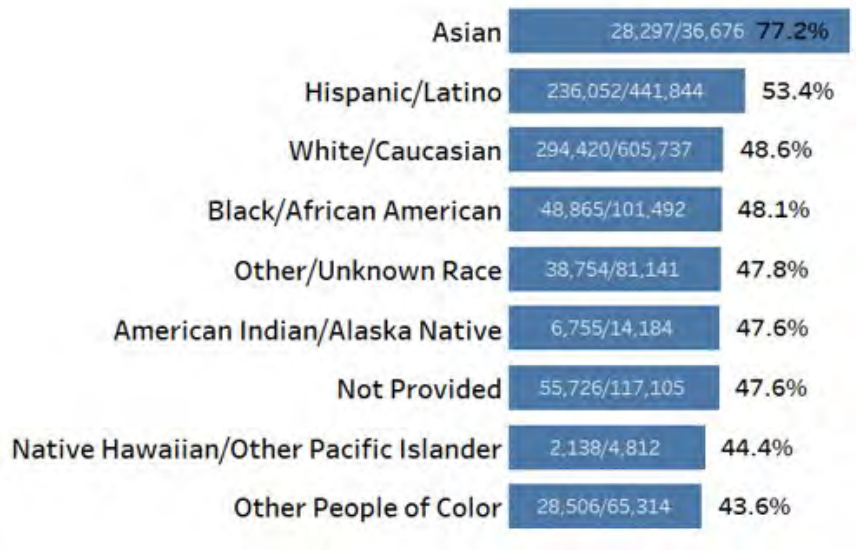
Member Health During COVID-19

During the previous fiscal year, the RAEs played a critical role in identifying and reaching out to unvaccinated members and collaborating with providers and community-based organizations to increase vaccination rates. To increase vaccination rates, the Department secured $13.3 million in Federal Emergency Management Agency (FEMA) funds for RAEs to use to support vaccination clinics, reach out to members disproportionately impacted by COVID-19, and draw on existing community partnerships and build new ones to remove barriers to vaccination.

When FEMA funding ended and the COVID vaccination became available to children aged 5 to 11 years old, the Department collaborated with the RAEs to develop a new COVID-19 Vaccination Response Report that outlined their continued vaccination and outreach efforts, with an emphasis on children. As of May 2022, 49.9% of Medicaid and CHP+ members ages 5 and older were partially or fully vaccinated. This rate is significantly lower than the vaccination rate in the general population but better than

the average of other Medicaid programs. Such disparities among low-income populations, measured by comparing vaccination rates for the state's general population and its Medicaid member population – have occurred across the nation. However, the ACC met goals for disparity reduction based on race within Medicaid, which was its target: ensuring that vaccination rates between white members and members of color were within three percentage points. At 50.6%, the vaccination rate for members of color was higher than the rate for white members (45.9%).

Figure 2. Vaccination Rates by Race/Ethnicity, Updated July 24, 2022



RAEs worked to increase vaccination rates and close the equity gap through the following strategies:

- **Provider outreach**. The Department and RAEs continued to identify unvaccinated members and distribute lists to PCMPs along with suggestions for reaching these members. RAEs supported PCMPs in communities most likely to experience disparities. This support including administrative support, supplies, and in some cases, incentive payments.

- **Increased provider reimbursement for vaccination**. The Department increased the COVID-19 vaccination and booster provider reimbursement rate from $28.39 to $61.77. There are no out-of-pocket costs for members.

- **At-home COVID tests for members**. At-home COVID-19 tests were covered for members effective Jan. 15, 2022. Each enrolled member could get up to 15 free at-home tests per month from network pharmacies.

- **Transportation**. The Department worked with RAEs to fund alternative transportation options for members so they could be vaccinated.

- **Partnering with Long-Term Services and Supports.** SEPs agencies, CCBs, RAEs, and MCOs ensured that all homebound members who wanted a vaccine received one.

- **Partnering with trusted community leaders**. The Department funded *promotores* (Hispanic/Latinx community health workers) to outreach to their communities about why and how to get vaccinated. RAEs also worked with communities to set up pop-up clinics, often with bilingual staff. RAEs worked with housing partners, advocacy groups, schools, community-based organizations, local public health agencies, vaccination task forces, childcare providers, radio and media groups, and faith-based organizations to help communities trust and access the vaccine.

The relationships developed and strategies used to address COVID-19 disparities are resources that the ACC may draw upon in the future to improve health equity in other areas, too.

Table 4. COVID-19 Vaccination Activities, FY 2021-22

# Providers Funded	511
# Outreach Attempts	189,983
# Partnerships	761
# Community Education Events	324
# Community Vaccine Events	2,627

Condition Management

To achieve the Department's objectives to control Medicaid costs and improve member health, the Department developed a Population Management Framework to address the health care needs of high-cost, complex populations and prevent disease progression of conditions impacting the Medicaid population. **A key strategy to this Framework is working with the RAEs to create programs, *which meet Department requirements, that will improve Medicaid member health and better control costs for Department identified conditions commonly impacting the Medicaid population:* maternity, diabetes, hypertension, congestive heart failure/coronary artery disease, chronic obstructive pulmonary disease, anxiety, depression, and chronic pain.**

Diabetes

RAE 1 implemented a "gaps in care" program providing practice support and resources to improve care for members with diabetes. This program gives PCMPs the opportunity to use HEDIS data to close gaps in care. Once a provider completes this six-month program they are awarded a financial incentive that can be used to purchase equipment to close diabetes gaps at the point of care (e.g., rapid HbA1c testing equipment or retinal eye scanners). They have partnered with Health io., who sends kidney home test kits to members identified as high risk for kidney disease. RAE 1 has also contracted with Care Angel, an artificial intelligence virtual nurse to answer questions and support members with diabetes and can also refer and connect to live care coordination staff. There are plans to extend this program to members with hypertension and potentially other conditions.

RAE 2 offers a Diabetes Management and Outcomes Improvement Grant opportunity to contracted PCMPs, who propose innovative and novel approaches to improve diabetic care. Funds have been awarded and programs are in the initiation phase. They continue their Statin Medication Program, identifying members with 60% or greater medicine non-adherence. These members are reached out by a clinical pharmacist or a certified technician to review medication and provide education for members.

RAE 3/5 developed and launched a SMS-based bidirectional program for diabetes self-management. Care coordinators can discuss real time lab results with members and enables them to match the member with appropriate level of diabetes programming. They launched the DarioHealth program which provides specific tools to assist members in weight and hypertension management.

RAE 4 has developed diabetes workgroups to collaborate with diabetic experts locally and at the Colorado Department of Public Health & Environment, to provide self-management education and support to help meet the needs of members with diabetes. In their provider transformation efforts, they support practices treating members with asthma by implementing projects like enhanced reporting to connect members with coordinated services.

RAE 6/7 continues to partner with Project Angel Heart to provide medically tailored meals for up to eight weeks for members with diabetes who have been recently discharged from the hospital. They have established protocols for anxiety screening and provide outreach to members with qualifying scores to help coordinate and manage follow up care.

Maternal Health Equity

Maternal and infant health outcomes are among the most important indicators of the health of the state and nation. Providing prenatal care for more than 40% of births in the state each year, the Department is focused on improving health outcomes for parents and newborns. Long-standing systemic racism, including economic and environmental injustice, has had a deleterious effect on pregnant people of color and created a disparity in maternal health outcomes. According to Department claims data, in 2020, 7.4% of birthing parents had pre-existing hypertension, with Black birthing parents having the highest rate (12.6%). Preterm birth occurs more frequently among birthing parents with pre-existing hypertension: in 2020, 22.7% of births involving chronic hypertension resulted in preterm birth, compared to 9.4% of preterm births among birthing parents without hypertension. Over the past several years, behavioral health issues (i.e., suicide and drug overdose) have become the leading causes of maternal mortality in the U.S. However, in 2020, "cardiac and coronary conditions" is the top cause of maternal mortality for Black birthing parents only. See the Department's upcoming Maternal Health and Equity Report (to be published in January 2023) for more data and information.

The Department and the RAEs have been using a broad array of initiatives to improve maternal health, from special programs for pregnant and postpartum people to new payment models that incentivize better maternal health outcomes. All RAEs are required to have a program in place to support pregnant and postpartum members that meets Department criteria, such as prenatal education, high risk screening and support for high-risk pregnant people. The following are examples of initiatives to close disparities:

- RAE 1 supported and funded infrastructure for a specialty behavioral health program that focusses on pre- and post-partum care as well as supporting parental, infant and early childhood mental health.

- When RAE 6/7 learned of the nationwide formula shortage, they reached out to community partners to discuss response plans and drew on its partnership with the local Women Infants Children (WIC) program to connect members with different types of formula, breast pumps, and breastfeeding support.

RAE 2 launched the Maternal Mental Health Program, which works with hospitals and OB-GYN doctors to screen and treat postpartum mental health disorders. RAE 3/5 convened members, community partners, and providers to participate in Black Birthing Health, a design challenge to identify solutions to specific inequities. Out of that effort emerged two projects: a Black doulas pilot and an online community

resource hub, as well as a community behavioral health fund focused on supporting Black members.

Table 5. Members Utilizing MCE Maternal Health and Diabetes Programs: Q4 FY 21-22

Managed Care Entity	Members in a Diabetes Program	Members with Diabetes	Members in a Maternal Health Program	Pregnant Members
RAE 1	7,645	8,426	5,278	6,531
PRIME	4,129	4,324	2,190	2,531
RAE 2	3,050	6,989	1,325	3,388
RAE 3	9,694	23,470	4,928	13,938
RAE 4	6,178	12,339	1,669	3,636
RAE 5	6,162	13,944	2,678	6,230
RAE 6	3,392	7,587	1,098	3,380
RAE 7	4,428	8,144	2,380	5,101
Denver Health	643	4,634	346	1,901

Social Determinants of Health

A focus on the SDoH—the life circumstances that support or undermine good health—has been a part of the vision for the ACC from its inception. By being located and embedded in the communities they service, RAEs are uniquely positioned to make the necessary connection between health care and nonmedical drivers of health and wellbeing. This is a challenge for any health plan, especially those without any connection to the regions or communities they serve. Because of their commitment to serving their regions, RAEs have been able to take an active role in making this connection.

Going forward, the Prescriber Tool will be an important tool that propels the ACC evolution in the area of social determinants of health. The current Phase I of the Prescriber Tool reduces overprescribing of opioids, improves control of prescription drug spending, eases administrative burden for prescribers, and improves service to members. The first module, OpiSafe, was released in January of 2021. This module was concurrent with a 16% reduction in Medicaid opioid use in its first year. The second module, the affordability module, was released in a soft launch in June 2021,

with most of the year spent working with hospitals and electronic medical record vendors implementing the tool. Still, the tool has achieved its initial savings target. As stated, this module further enables providers to e-prescribe and increase their use of the Medicaid preferred drug list, which lowers costs and improves member outcomes while facilitating an easier prior authorization process. More than 10,000 providers (more than 40% of Medicaid prescribers) are already using the Prescriber Tool. Phase II of the tool will enable providers to prescribe programs not just pills (e.g., prescribing WIC or the prenatal program to pregnant Medicaid members, diabetes programs to those with uncontrolled A1C, or housing supports to those who are housing insecure). This phase is in the RFP creation phase right now and will be bid and awarded in 2023. It will be a significant step forward in meeting the SDoH needs of members.

