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

December 1, 2020

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

Dear Senator Moreno:

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.

Attached is the Accountable Care Collaborative annual report for FY 2019-20. This report provides information regarding program enrollment, performance with an emphasis on member health impacts, program costs and fiscal performance, activities that promote access to services for Medicaid 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.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Dolin at Jo.Donlin@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2020 Accountable Care Collaborative Implementation Report

Cc: Representative Julie McCluskie, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Tracy Johnson, Medicaid Director, HCPF
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Bonnie Silva, Community Living Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Anne Saumur, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

December 1, 2020

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.

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Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2020 Accountable Care Collaborative Implementation Report

Cc: Senator Faith Winter, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Joann Ginal, Health and Human Services Committee
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Jo Donlin, Legislative Liaison, HCPF

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Department of Health Care
Policy & Financing

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

December 1, 2020

The Honorable Jonathan Singer, Chair
House Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the House Public Health Care 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.

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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 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2020 Accountable Care Collaborative Implementation Report

Cc: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Sonya Jacquez Lewis, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Kyle Mullica, Public Health Care and Human Services Committee
Representative Rod Pelton, Public Health Care and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

December 1, 2020

The Honorable Susan Lontine, Chair
House Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

Enclosed please find a legislative report to the House Health and Insurance 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 2019-20. This report provides information regarding program enrollment, performance with an emphasis on member health impacts, program costs and fiscal performance, activities that promote access to services for Medicaid 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.

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 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): HCPF 2020 Accountable Care Collaborative Implementation Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Kerry Tipper, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
Representative Perry Will, Health and Insurance Committee
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Anne Saumur, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Accountable Care Collaborative FY 2019-20

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

December 1, 2020

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

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Department of Health Care Policy & Financing

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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. At a minimum, the state department's report must include the following information concerning the accountable care collaborative:

(a) The number of Medicaid clients enrolled in the program;

(b) Performance results with an emphasis on member health impacts;

(c) Current administrative fees and costs for the program;

(d) Fiscal performance;

(e) A description of activities that promote access to services for Medicaid members in rural and frontier counties;

(f) A description of the state department's coordination with entities that authorize long-term care services for Medicaid clients;

(g) Information on any advisory committees created, including the participants, focus, stakeholder feedback, and outcomes of the work of the advisory committees;

(h) Future areas of program focus and development, including, among others, a plan to study the costs and benefits of further coverage of substance use disorder treatment; and

(i) Information concerning efforts to reduce Medicaid waste and inefficiencies through the accountable care collaborative, including:

(I) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment; reducing avoidable, duplicative, variable, and inappropriate uses of health care resources; and the outcome of those efforts, including cost savings, if known;

(II) Any statutes, policies, or