Colorado Blueprint to End Hunger

The Department's ACC program staff are active in implementation of the Colorado Blueprint to End Hunger through the Cross-Program Alignment Workgroup, which also includes other state departments, local governments, and community groups. Its goal is to improve co-enrollment for food assistance programs and Medicaid. Staff from the Blueprint to End Hunger joined the ACC Learning Collaborative in August 2021 to build relationships, share best practices, and improve collaboration.

Through its work with the Blueprint, the Department connected with the Colorado Department of Education to work on an application to USDA for Direct Certification with Medicaid Demonstration Projects. Once completed, this would allow local schools to use Medicaid eligibility information to determine students' eligibility for free and reduced meals. Many families enrolled in Medicaid would be spared the process of completing free and reduced meal applications, and the school would be spared the process of reviewing them. Development of the initiative was already underway when the legislature mandated the effort as part of Senate Bill 22-087.

Community Investment Grants

As part of their work to build member local supports, RAEs make community investment grants to support organizations in their communities that meet nonmedical needs. By supporting community organizations, RAEs improve member experience and care, expand the services available to members, avoid duplication of services, and promote a more connected health neighborhood.

In FY 2021–22, RAEs made more than $24 million in grants to community centers, community-based recovery programs, educational programs, and local public health departments. For example, RAE 2 awarded one of its grants to Frontier House, a clubhouse to support people living with mental illness, to fund a program focused on

providing food to members and teaching them how to shop for groceries and prepare meals on a budget. In another example, organizations in RAE 4 that received grants include the Southern Colorado Harm Reduction Association for help with SUDs, and the Senior Resource Development Agency, which enhances quality of life for older adults and increases opportunities for independent living. RAE 1 provided funding to two independent living centers to support transportation for people to attend and participate in community and/or social events. This program has received excellent feedback from the organizations in the southwest and northwest areas of RAE 1 for the impact on whole person wellbeing.

Health Effects of Climate Change

The ACC's regional model is well positioned to help communities address the health ramifications of climate change with both local support and strategic policies. Health effects may be the result of a natural disaster like a wildfire, or more ongoing issues such as air pollution and its effect on respiratory conditions.

In FY21-22, four significant fires, including the devasting Marshall Fire, broke out across Colorado and affected hundreds of members. RAEs responded by providing information about mental health services, posting assistance resources to social media, assisting with housing needs, and connecting members to needed physical and behavioral health care. They also assisted with care transitions, disseminating medication refills, and expediting durable medical equipment (DME) needs.

Services for Justice-Involved Members

Colorado is nationally known for its work in supporting members with justice system involvement. ACC program staff shared best practices, successes, challenges, and plans for improvement with the Pew Charitable Trusts and MassHealth so other states can learn from the work done in Colorado. The ACC program participated in multiple initiatives to support members involved in the criminal justice system during the past fiscal year, including an initiative by the Office of Behavioral Health and Colorado Health Institute to develop a guide for the new BHA.

Collaboration with the Department of Corrections

Collaboration with the Department of Corrections (DOC) is essential for supporting Medicaid-eligible Coloradans involved in the criminal justice system. This fiscal year, the Department facilitated monthly workgroup meetings with RAEs, the DOC, and community partners to improve coordination and access to care for these members. This workgroup monitors RAE performance on a Performance Pool metric that tracks the percentage of DOC-released members who engage in behavioral health services within 14 days of release. This metric was developed in close consultation with the

Behavioral Health Integration Strategies subcommittee of the ACC Program Improvement Advisory Committee (PIAC). The ACC program consults regularly with this subcommittee regarding performance and target setting for this metric.

The ACC's work has led to updates in the DOC's organizational structure, with specific work units focused on increasing Medicaid enrollment among eligible justice-involved members and connecting members to needed care and services. The workgroup has been collaborating to ensure that these changes do not disrupt enrollment and coordination.

Health Care for Members on Probation

The ACC program used the DOC work as a model to expand collaboration with the Colorado Judicial Branch, signing a data-sharing agreement that allows for better coordination for Medicaid members involved with probation and problem-solving courts. Members on probation sign a release of information to authorize coordination between the Department and probation. The Judicial Branch then provides a roster of members to RAEs and MCOs. This collaboration has led to the following efforts:

- ACC staff joined judicial staff to train probation office leadership and staff.
- A process to share information was established, despite limitations in the Judicial Branch's data systems that made automation a challenge.
- Monthly meetings have been established with Department ACC staff, the Judicial Branch, RAEs/MCOs, and community partners to share progress, best practices, challenges, and issues.
- RAEs/MCOs are building connections with local probation offices. For example, the 21st judicial district and RAE 1 are meeting regularly to coordinate care for justice-involved members.

Access to Services for Members in County Jails

The ACC program is working to improve Medicaid enrollment and access to services for members in county jails. This work was reinforced and expanded by the passage of Senate Bill 22-196. This work has some things in common with other justice-related work the Department has done — though the multitude of independent county jail systems makes it significantly more complex. ACC staff worked with the Department of Human Services (CDHS) Jail-Based Behavioral Health Services to ensure members are accessing the benefits they receive under Medicaid, and that these services are billed appropriately. Providers also received information about coordinating services so that member needs are met without duplication or gaps.

Services for Members in the Child Welfare System

Children that have contact with the child welfare system as a population face short- and long-term challenges. While not all children need behavioral health services, the population outcomes warrant at screening, assessments, and comprehensive wrap around services available if needed. These children and youth also often need care navigation supports to address the multiple funding sources and policy requirements developed to support them.

The funding of behavioral health and medical services for children in child welfare is rooted from several sources. Medicaid along with funds from counties, CDHS, and the BHA, fund the various services and associated supports for children in child welfare, all of which need to work in concert. The funding source is dictated by the custodial status of the child along with the type of service being provided. The services that are covered by Medicaid funding, may be managed by the RAEs or paid directly from the Department via fee-for-service. In the state's effort to improve services and outcomes for youth, who are or have been part of the foster system, multiple entities must come to the table to develop joint solutions, as no one entity, including Medicaid can solve for this disparity. However, as the state's largest payer, the Department often can take a leadership role in this space and has been working with the ACC, hospitals, residential providers, counties, and CDHS including the BHA to improve our system as outlined below.

Qualified Residential Treatment Programs and Family First Preventions Services Act

As of October 2021, Colorado was required to demonstrate compliance with the federal Family First Preventions Services Act of 2018 (FFPSA). This legislation overhauled financing of child welfare services to prioritize families and family-like settings and minimize the use of group settings. The legislation has significant implications for the Department and its provider network; Medicaid is the primary health care payer for children in out-of-home placements, and the law created a new out-of-home provider type: Qualified Residential Treatment Programs (QRTPs).

In collaboration with CDHS, the Department crafted a reimbursement policy to ensure that child-serving residential facilities remained in compliance with federal regulation. Most of these facilities were enrolled with Medicaid as Residential Child Care Facilities (RCCFs) and were allowed to bill for clinical services throughout FY 2021–22 (until June 30, 2022) in order to transition their programming and business models to meet both FFPSA and the new reimbursement policy. Only RCCFs that serve our Children's Habilitation Residential Program (CHRP) Waiver population were allowed to bill the RAEs for individual services not included in a per diem rate after

June 30, 2022. Otherwise, RCCFs were required to become QRTPs or Psychiatric Residential Treatment Facilities (PRTFs) in order to be reimbursed by Medicaid. As a part of this reform work, the Department created a per diem clinical rate for the new QRTP provider type, as well as reviewed and increased the reimbursement rate for PRTFs. As of July 1, 2022, 13 QRTPs were enrolled with Medicaid and three new PRTF providers enrolled with Medicaid to provide services at this level of care.

Utilization Management Guidelines for Children and Youth

The Department has been working with the RAEs to create statewide standardized utilization management (SSUM) guidelines for children and youth. Although RAEs are required to use national tools in their UM processes, these tools do not have robust youth-specific guidelines that reflect levels of care for members under 21 years old. These guidelines are intended to fill in that gap of standardized guidelines. RAEs are already expected to use Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards in their Medical Necessity determinations for members 21 years old and younger. EPSDT is being factored into this work both by being identified in the official definition of medical necessity included in the document as well as in the admission criteria that calls out EPSDT standards to be considered. This work started with the adoption of the Child and Adolescent Needs and Strengths (CANS) as the statewide assessment tool for youth, as mandated by federal FFPSA regulations. It currently focuses on residential levels of care (QRTPs and PRTFs). However, it will ultimately include all levels of care where RAEs are responsible for utilization management of behavioral health services for children and youth.

New Referral Form for Youth in Child Welfare

In August 2021, a joint Department/CDHS workgroup created a Placement Support referral form used by counties to support youth in child welfare or those using prevention dollars. The form allows the counties and hospitals to request additional state-level support for high-risk, high-intensity individual child/youth whose needs are unmet due to gaps in services or systematic barriers. This form has two purposes: (1) to provide concrete support to county staff who have a high-needs youth; (2) to track and understand individual child/youth characteristics that are unmet due to gaps in services and/or systematic barriers. The form should not be used as a substitute for placement outreach at the county level or replace communication and contact with the child's/youth's RAE. Placement searches for children/youth with complex needs often require many phone calls, completion of placement packets, and other avenues of outreach to providers. This function is completed at the direct services or case management level. All requests will be staffed in collaboration between the Division of Child Welfare (DCW) intermediary administrator and provider services unit with the

addition of a specified staff within the Department and the BHA. To date, this form has been used to refer 107 youth for support.

The HRCC

The Department continues to facilitate the HRCC forum, so named because it is co-chaired by the Department, the RAEs, CDHS, and the counties. The HRCC's work this fiscal year included the following:

- Reviewed processes to address challenges for children in care and recommended a new state-level staffing meeting so all parties can discuss the care of high-needs children requiring intensive care coordination.

- Finalized multiple tip sheets to educate and build common understanding of child welfare processes. This includes out-of-state placements, attribution to a RAE and PCMP for foster care children, and hospital discharge roles and responsibilities.

Other Activities

As improving services and outcomes for children in child welfare is an ongoing priority, the Department also conducted the following activities:

- Interviewed reputable residential placement programs to learn about how to improve in-state programs, and to understand how to relieve pressure on in-state providers through short-term use of out-of-state placement.

- Explored tiered reimbursement for residential levels of treatment in order to serve children who are difficult to place. Department staff also secured a higher rate for a program with Devereux Advanced Behavioral Health to serve children living with autism spectrum disorder.

- Revisited guidance document about psychotropic medication for children in child welfare. The Department and its stakeholders reached consensus that the document must be a collection of resources that can be easily updated with the most current information.

- The Department is engaged in a foster care population analysis project, in collaboration with CDHS, funded with the University of Colorado School of Medicine (CUSOM) financing initiative. The external entity engaged to complete the work is the Farley Health Policy Center. The two main goals of the project are to better understand the utilization and cost trends for the foster care population and to understand the analysis that combines claims data and Electronic Health Record (EHR) information. The Foster Care population costs

and utilizes services at twice the rate (or more) of the children's population in Medicaid. The first area of analysis—analysis of utilization and costs trends for the foster care population —is to answer the question: Is there waste or other findings from this analysis to better serve this population during their younger years of life? In the first two project years, the initial analysis conducted was to identify opportunities to lower cost and utilization by reviewing prescription drug expenditures. The addition of CDHS' Trails case management and enrollment data on Foster Care was added to better understand when placement changes occurred and what type of setting differences existed. The project is in the early stages of the third year of work.

Services for Members Experiencing Homelessness

One way the ACC seeks to improve member health is by addressing homelessness. This fiscal year, the Department improved how it defines and identifies members experiencing homelessness. The data revealed that 30% of members with six or more emergency department uses in a year are potentially homeless and many of these members have not had a physician visit in the last 12 months. This suggests that while this population may be high utilizers of emergency services, many are not utilizing primary health care often enough to prevent poor health outcomes. The ACC continues to expand these analyses to design interventions and policies that address the needs of this population.

The RAEs and MCOs are working to address the needs of these unhoused members. Denver Health Medical Plan (DHMP) and Rocky Mountain Health Plans (RMHP) Prime both operate pilot housing programs to serve members experiencing homelessness or at risk for it. For example, a member, who recently relapsed into substance use, did not have money for rent and food. Through interventions by his treatment team, the participant agreed to get a payee through Colorado Coalition for the Homeless, arrange a payment plan to avoid eviction, and participate in residential SUD treatment. The member received recovery services and maintained stable housing.

RMHP Prime's program uses a Housing First model. One member, who was experiencing homelessness, was hospitalized for a lung mass in 2020. He then had a heart attack and quadruple bypass in April 2020. The previous year, the member was admitted to the hospital for suicidal ideation and attempt. Through RMHP's work, the member now has stable housing. With his housing situation stabilized, he can care for himself and engage with all his providers. The participant has had no emergency department or inpatient admissions, and his total medical costs are down 35%.

Another example of how a RAE is helping members experiencing homelessness is RAEs 3/5, who worked with the Colorado Coalition for the Homeless, Salvation Army, Non-Emergent Medical Transportation (NEMT) providers, case management agencies, providers, and other community organizations to support members when the emergency shelter at the Denver Coliseum was closed. This included evaluating members for waivers, ensuring medical care, finding placement at healthcare facilities, and ensuring members had transportation to access services—all in the space of a few weeks.

In FY 2021–22, the Department received approval for an ARPA-funded project that expands funding for supportive housing services, specifically for those with serious mental illness, a history of homelessness, and repeat hospitalizations. This evidence-based model combines affordable housing with access to voluntary services to help individuals facing complex barriers to housing stability. The Department has completed a preliminary analysis of claims data to assess the unmet health needs of members experiencing homelessness and to establish eligibility criteria for the pilot.

IV. Care Access

One of the strategic pillars of the Department and the ACC is to improve member access to affordable, high-quality care. This section describes how the ACC is expanding access to both behavioral and physical health care.

Behavioral Health

Between April 1, 2021, and March 31, 2022, 18.4% of members accessed behavioral health services through the capitated behavioral health benefit or through a short-term behavioral health service offered in a primary care setting. The capitated behavioral health benefit includes outpatient services such as individual and group therapy, medication management, psychiatrist services, and outpatient hospital psychiatric services. It also includes drug screening and substance use recovery services, like medication-assisted treatment and intensive outpatient programs, and emergency services, inpatient hospital psychiatric care, and residential and inpatient SUD treatment.

Although 18.4% of members accessed behavioral health services, the need for these services likely exceeds this rate. National estimates indicate that 21% of adults and 17% of adolescents report having a mental illness.[3] Colorado survey data show similar trends. According to the 2021 Colorado Health Access Survey, 24.3% of all Coloradans report eight or more days of poor mental health in the 30 days prior to the survey.

The behavioral health capitated benefit allows the state to maintain a comprehensive behavioral health benefit and bring value to the delivery system. With managed care, RAEs can identify needs and coordinate a variety of services to help members avoid unnecessary inpatient care and remain in the community. The benefit covers community-based services ("B3" services) that help members connect with peers, develop life skills, and prevent isolation. B3 services include respite care, peer support services, supported employment, clubhouse and drop-in center services, and case management. These services are especially important for members with serious mental illness.

Substance Use Disorder Benefit Expansion

This fiscal year was the first full year of the expansion of the SUD benefit to include residential level of care, ensuring that members can access the level of care most appropriate for them. The benefit includes withdrawal management, allowing these services to be provided to Medicaid members residing in Institutions for Mental Diseases for primary diagnoses of a substance use disorder. The expansion of the SUD

[3] SAMHSA. 2020 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pdf

benefit also supports state efforts to build provider capacity across the full American Society of Addiction Medicine (ASAM) continuum, improving member access to medication-assisted treatment and improving continuity of care across a continuum of evidence-based SUD services at varied levels of intensity.

In the first calendar year of the expanded benefit (January 1 to December 31, 2021), 33 providers at 58 locations offered covered residential services to 8,844 unique members who received 16,486 episodes of care.

The Department has continued to monitor provider enrollment and contracting with MCEs at each level of care on a monthly basis to ensure continued focus on growth of SUD networks in accordance with 1115 waiver requirements. All MCEs continued to expand their SUD networks. The Department, in collaboration with the BHA, is also working to develop the capacity tracker. This will allow for real-time access to waitlist by provider and access to where space is available based on level of care need and any additional characteristics such as gender or age.

Short-Term Behavioral Health Services

Since July 1, 2018, members have had the opportunity to receive short-term behavioral health services for low-acuity behavioral health needs, provided by a behavioral health clinician working as part of the member's PCMP. By design, this benefit is capped at six visits. Members with more complex needs are referred to appropriate specialists and receive services through the capitated behavioral health benefit.

Although the numbers are relatively small, the growth in the number of members accessing the short-term behavioral health services from 14,952 in FY 2018-19 to 17,553 in FY 2021-22 demonstrates continued interest and need. An analysis by the Eugene S. Farley Jr. Health Policy Center found that there were disparities in the utilization of capitated behavioral health services by race and ethnicity, but not in rates of short-term behavioral health utilization. This indicates that the short-term behavioral health services may provide a new avenue of access for members of color.[4]

Behavioral Health Provider Network Expansion

Once enrolled as a Colorado Medicaid provider, a behavioral health provider may contract with any of the RAEs to offer services in that region of the state. Each RAE establishes its own contracts with its providers with its own requirements and

[4] Eugene S. Farley, Jr. Health Policy Center. "Health First Colorado's Short-term Behavioral Health Benefit: Who's Using It?" Brief 23, August 2022.

reimbursement rates, within the parameters of the RAE's contract with the Department.

The first step in the contracting process is credentialing. To reduce provider burden, Colorado requires that the RAEs use the Colorado Health Care Professional Credentials Application to streamline the process when providers apply to multiple RAEs. RAEs are also required to use the CAQH VeriFide™ application for verification of primary source documents for the credentialing and recredentialing processes. RAEs may not require any additional documentation unless needed to clarify a question. Starting in January 2022, RAE contracts were adjusted to reflect that RAEs are required to make contracting decisions within 90 days of receiving a provider application.

Despite workforce challenges, the RAEs have increased the total number of contracted behavioral health practitioners. The goal was to add 950 newly enrolled behavioral health providers, including licensed psychologists and licensed behavioral health clinicians, by June 30, 2022. By July 19, 2022, 1,150 providers were added. Practitioners were added in every quarter of 2021 in all regions.

Table 6 demonstrates the number of new behavioral practitioners added to RAE networks in calendar year 2021. It should be noted that Beacon Health Options provides administrative services for both regions 2 and 4, so the contracted behavioral health networks in both regions are nearly identical. Similarly, CCHA is the RAE for both regions 6 and 7 and uses an identical behavioral health provider network for both regions.

Table 6. Number of RAE-Contracted Behavioral Health Practitioners, Added by Quarter, Calendar Year 2021

RAE	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
RAE 1	35	14	7	12
RAE 2	127	120	*1,386	269
RAE 3	142	180	152	165
RAE 4	127	120	*1,385	269
RAE 5	205	180	140	162
RAE 6	242	76	166	185
RAE 7	242	76	166	185

* *RAE 2 and RAE 4 reported higher than usual new practitioner counts. This includes CMHC facility service staff roster updates totaling 1,188 licensed practitioners.*

Table 7 shows the number of RAE-contracted behavioral health practitioners at the end of calendar year 2021. As practitioners may contract across multiple RAEs, this table does not represent total statewide contracts.

Table 7. Number of RAE-Contracted Behavioral Health Providers at the End of Calendar Year 2021

RAE	2021 Year-End Total Behavioral Health Practitioners
RAE 1	3,290
RAE 2	3,166
RAE 3	7,040
RAE 4	3,164
RAE 5	6,983
RAE 6	4,113
RAE 7	4,113

More behavioral health providers are still needed with behavioral health network expansion a continued focus of the Department and the RAEs. A promotional marketing solicitation was released in 2022 in partnership with the Department of Regulatory Affairs (DORA) to encourage all licensed behavioral health providers in the state to join the Medicaid network through the RAEs. In addition, Medicaid behavioral health funding has grown over the last several years (more than $500 million in additional behavioral health funding when comparing the Governor's FY 2023–24 Medicaid behavioral health budget and the FY 2018–19 Medicaid budget).

Behavioral health workforce is a complex issue that requires multi-faceted community response and creative policies from the RAEs, state and regulatory agencies, community partners, and education systems. Even with the existing efforts, workforce shortages will take time to resolve. The Department will continue to collaborate with sister agencies, RAEs and stakeholders to support and lead workforce development strategies in the coming years. The BHA recently released Strengthening the Behavioral Health Workforce in Colorado: An Approach to Community Partnership, a strategic plan that outlines the vision for strengthening the behavioral health workforce in Colorado to ensure we have a behavioral health system that offers meaningful, culturally relevant, and trusted services.

Behavioral Health Transformation in Progress

The behavioral health system in Colorado is in the process of transformation to address significant challenges in access propelled by an insufficient number of providers and a lack of network participation across Medicaid and commercial plans among providers; challenges within the safety net; lack of cultural competencies

which propel health disparities, and more. The ability of the RAEs to meet the behavioral health goals established by the Department and voiced by stakeholders is severely impaired due to systemic challenges and will improve as the many transformative behavioral health initiatives are implemented. Consider the below behavioral health ACC summary points, given this systemic challenge:

- Between April 1, 2021 and March 31, 2022, 18.4% of Medicaid ACC members accessed services for mental health and SUD through the capitated behavioral health benefit or through primary care settings.

- The capitated behavioral health benefit includes coverage for the full continuum of behavioral health services including outpatient, inpatient, wraparound services, crisis, residential and emergency services for mental health and SUDs.

- The capitated benefit structure also supports the RAEs in covering and coordinating a variety of support services to help members avoid unnecessary inpatient care and remain in the community. Through the capitated benefit can members access alternative community-based services ("B3") services, authorized through a federal 1915(b)3 waiver. These services are especially important for members with serious mental illness and co-occurring needs and includes prevention/early intervention, clubhouses/drop-in centers, vocational services, intensive case management, assertive community treatment, mental health residential treatment, respite care, and recovery services/peer support. B3 services also help members connect with peers, develop life skills, and prevent isolation.

- The ACC has been successfully expanding the provider network beyond the Community Mental Health Centers (CMHCs) by building out services available through the Independent Provider Network (IPN). The volume of services provided by the IPN has increased by 24% over the SFY 2021 period. The weighted average reimbursement rate for independent providers increased by 6.9% year over year between SFY 2020 and SFY 2021.

- All members have access to short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's PCMP site through integrated behavioral health care. Nearly 70% of members (12,230) who used the short-term behavioral health benefit in FY 2021–22 had not accessed behavioral health through the capitated benefit in the previous year, suggesting that this benefit may be expanding access to behavioral health care. In addition, there were disparities in the utilization of capitated behavioral

health services by race and ethnicity, but not in rates of short-term behavioral health, indicating that these services may be an effective strategy to closes behavioral health disparities – a key goal for the Department.

- From January to December 2021, the first calendar year of the SUD expanded to include residential treatment, 33 providers at 58 locations offered covered residential services to 8,844 unique members who received 16,486 episodes of care.

- Measuring licensed psychologists and licensed behavioral health clinicians, from July 1, 2021 to June 30, 2022, the Department exceeded its goal (to add 950 providers) with the addition of 1,150 providers to the ACC behavioral health network.

- The Department has collaborated with the Joint Budget Committee and the General Assembly to increase investments into Medicaid behavioral health by more than $500 million between FY 2018-19 and FY 2023-24 (as submitted in the Governor's budget and as of the writing of this report) supporting expanded access to quality care for all members.

- In 2021, many changes to the behavioral health services delivery system were initiated as the first phase of a multiyear behavioral health systemic and transformational process. Several of these changes to the delivery of behavioral health services have changed the behavioral health landscape for Health First Colorado members and will help us address root causes and systemic challenges. Examples of these fundamental shifts in services available to members and processes for accessing services include expansion of the Medicaid SUD benefit under the 1115 waiver, providing coverage of residential treatment services for members, changing the definition of safety net providers, and launching the BHA. Under the BHA, safety net providers may be licensed to provide essential services or comprehensive services. The BHA is also charged with removing barriers to participation through a streamlining and standardization of procedures for licensing, payments, and reporting between provider types and between differing payers.

The Department has taken an active role over the last several years in transforming the behavioral health system across Colorado. Given that Medicaid is the largest payer of behavioral health services in the state – by far - the state's systemic behavioral health challenges are a serious impediment to the achievement of our behavioral health goals. For this reason, the Department has been actively engaged in all aspects of the in-process systemic transformative changes.

- The Departments has been working statewide, cross-agency, and with stakeholders for the past three years to develop a plan and implement transformative changes. Stakeholders were critical to informing this plan, which includes a needs assessment based on the review of over 100 behavioral health reports, and a call to increase accountability and update oversight processes and standards that were previously in place. Feedback, a foundational element of this transformation, critically informed the Behavioral Health Blueprint for Transformation created by the 2019 Behavioral Health Task Force.

- This plan informed the allocation of $450 million in ARPA investments through recommendations from the 2021 Behavioral Health Transformational Task Force, which included seats for the Department and input from the RAEs and Medicaid members. This led to the Department-supported passage of 20 behavioral health transformation bills during the 2022 Legislative Session, including the historic creation of the BHA. These bills can be found in Appendix A and helped provide the foundation for many of the initiatives below.

- The Department also identified and allocated of another $115 million in behavioral health grants and programs funded by the HCBS ARPA transformational initiatives, with a focus on individuals with disabilities.

- The Department has created an implementation plan, in coordination with the BHA, to expand and strengthen the Behavioral Health Safety Net, as required by SB19-222. To support the state behavioral health safety network, new definitions of the safety net and safety net provider and new sustainable funding models are emerging to the benefit of all Coloradans, especially those who are low income and suffer from serious mental illness (SMI). The impacts of this bill have already begun and will be fully complete by July 1, 2025.

- The Department is working with the BHA, through federal grant supports, on rewriting the BHA provider standards for all behavioral health providers. HB22-1278 modernized the definition of safety net providers and associated safety net services, which also created a new provider type for small- and medium-sized safety net providers. These definitions will ensure new criteria, accountability, and payments for safety net providers, while increasing the number of providers who can be part of the safety net system. The BHA will be revising, amending, or repealing their provider standards, and other regulations, based on these statutory changes. These first set of new rules will be effective by July 2022.

- The Department Cost Reporting and Safety Net Rate Setting. To increase diligence and transparency about cost-based rate setting, the Department released new Cost Report Templates for the CMHCs in May 2022. Those reports will be used to set new rates effective July 2023.

- The Department is working with stakeholders and the BHA to develop new reimbursement methodologies for safety net providers that create greater accountability to the community and reward member outcomes. Specifically, the new Alternative Payment Models (APMs) and Value-Based Payments (VBPs) will create sufficient flexibility for providers to meet the needs of the community and members, and better correlate reimbursements with results, to be effective by July 2024.

- Two bills (HB 22-1278 and HB 22-1302) require the Department and BHA to work together and develop Universal Contract Provisions that will define expectations for behavioral health providers that contract with the state for behavioral health services. The Universal Contract Provisions will standardize contract content expectations around things such as data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission, billing for procedures, etc. Concurrently, payers like the RAEs and the BHA will be held accountable for financial reporting, utilization review, provider service, Medicaid claim payment turnaround time, and more. The Universal Contract provisions will also correlate to the Department medical and behavioral provider agreement, which is being modernized.

- The Department is closely involved as the BHA works through the process of promulgating rules that will impact the behavioral health system by:

    - Reducing and aligning data collection and reporting requirements for behavioral health providers.

    - Aligning on the minimum performance standards and key metrics for youth and adult services funded by the BHA and the Department.

    - Providing minimum standards for all aspects of the operation of Behavioral Health Entities (BHEs), licensed within the state; these standards will impact some Medicaid providers. The BHA will additionally license and monitor BHEs in accordance with those standards.

- The Department is working to finalize an interagency agreement with the BHA. The agreement will address processes that occur across multiple agencies as an effort to reduce duplicative or overlapping efforts. Specifically, the agreement

will streamline the process of auditing large safety-net providers, improve data sharing, as well as standardizing grievance processes. For example, these have already improved the on-site review and quality oversight process. As a result, providers will have fewer independent, disconnected interactions with varying departments on the same matters being reviewed at a state level. The interagency agreements will be reviewed and improved annually.

- An example of this better process is a recent tri-agency audit to improve care quality. In April 2021, the Department began auditing Mind Springs Health (MSH) through Rocky Mountain Health Plans (RAE 1). A June MSH audit summary provided by RAE 1 included several performance and quality of care concerns, which continued to grow over the summer of 2021 and into the fall. Local community inquiries, along with MSH site visit findings by CDHS, resulted in a tri-agency audit (Department, CDHS, CDPHE) of CMHC Mind Springs Health. The audit reviewed quality, access, compliance with licensing and designation standards, and fraud, waste, and abuse. After several visits, discussions, additional MSH audit segments conducted by the agencies, detailed corrective action plan (CAP) improvements designed to drive better results and service to the community, a final CAP was accepted, with limited caveats, on August 26, 2022 by the Department, CDPHE, and the BHA (reflecting the launch of the BHA on July 1, 2022). The agencies are monitoring and driving MSH improvements and compliance independently, due to the breadth of findings and CAP requirements underway.

Coordinating with Long-Term Services and Supports

The ACC coordinates with LTSS entities to ensure access to comprehensive services for members with a range of needs, including those with physical disabilities, serious mental health needs, and developmental or intellectual disabilities.

Most members access the LTSS system through the 24 SEPs and 20 CCBs in the state. SEPs serve as the case management agency for older individuals, adults with mental health needs, individuals with traumatic brain or spinal cord injuries, and children with life-limiting illnesses. CCBs predominately serve as the case management agency for individuals with intellectual or developmental disabilities and children with autism.

RAEs coordinate with SEPs and CCBs in different ways. Some have a dedicated staff member who works to coordinate with the SEPs and CCBs in the region. Others train their care coordinators, especially those who focus on members with complex

conditions, to work collaboratively with SEPs and CCBs and review complex cases together.

As stated, the Department was awarded more than $500 million in ARPA funding to transform HCBS. In collaboration with stakeholders, the Department has identified 63 projects to transform the industry currently in process, along with the funding of significant increases to frontline worker wages.

The RAEs and ACC staff are part of implementing several ARPA projects, which can be found on the ARPA webpage, along with other projects. Some of the projects are described below.

Wrap-Around Services, Including Peer Supports, for Members with Complex Needs

The Department will fund and develop a sustainability strategy for wraparound services. This includes housing support services and community-based peer support, for recipients of complex social service benefits, such as housing vouchers and supportive housing services. The strategy will prioritize individuals who are living with SMI and have a history of homelessness and repeat hospitalizations. Specifically, the Department will implement a pilot program with about 500 members to provide supportive services, including peer supports, behavioral health services, and supportive housing services. Participating members will receive housing vouchers from the Colorado Department of Local Affairs. Stakeholder engagement with the RAEs began in mid-2022. The RAEs will be encouraged to engage by partnering with their local housing services to support shared members participating in this pilot program.

Expand the Behavioral Health Safety Net

These funds provide the opportunity to strengthen and expand the behavioral health safety net through provider training, workforce development, enhanced standards, high-intensity outpatient services, and value-based pay for performance models supporting whole-person care. Over the past two years, the Department and the RAEs aligned on a definition for high-intensity outpatient services identified through a collaborative stakeholder engagement process. The Department will continue to partner with the RAEs to develop strategies to expand the behavioral health safety net and ensure members are adequately supported during transitions of care.

Case/Care Management Best Practices

Person-centered case management and care coordination requires adapting outreach strategies and support services to the needs of the population and of individuals, which may be different depending on the disability. The Department will research national best practices and develop and pilot these practices through models of care

coordination that meet the unique needs of a variety of member profiles such as complex care coordination for those with dual or poly-diagnoses. The Department will develop a training plan, including developing appropriate materials, for the staff of the case management agencies and the RAEs. This will address their roles and responsibilities and collaboration across the continuum of care, especially for members with complex needs.

Systems Infrastructure for Social Determinants of Health

The Department, in partnership with the Office of eHealth Innovation, will expand the infrastructure for a Social Health Information Exchange, which provides case management agencies, RAEs, care coordinators, and health care providers with real-time connections to resources like food, energy assistance, wellness programs, and more. Going forward, the Prescriber Tool will be an important tool that propels the ACC evolution in the area of SDoH. More than 10,000 providers (more than 40% of Medicaid prescribers) are already using the Prescriber Tool. Phase II of the tool will enable providers to prescribe programs not just pills (e.g., prescribing WIC or the prenatal program to pregnant Medicaid members, diabetes programs to those with uncontrolled A1C, or housing supports to those who are housing insecure). This phase is in the request-for-proposal creation phase right now and will be bid and awarded in 2023. It will be a significant step forward in meeting the SDoH needs of members.

Expand Behavioral Health Crisis Teams

The Department will expand activities related to the mobile behavioral health crisis teams, which offer an alternative to police or emergency transport for a person in a mental health or SUD crisis. Currently in Colorado, there are differing practices, pilots, and approaches to behavioral health crisis calls. The Department will provide funding in the form of grants to support this work. Grantees could start a program or bring their current program into compliance by implementing required staff training, increasing their capacity for 24/7 response, purchasing equipment, and improving technology. Funds would also be available to create more culturally responsive mobile crisis services in Colorado. Funding may be open to providers and RAEs.

Access to Care in Rural and Frontier Counties

Colorado is a geographically diverse state with five of the seven RAE regions containing rural or frontier counties; only Region 3 (Adams, Arapahoe, Douglas, and Elbert) and Region 5 (Denver County) do not. Access to all care is limited in these areas, but especially behavioral health and medical specialty services. Below are examples of how RAEs are taking steps to improve access to care and increase provider capacity in Colorado's rural and frontier counties.

- RAE 6/7 has placed tablets and kiosks in Park County and Teller County locations to expand access to behavioral telehealth. While these kiosks may be used for a range of services, including routine physical health care, the emphasis is on using them for behavioral health access.

- On the Western Slope, RAE 1 has funded two tribal health navigators, a new Native American Resource Center in Mesa County, and new SUD residential program on Southern Ute land.

- RAE 1 pays an enhanced PMPM to Indian Health Centers and other PCMPs affiliated with a tribe and pays enhanced rates to independent behavioral health providers who serve members in rural and frontier counties.

- In southern Colorado, RAE 4 funded two vehicles for intense case management and wraparound programming for the Center for Restorative Programs, which supports programs in Alamosa, Conejos, Costilla, Rio Grande and Mineral Counties.

- RAE 4 funds Chaffee County Public Health to support a free mobile health clinic that provides health navigation, education, direct services, and prevention and early intervention services and programming throughout the county.

- In northeast Colorado, to support access to care in rural and frontier areas RAE 2 developed in-house medical assistance trainings within practices, which is helping to support small and larger provider locations provide outreach and care. RAE 2 continues to offer virtual care, for both behavioral health and physical health, which includes tools for members to use such as cell phones with data. Region 2 is also evolving additional options for specialty care via telehealth which is inclusive of medication-assisted therapy and dental.

- RAEs are supporting rural primary care practices so they can expand the services they offer and make the most of the ACC's resources and tools.

- RAEs support rural members with accessing nonmedical services that support health. For example, RAE 6/7 works with a regional transportation provider to provide rides to members to get groceries, attend vaccination events, and pick up prescriptions at the pharmacy. RAE 4 partners with community providers to have meals delivered to members with serious illness or disability. While RAE 2 worked with Food Bank of the Rockies and Prairie Family Center to have emergency food boxes delivered to members when a local food pantry closed.

- The Department is managing or supporting three additional workstreams and funding to further improve access, quality outcomes, and affordability in rural communities. This work is leveraged by the ACC and the RAEs to the betterment of members we serve and include:
    - $17 million is dedicated to connecting rural providers to the Health Information Exchange, as well as additional funding for rural hospitals and physician groups in the FY 2023-24 budget to maintain this connection.
    - $10 million is being equally split to fund increases in access and affordability initiatives focused on rural hospitals and their rural health clinics. These funds will be awarded in 2023.
    - $12 million in funding per year, totaling $60 million over five years through the Rural Assistance Fund, a component of the HTP to help rural hospitals transform for the future. This funding helps prepare rural hospital systems for VBPs and improve quality, affordability, and infrastructure.

V. Operational Excellence and Customer Service

One important role of the ACC is help members, providers, and partners to navigate Medicaid and the health care system in general. This section of the report describes the experience of members, providers, and other stakeholders with the ACC.

Member Experience

The Department contracts with the Health Services Advisory Group, Inc. (HSAG) to annually administer a standardized survey to members receiving services through Colorado Medicaid and to report the results. This year, HSAG administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, rather than the Patient-Centered Medical Home Survey that has been used in past years. This change was made primarily to comply with a federal data collection requirement. In addition, the Health Plan Survey allows the Department to survey the entire Medicaid population rather than just large provider groups.

The survey sampled 1,620 adult members and 1,980 parents/caretakers of child members per managed care entity. A total of 1,055 RAE adult members (9.48% response rates), 326 DHMP members (9.52%) and 237 RMHP Prime members (12.70%) returned a completed survey. Parents/caretakers returned a survey for 1,500 child RAE members (10.95%), 190 child DHMP members (9.23%), and 287 child RMHP Prime members (16.06%).

This year, Health Services Advisory Group, Inc. (HSAG) administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, rather than the Patient-Centered Medical Home Survey that has been used in past years, to comply with a federal data collection requirement. The survey looked at factors such as getting needed care, getting care quickly, provider communication, health plan customer service, and coordination of care.

Ratings varied across RAEs for each factor, but most members reported being able to get needed care (80.9% for adult care and 80.2% for children) and get care quickly (78.9% for adults and 84.9% for children). They also reported satisfaction with care coordination (79.7% for adults and 82.3% for children) and how well their doctors communicate with them (91.3% for adults and 93.6% for children). HSAG recommended that the RAEs continue to expand options for after-hours care and explore additional ways to understand member experience, such as focus groups.

In addition, the following examples provide insight into how the RAEs and MCOs make the system more navigable and accessible than it would be without their services.

- A member with multiple sclerosis who uses a wheelchair and frequently accessed the emergency department met with a care coordinator. The coordinator found ADA-compliant housing that helped the member escape an abusive relationship. The care coordinator also connected the member with behavioral health services. The member reported improved wellbeing.

- The RAE and behavioral health provider worked with a 16-year-old member to connect the member with step-down services after his fourth hospitalization in a year. After meeting with the CMHC, the family was impressed by the depth and breadth of services made available. Their experience with the CMHC was so good that they sought services from another CMHC when they moved out of state.

- A member used the RAE's mobile chatbot app to obtain housing assistance and, while using the app, also found LGBTQ+ resources. Although the member did not disclose it during enrollment, the member indicated through the app that they were transgender and needed support. The in-app support provided a comfortable way for this member to stay connected and talk/chat about challenges such as finding community, working through family issues, and dealing with food insecurity.

- A member frequently went to emergency department and received hospital care for behavioral and physical health issues. The RAE helped refer the member for additional services and get them into an alternative living facility, as stress in the home contributed to their frequent hospitalizations. They feel much better and are also connected with day programming, attending all appointments, and working toward obtaining a part-time job.

These are just a few examples of the ways the ACC is making a difference for people by meeting a wide range of diverse needs. For more information about the CAHPS survey, see www.colorado.gov/hcpf/client-satisfaction-surveys-cahps.

Provider Experience

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 primary care doctors and work closely with other physical health providers in the region.

Within a managed care arrangement, one of the most important factors for a positive provider experience is the timely processing of claims payment. 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, the Department 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 a claim that can be processed without obtaining additional information from the provider of the service or from 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, but 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 8. Percent of RAEs Meeting Claim Adjudication and Provider Response Standards 2021, by RAE

	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
% of clean claims paid or adjudicated within 30 days	99.6%	100%	99.0%	100%	99.4%	99.5%	99.5%
Response to provider questions within two business days	100%	100%	100%	100%	100%	100%	100%

During the past year, the Department continued to work with independent behavioral health providers to facilitate their participation as Medicaid providers. To participate, independent providers often need additional guidance and support with contracting, credentialing, and billing, as well as adequate reimbursement rates. Below are some examples of support given to these providers and others in the RAE network.

- RAE 1 worked with a specialist provider group and educational consultant to develop and deploy an in-depth course for behavioral health providers to better serve members who have co-occurring behavioral health and intellectual and developmental disability diagnoses. RAE 1 offered reimbursement for time spent attending the course which supported more than 50 clinicians' participation in the six-day opportunity.

- RAE 2 offered education on documentation standards for behavioral health providers. These sessions are offered by the team that conducts the audits. Providers have been taking advantage of these Zoom sessions to ask questions and clarify technical processes to ensure they are billing correctly.

- In RAE 4, the auditing team is working to build relationships with providers and help them come into compliance. Providers have given feedback such as, "Thank you, I always appreciate your feedback, help, and support," "All you have done is making us BETTER," and "I really appreciate your past trainings and motivation to continue to support us. Ultimately this directs greater care to our clients."

- RAE 3/5 formed a new behavioral health facilitation team to increase support for independent providers. In addition, they launched a new behavioral health performance improvement project focused on screening for depression in the primary care setting. Through this process, the RAE and a provider uncovered a claim coding and billing issue. When it was fixed, the data finally reflected the PCMP's actual depression screening rate.

- RAE 6/7 helped to address staffing challenges in behavioral health facilities by providing funding for workforce development, including hiring bonuses, retention bonuses, internship programs, and funding for training and certification.

RAEs are working with PCMPs and community providers to remove barriers so they can work efficiently to best serve members. Practice transformation teams have helped PCMPs expand the services offered, especially in rural areas; identify billing and data collection issues; and solve problems with medical assistant staff turnover.

RAE Accountability for Provider Experience

The Department seeks to give RAEs enough flexibility to fulfill responsibilities while ensuring that each RAE meets standards to ensure compliance, consistency, and a good experience for providers and members. The Department uses contract management, incentives, and accountability measures to achieve this balance.

RAEs have extensive contracts that detail federal and state requirements, including reporting requirements, network adequacy, member and provider engagement, supportive services, and more. This year, the Department added new requirements for contracting with behavioral health providers and paying behavioral health claims to streamline these processes and reduce administrative burden.

Advisory Committees and Stakeholder Engagement

In FY 2021-22, the ACC offered members and stakeholders several ways to participate in decision-making and offer feedback.

Program Improvement Advisory Committee (PIAC)

Established in 2012, the PIAC is the Department's primary means to solicit guidance and recommendations from community members for improvement of the ACC. Membership includes Medicaid members, physical and behavioral health providers, LTSS providers, oral health providers, local advocacy organizations, and member advocates.

In FY 2021–22, the statewide PIAC continued its work on ensuring member support and follow-up after members access the Colorado behavioral health crisis service system and coordination of services for justice-involved members. In addition, the Performance Measurement and Member Engagement Subcommittee made recommendations for improving data collection practices to assess equity in depression screenings. The PIAC also tracked and discussed provider experience during this high-pressure year defined by the ongoing COVID-19 pandemic.

Regional Program Improvement Advisory Committees and Member Advisory Councils

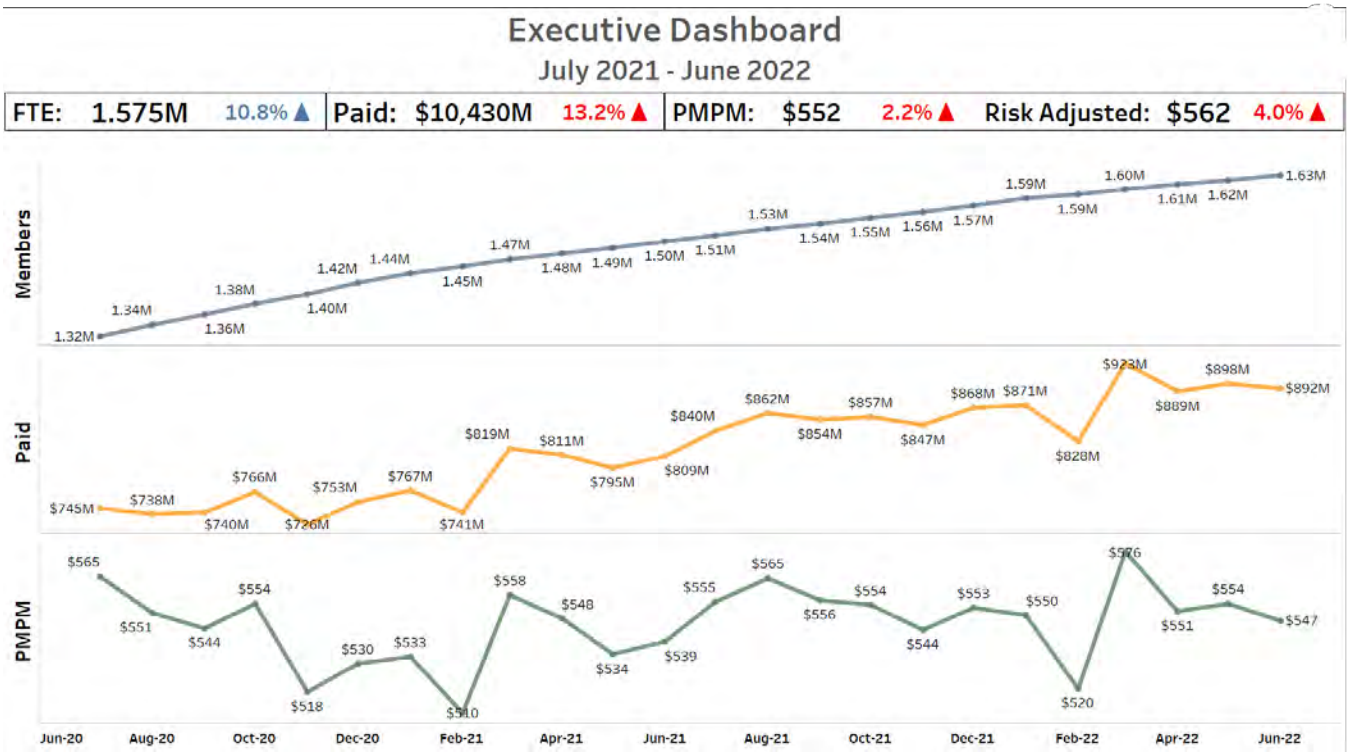
Each RAE has a regional performance advisory committee with meetings held monthly or quarterly. This provides each region a forum for stakeholder participation on program improvement activities at the local level. These meetings help the RAEs understand the unique needs within their community and design and implement solutions that best address the needs. The regional committees focus on issues such as care coordination efforts, member support services, RAE performance review, and establishing policies for distributing earned pay-for-performance program payments.

All the RAEs have also formed member advisory councils, which focus on understanding the member's perspective to inform policy, program decisions, and communications.

VI.Health First Colorado Value

The ACC is designed to support the Department's strategic pillar to provide value to the state, ensuring that members get the right services, at the right place, for the right price, and the right health outcome. Together, this focus drives affordability across the Medicaid program, enabling the Department to better control cost trends and therefore protect provider reimbursements, member benefits and program access, especially during economic downturns.

The effectiveness of ACC cost control can be evaluated by reviewing the overall Medicaid claim cost trend, which is measured in several ways. From July 2021 to June 2022, the Medicaid PMPM trend is 2.2%, while risk-adjusted trend is 4.0%. Paid trend is 13.2%, which reflects the significant membership growth of 10.8%. The ACC was also part of a comprehensive Medicaid cost control strategy that controlled Medicaid trend during the PHE such that the Department was able to return $1.2 billion of the additional 6.2 points of FMAP received during the PHE over the 10 quarters since the PHE began, after covering claims from the hundreds of thousands of additionally eligible Coloradans.



The primary drivers of this trend growth were an increase in fee-for-service reimbursement rates approved by the Joint Budget Committee and the General Assembly; an increase in utilization of services, which the pandemic suppressed the previous year; and an increase in behavioral health capitation payments due to the

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addition of inpatient/residential SUD benefits as well as behavioral health rate reimbursement increases. Program costs include administrative costs, incentive payments, and all expenses for benefits and services provided during FY 2021–22, including capitation and fee-for-service payments.

Further, the Department strives to efficiently operate the Medicaid program, with a 4% administration allowance, meaning that 96% of the budget goes to reimbursing providers for their services to Medicaid members. This section describes ACC's budget and summarizes the work done in the ACC in the past year to increase value and control costs.

Accountable Care Collaborative Budget

Costs for the ACC fall into three major categories:

- **Payments for medical and behavioral health care**. These payments cover the cost of care. For most physical services, the Department pays fee-for-service claims directly to the provider that delivered the service. (The exceptions are the two managed care organizations, Denver Health and RMHP Prime, which receive a capitated monthly PMPM payment for physical health services provided to members.) Most behavioral health services are covered as part of a capitated benefit in which RAEs receive a PMPM payment to provide most behavioral health care services.

- **Administrative payments**. These PMPM payments go to the RAEs for doing the administration, care coordination, and population health work of the program. The RAEs distribute a portion of these payments to their PCMPs for the work they do to serve as medical homes for members and provide some care coordination.

- **Incentive payments**. These payments incentivize and reward RAEs for meeting or exceeding performance targets:

    - **KPI payments**. A portion of the RAE administrative PMPM payment is set aside to incentivize RAEs to meet or exceed KPIs. These are indicators of how well the RAEs and the overall system are functioning.

    - **Behavioral Health Incentive Program payments**. These are used to incentivize performance on behavioral health indicators.

- The **Performance Pool** is a flexible pool of funds that the Department can use to support the improvement of RAEs or PCMPs, or incentivize their performance.

Table 9. FY 2021-22 Budget for the Accountable Care Collaborative

Accountable Care Collaborative Budget Category	FY 2021-22 Expenditures
Payments for Services	
Fee-for-service payments	$8,378,725,778
Denver Health MCO capitation payments	$284,713,556
RMHP Prime MCO capitation payments	$248,861,113
Behavioral health capitation payments	$1,055,950,861
Administrative and Incentive Payments	
Administrative per-member-per-month (PMPM) payments	$187,680,197
Key performance indicator (KPI) payments	$28,712,095
Behavioral health incentive payments	$17,797,972
Performance pool payments	$17,834,561
TOTAL ACC EXPENDITURES	**$10,220,276,133**

The Value of the ACC Model

One of the original goals of the ACC was to avoid expensive care such as emergency department visits and inpatient hospitalizations by having members engage with their PCMPs. The Department evaluated the impact of PCMP engagement on costs with the hypothesis that members who engaged with their PCMP would have lower than expected costs due to the medical home function performed by the PCMP. Engagement was defined as having at least one visit with any PCMP during either FY 2020-21 or FY 2021-22. The Department compared the expected per member cost in FY 2021-22 to their observed cost. The Department can estimate the expected annual costs for members using an assigned risk score produced by IBM that considers a member's diagnoses, eligibility category, and demographics. The analysis found that

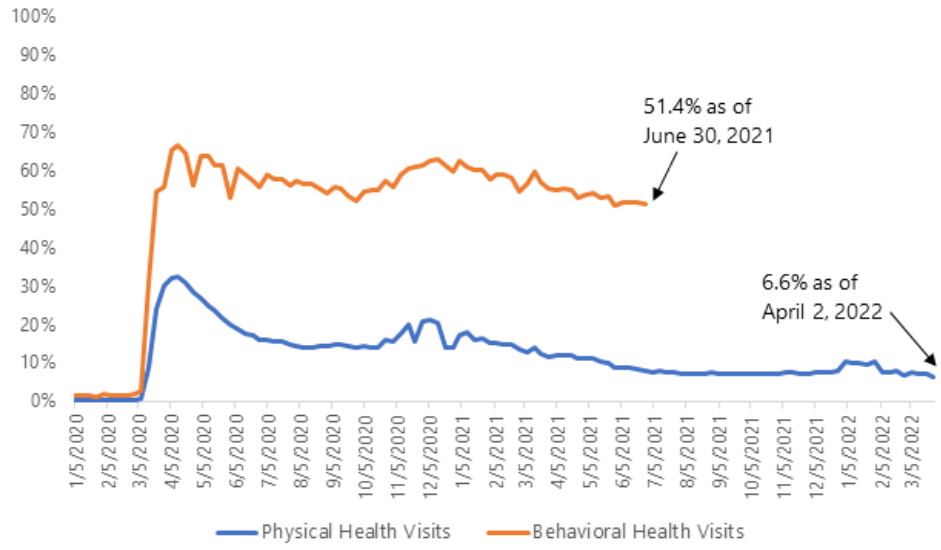
members who engaged with a PCMP in either FY 2020-21 or FY 2021-22 were less costly than expected. The Department avoided up to $189 million in costs for members who engaged with a PCMP.

Cost-Effective Access through Telehealth

Telemedicine utilization increased dramatically at the onset of the COVID-19 pandemic, and as time has progressed, tele-behavioral health has remained a popular choice among Medicaid members. As of June 2021 (the most recent date for available behavioral telehealth data), over half of all telemedicine-eligible behavioral health services were still provided by either video or audio only (telephone calls). This is the most recent date for available tele-behavioral health data due to an encounter data lag issue.

While tele-behavioral health utilization has remained high, the opposite is true for physical health services. Members are choosing in-person care over telemedicine for physical health visits with just 6.6% of all visits being conducted via telemedicine as of the beginning of April 2022. This difference may be due to many factors. One reason is that providers prefer in-person care for many chronic health conditions due to the need to take vitals.

Figure 3. Behavioral Health and Physical Health Telemedicine Visits



Source: Health First Colorado claims data, January 5, 2020–April 2, 2022

Note: The orange line represents the percentage of all behavioral health visits that were eligible for telemedicine and were conducted by telemedicine. The blue line represents the percentage of all physical health visits that were eligible for telemedicine and were conducted by telemedicine.

National and state sources suggest that Medicaid members tend to be higher utilizers of telemedicine than individuals with Medicare or private payers.[5] [6] One influencing factor could be greater use of audio-only telemedicine among underserved communities.[7]

Telemedicine uptake varied by the type of behavioral health service category (Figure 4). As expected, psychotherapy services are often provided by telemedicine versus in-person and are driving overall tele-behavioral health utilization. However, outpatient SUD treatment is also commonly provided by telemedicine (63%), which mostly includes therapy and education services and not medication-assisted treatment. The Department's interviews with providers revealed a general preference for video telemedicine appointments for clinical quality reasons, and there was some anecdotal evidence that telemedicine can be beneficial for higher acuity patients. This information should not be generalized due to the small sample size of interviews, but it is a positive indication that telemedicine can work in many different settings. For example, some providers talked about the benefits of tele-crisis services in rural areas where staff shortages and long drives make service delivery challenging. Additionally, targeted case management can be effective at keeping members engaged regularly if phone and video options are available.[8] Interviewees also discussed the value of audio-only telemedicine as an option for when members lack reliable connectivity, for older populations of members; and for turning a missed appointment into a phone appointment, when appropriate, to reduce no-show rates.

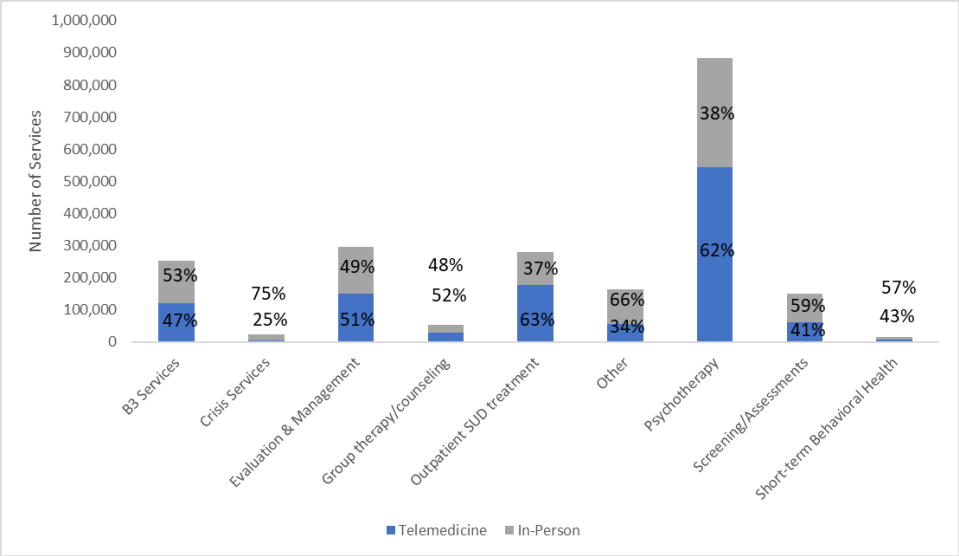
[5] Karimi, M., Lee, E.C., Couture, S.J., Gonzales, Al, Grigorescu, V., Smith, S.R., De Lew, N., & Sommers, B.D. (2022). National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. U.S. Department of Health & Human Services. https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.

[6] Center for Improving Value in Health Care. (2021). *Telehealth service analysis.* https://www.civhc.org/covid-19/telehealth-services-analysis/

[7] Uscher-Pines, L., Sousa, J.L., Jones, M., Whaley, C.M., Perrone, C., McCullough, C.M., & Ober, A.J. (2021). Telehealth use among safety-net organizations in California during the COVID-19 pandemic. Journal of the American Medical Association. https://doi.org/10.1001/jama.2021.0282.

[8] Colorado Department of Health Care Policy and Financing's interviews with providers, 2022.

Figure 4. Telemedicine Utilization by Behavioral Health Service Type



Health First Colorado claims data (January to June 2021). Fee-for-service and capitated behavioral health data are included.

The Department produced the first of its kind Health First Colorado Telemedicine Evaluation in 2021. A second report is being finalized. These reports provide the insights that help the Department craft and implement telehealth strategies that improve member access, quality outcomes, equity, and affordability while improving the member experience. At the same time, the Department is advocating for the continued ability to reimburse for telephonic care—not just virtual care—at the federal level, as this medium is at risk for not being covered in the future.

RAEs have been engaged in tracking telemedicine utilization and establishing partnerships and programs to increase access to care. Below are several examples of how RAEs have been involved in telemedicine efforts this fiscal year.

- RAE 1 tracks telemedicine outpatient utilization data regularly, and they report some success in leveraging telemedicine for quickly connecting members to care during mental health crises. They also give members the option of using the telemedicine platform CirrusMD, which is available all times of day for direct virtual access to physicians for emergency or primary care needs. CirrusMD providers are enrolled in Medicaid, and the RAE offers it as a free service to their members. Visits are triaged telemedicine visits with a majority of members saying that without it, they would have likely gone to the emergency department or to urgent care. These telemedicine physicians can

write prescriptions and typically see conditions related to respiratory and ear/eye/sinus issues, behavioral health conditions, skin conditions, or genitourinary/STD/OBGYN conditions.

- RAE 6/7 has tracked telemedicine utilization over time and is currently focused on implementing telemedicine kiosks in community locations so that their clients can connect directly to Medicaid providers. It has already placed two kiosks in Teller County and is planning to deploy more.

- RAE 3/5 operates a telemedicine platform called Virtual Care Collaboration and Integration, which directly connects members to short-term behavioral health providers and psychiatrists. Care coordinators can refer members to these clinicians to help members begin treatment, and then if longer-term care is determined to be necessary, members can be transitioned via a warm hand-off to an enrolled behavioral health provider. They also administer a virtual program that focuses on children and youth, who have behavioral health needs, but can also address health issues such as eating disorders. School-based health centers are involved in this work as partners.

- RAEs 2 and 4 have used telemedicine to contract with providers in areas of the state that need specialty care. For example, one RAE contracted with a provider that offers gender-affirming care and support for eating disorders.

eConsults for Cost Effective Access to Specialist Expertise

To expand access to cost-effective specialist services, the ACC plans to implement a statewide eConsult platform that will allow PCMPs to communicate electronically with specialist providers to decide the best treatment for members. Specifically, eConsults facilitate e-communications between a Medicaid PCMP and a specialist in order to expand care access at the PCMP level. This reduces no-shows for specialist appointments, helps address member challenges with accessing specialty care, and equips the PCMP to provide better care to the member. If a specialist visit is appropriate, the eConsult will employ the emerging Providers of Distinction cost and quality indicators to help PCMPs make informed referral decisions that will improve the member outcomes while closing disparities. The Department expects to award an eConsult vendor to operate the statewide platform by the end of 2022 and implement it in the summer or fall of 2023.

Hospital Transformation Program

The Hospital Transformation Program (HTP) improves the quality of hospital care provided to members by tying provider fee-funded hospital payments to quality-based

initiatives. Over the course of the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure. Activities and quality measures for HTP are consistent across the state, yet flexible enough to allow hospitals to work with their communities on the best interventions and approaches that serve them. As part of the HTP, hospitals receive supplemental payments based on community health neighborhood engagement, performance on quality measures, and interventions to impact those measures.

RAEs have been supporting hospitals in the HTP throughout the fiscal year. For example, in RAE 2, the HTP team meets regularly to assist with aligning measures and implementing activities. To address health equity in the region, the HTP Quality Team is using the Every ONE Project Toolkit, which aims to advance health equity through education and training. RAE 1 collaborated with Quality Health Network and Contexture (local Health Information Exchanges) to prioritize and present via a webinar series an aligned approach to supporting participating hospitals on streamlining data transfer processes. Additionally, this collaboration aims to reduce duplication of care management services. RAE 4 is working with hospitals on aligning the measures required for the HTP, including the social needs screening and notifications to screen for nonmedical needs and refer appropriately.

Alternative Payment Models

Traditional fee-for-service payment models reward volume over health outcomes or quality performance. These models do not incentivize care providers to control costs while ensuring good patient health outcomes. Colorado intends to have half of all Medicaid payments tied to a value-based arrangement by 2025. The following alternative payment models (APMs) are currently being implemented:

- **AAPM 1**: Under this APM, the Department adjusts payments to primary care providers based on the providers' performance. Progress within this framework not only encourages higher organizational performance but also helps the ACC achieve its programmatic goals. The APM is a point-based system. PCMPs earn points by reporting on quality measures and demonstrating high performance or improvement. The number of points earned by each PCMP determines the impact on payment for that practice. PCMPs with 500 or more attributed members can participate.

- **APM 2**: This program is open to PCMPs with 500 or more attributed members. It empowers PCMPs to support members by changing the way they receive payments for services. Participating practices can choose to receive some or all their revenue as PMPM payments to provide stable revenue and allow for

increased investment in care improvement. Participating providers are also eligible to share in the savings from improved chronic care management.

- **Maternity Bundled Payment**: Bundled payments are a single, comprehensive payment that covers all the services within an episode of care. Under a bundled payment model, participating providers are responsible for outcomes of the episode; they hold limited risk for staying within the designated budget threshold and are eligible for shared savings when the threshold is not exceeded. The approach aims to reduce silos in a member's care experience and create efficiencies that lower costs. The Maternity Bundled Payment program specially addresses SUD and mental health issues through the program incentive design to promote quality mental health and substance use screening, referral, and treatment to pregnant and birthing parents.

Prescriber Tool

In 2019, the Department began creating a Prescriber Tool that would improve prescription drug cost control, reduce opioid addiction risk, and improve patient health. This tool is the first in the nation that includes both commercial and Medicaid prescription drug information, so Colorado providers can use one tool to serve the vast majority of their patients.

The goals of the Prescriber Tool are to help improve patient health outcomes and service, reduce administrative burden for prescribers, and improve prescription drug affordability. To achieve these goals, the tool offers the following modules that work in most electronic health records (EHRs):

- **Real-Time e-Prescribing (eRX):** Prescribers can send prescriptions electronically to pharmacies for Medicaid members, increasing convenience and saving time for patients, prescribers, and pharmacies.

- **Real-Time Benefits Inquiry (RTBI):** Prescribers get rapid insight into preferred medications from the preferred drug list. This empowers them with drug affordability and cost options, including up to three more cost-effective alternatives than the medication originally inputted.

- **Real-Time Prior Authorization (ePA):** Prescribers get rapid, electronic prior authorizations and reduce their workload.

- **Opioid Risk Module:** Prescribers access an integrated opioid risk tool to help prevent the misuse and abuse of opioids, benzodiazepines, and other controlled substances. The application compiles a comprehensive patient risk

profile by leveraging the following data and features: integrated Prescription Drug Monitoring Program data, toxicology reports, clinical guidelines, education, a GPS treatment locator, and patient-accessible tools for overdose prevention.

The Department has created an APM program to incentivize the use of the RTBI module as well as Preferred Drug List (PDL) compliance to promote cost efficiency and compliance in the pharmacy benefit. The pre-APM phase was implemented in April 2022 to support practices in integrating the module into their EHR systems. The RAEs developed implementation plans to detail their strategies for ensuring completion of an attestation form. The Department received over 700 responses to the attestation form, reaching close to 83% of the total contracted PCMPs across Colorado. RAEs are supporting practices in developing training materials to ensure that providers are aware of the module and have integrated it into their prescribing workflow.

The Department has communicated a follow-up process for the attestations to ensure that as many practices as possible receive support in establishing RTBI module functionality before the launch of the APM in July 2023. The Department and RAEs will follow up with practices that have indicated the module is working and provide training materials. For practices that indicate the module is not working, the RAEs will follow-up with EHR vendors and coordinate practice meetings with the Department to address the problems with the module.

Reducing Waste and Inefficiencies

The ACC is one of the Department's efforts to reduce waste and inefficiency in the Medicaid program. It was designed and developed to promote service efficiency and the reduction of duplicative and inappropriate services, as well as to provide administrative efficiencies for both providers and members.

Regional Model

The RAE model is designed to reduce inefficiencies. RAEs served as a single resource to help both providers and members navigate the Medicaid system of care. Based on practice needs, RAEs help practices enroll as a Medicaid provider, establish relationships with hospitals and other providers in the region, create effective administrative systems, implement data and technology tools, improve billing and coding practices, and implement better patient communication strategies.

For members, the RAEs help explain Medicaid benefits, establish relationships with PCMPs, coordinate care with behavioral health providers and other Medicaid

providers, address grievances, arrange NEMT services, and connect members with community resources to address nonmedical needs. Each RAE collaborates with local public health agencies, county human services, case management agencies, and other partners in the region to align resources, improve coordination of services, and reduce waste and inefficiencies.

Utilization Management

The ACC has several utilization management (UM) programs to ensure that services are available as needed but are used appropriately. ColoradoPAR is the Medicaid UM program for fee-for-service medical care such as physical/occupational therapies, imaging, and medical equipment.

RAEs have their own UM programs for behavioral health services to promote efficient and cost-effective care while reducing burden on providers. For example, RAE 3/5 launched its UM Centers of Excellence program to streamline SUD treatment authorization and get quality services to members who need them quickly. These efforts have led to better relationships with providers and a decrease in unnecessary denial rates. It reduces the need for medical director reviews and reduces administrative burden.

RAEs also have programs to prevent the use of expensive services of limited effectiveness. For example, RAE1 is partnering with ambulance providers to prevent unnecessary emergency department utilization by allowing paramedicine providers to treat instead of transport members when appropriate, or to transport to an alternative destination. RAE 2 completed a regional needs assessment looking at high-cost areas of the region and identified opportunities to reduce waste and increase efficiency in areas such as cultural competency and behavioral health capacity.

VII. Priorities for FY 2022-23

Advancing Health Equity and Social Determinants of Health

The Department outlined its health equity priorities in the recently published Health Equity Plan. During FY 2022–23, the ACC will continue to address gaps in health equity by continuing to close COVID-19 vaccination disparities and ensuring that members can access COVID-19 testing and treatment.

One of these priorities is maternal health. To address the racial disparities in maternal health outcomes, the Department established the Maternity Advisory Council to hear from members about their experiences and get their input on strategies to reduce disparities. The Department is using the reproductive justice model as an organizing framework to shape the Maternal Health Program. The Department leveraged new federal authority available through the ARPA to extend postpartum coverage from 60 to 365 days, effective July 1, 2022. Maintaining coverage for new birthing parents in this period will help reduce barriers to care and increase access to lifesaving services that have impact for generations. The Department will also release its next Maternity Report, which uses birth certificate data linked to health care claims data to analyze trends in perinatal care for Medicaid members. You can find the inaugural report published in 2021 on the Department's publication's page here.

Another equity priority is behavioral health. The Department continues to invest in behavioral health, expanding mobile crisis services and creating a new secure transport benefit that will reduce reliance on law enforcement for community response and transportation in a behavioral health crisis. The Department also continues to expand and strengthen the behavioral health safety net network and support the implementation of a transformative behavioral health legislative package that puts people first.

The Department is also focusing on prevention to address equity. The Department is standardizing practices to address unconscious bias in providers, address SDoH, bolster prevention and wellness services, and incorporate screening and counseling into chronic disease management. The Department also recognizes the value of including non-licensed health care providers such as peers, behavioral health aides, and community health workers to help build individual and community capacity to advance health equity.

Effective July 1, 2022, health equity plans are now in our ACC contracts and due to the Department on July 31, 2023. This important lever is foundational in achieving desired health outcomes as well as decreasing disparities for members. In addition to targeted interventions to population needs and health priorities, listening to the lived

experiences of members and shoring up data collection will help guide the Department's decisions and innovations to improve quality of care.

Advancing Innovations like the Prescriber Tool (above), Colorado Providers of Distinction and eConsults

- **Colorado Providers of Distinction**

  In partnership with stakeholders, the Department plans to design Colorado Providers of Distinction for Facilities. This will allow members to make informed decisions on where to access care. Members will get up-to-date information on the quality of care and patient experience at hospitals and other facilities through the Find-A-Doctor tool on the Health First Colorado website. PCMPs will be given this information through the Department's eConsult platform so they can make referrals for members to the highest performing facilities. A stakeholder-driven design process will begin in 2023.

- **eConsults**

  eConsults facilitate e-communications between a Medicaid PCMP and a specialist to expand care at the PCMP site. This reduces specialist appointment no-shows, improves access to specialists, and equips PCMPs to provide better care. If a specialist visit is appropriate, eConsult helps PCMPs make informed referral decisions with the emerging Providers of Distinction cost and quality indicators. The Department expects to select an eConsult vendor to operate the statewide platform by the end of 2022 and implement it in the summer or fall of 2023.

Alternative Payment Models

CMS has directed the Department and other Medicaid programs across the nation to have at least 50% of payments in a Value-Based Payment structure by 2025. The Department has multiple pathways in process to achieve that goal, in the following areas: the Hospital Transformation Program, Primary Care, Primary Care, Maternity Care, Prescription Drugs (with manufacturers), use of the Prescriber Tool, specialty care (Providers of Distinction outcomes), Nursing Homes, PACE Providers and more – many of which are directly tied to the ACC.

Behavioral Health Transformation & Partnership with the BHA

One of the bills passed in 2022 was HB 22-1278, which created the BHA, a cabinet member-led agency that is designed to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health

needs. This law tasks the BHA with collaborating to create new standards for providers and new payment models that consider not just the cost of services, but critical factors such as service quality, access to care, access for priority populations, and health equity.

The BHA will evolve over multiple years with core functions being added over time and full capacity being achieved in 2024. The BHA will require ongoing iteration and refinement as it addresses the priorities in the Blueprint for Behavioral Health Reform, identifies new and emerging behavioral health challenges to tackle, and invests in evidence-based practices to achieve positive outcomes for Coloradans.

The Department is partnering closely with the BHA to ensure that its new policies and initiatives are compliant with federal guidelines and align with other initiatives. The Department will continue to work with the BHA to continuously identify areas for improvement and to successfully implement the BHA's vision for a people-first behavioral health system.

Other American Rescue Plan Projects

In addition to leveraging the $450 million in ARPA funding intended to transform the behavioral health system, the Department received $530 million in federal funding to implement the state's ARPA funds for projects focused on improving access to home and community-based services and supports, strengthening the provider network, and investing in the critical workforce providing services. These projects will also improve access by expanding availability of services, streamlining processes, and enhancing quality for members and their families. The Department has launched all projects as of July 1, 2022.

Prescriber Tool

The Prescriber Tool will be an important tool that propels the ACC evolution in the area of prescription drug cost control, driving appropriate opioid use, and addressing social determinants of health. The current Phase I of the Prescriber Tool reduces overprescribing of opioids, improves control of prescription drug spending, eases administrative burden for prescribers, and improves service to members. Continuing to increase Prescriber Tool adoption (currently at over 40%) will be a priority going forward, as will the development of Phase II of the tool, which will enable providers to prescribe programs not just pills (e.g., prescribing WIC, diabetes programs, or maternity programs for pregnant women). This phase is in the request for proposal creation phase right now and will be bid and awarded in 2023. It will be a significant step forward to meet the health-related social needs of members.

Care Access

Increasing care access with a special focus in the areas of behavioral health, specialty care and care in rural communities. The RAEs all have unique interventions aimed at increasing access in rural areas, discussed above. Additionally, the Department is managing or supporting three workstreams, also discussed above, and funding to further improve access, quality outcomes, and affordability in rural communities.

Accountable Care Collaborative Phase III

The Department has begun work to design the next iteration of the ACC that is scheduled to start on July 1, 2025. The Department is actively working with partnering agencies to leverage emerging advances across the industry, and with stakeholders to design new policies and programs to ensure the ACC can achieve goals. These goals include improving health equity, access, quality, member and provider experience, and cost management. The design will focus on protecting both provider reimbursements and member benefits, which is especially important during economic downturns.

The ACC was created with a long-term vision to transform Colorado's health care delivery system to improve member health, serve the increasing number of Coloradans, and control costs for the state. The program continues to evolve and iterate in response to increasing pressure on an evolving health care system. The ACC program has shown its ability to innovate to improve member outcomes and reduce health care costs, and it is poised to continue to do so in the future.

VIII. Appendix

Appendix A. Overview of 2022 Behavioral Health Bills

Bill	Impact to Communities
HB22-1243 School Security and School Behavioral Health Services Funding	Funding for school-based and free therapy for all Colorado youth through iMatter increases access to screening, treatment, and crisis care. Reducing suicide risk and teaching healthy life skills ($20M)
HB22-1268. Medicaid Mental Health Reimbursement Rates Report	Price transparency for behavioral health rates helps us understand the costs of healthcare and make recommendations for more equitable payment models.
HB22-1281 Behavioral Health-care Continuum Gap Grant Program	Extraordinary investment for mental health and substance use prevention, treatment, and recovery services. Locally directed grants lead to better quality, more access, and a more connected system. ($90M)
HB22-1278 Behavioral Health Administration	An agency that will take accountability for an improved behavioral health system. Strategic plans and local partnerships are developed t ($4.3M for first year)
HB22-1283 Youth And Family Behavioral Health Care	Increasing access to services for youth who need comprehensive home and services and residential care. ($55M)
HB22-1302 Health-care Practice Transformation	Integrated care grants for communities. Builds up the behavioral health workforce, more locations where children and adults can find care. ($35M)
HB22-1303 Increase Residential Behavioral Health Beds	New residential care beds for adults with mental health and co-occurring needs. A new level of care for people who don't need to be in the hospital, but aren't healthy enough to be at home. ($130M)
SB22-106 Conflict of Interest in Public Behavioral Health	Supports patient-centered programs by reducing conflicts of interest among intermediaries that administer public funds (MSOs, ASOs, and BHASOs)
SB22-147 Behavioral Health-care Services For Children	Psychiatric consults for youth help other provider partners better assess and treat youth with behavioral health needs. Funding in schools mean easier and more direct connection to care for kids. ($11M)
SB22-148 Colorado Land-based Tribe Behavioral	Funds culturally competent residential treatment programs for American Indians and Alaskan Native populations, which are more

Health Services Grant Program	likely to support lasting recover ($5M)
SB22-156 Medicaid Prior Authorization & Recovery of Payment	Reduces administrative burden and costs for providers, so they have more time to see patients.
SB22-177 Investments In Care Coordination Infrastructure	AS we build all of these programs out, the BHA must ensure system navigators are available online and in person, and to train staff across the system so they can help connect patients to care. ($12M)
SB22-181 Behavioral Health-care Workforce	Creates a workforce plan that can be connected to all of the grants and programs, plus funding to attract people to the state and to the workforce ($72M)
SB22-196 Health Needs Of Persons In Criminal Justice System	People with behavioral health disorders often end up incarcerated instead of in treatment. This bill supports early intervention, deflection, and redirection from the criminal justice system grants, getting people the help they need when they need it most. ($61M)
HB22-1052 Promoting Crisis Services to Students	Make sure all youth in Colorado know who to call in a crisis ($282K)
HB22-1214 Behavioral Health Crisis Response System	Improves the state's Behavioral Health Crisis Response System, especially for individuals with substance use disorders, individuals with disabilities and youth.
HB22-1256 Modifications to Civil Involuntary Commitment	Creates new procedures for 72-hour emergency mental health holds, as well as short-term or long-term commitments. The bill also outlines processes related to transport, oversight, care coordination, and access to legal representation. (BHA: $522K)
HB22-1378 Denver-metro Regional Navigation Campus Grant	Creates the Regional Navigation Campus Grant Program to provide a grant to build or acquire, and facilitate, a regional navigation campus in the Denver metropolitan area to respond to and prevent homelessness. (DOLA: $50M; BHA: $45K)
SB22-211 Repurpose The Ridge View Campus	Convert the Ridge View Campus into a supportive residential community, run by the Department of Local Affairs (DOLA), to provide transitional housing, behavioral health services, medical care, vocational training, and skill development. (DOLA: $45M; BHA: $45K)
HB22-1326 Fentanyl Accountability and Prevention	Creates programs for fentanyl use prevention, education, and treatment and updates fentanyl-related offenses. (CDPHE: $15.6M; DHS: $14.5M; HCPF: $360K; Judicial: $1.3M; DPS: $39M)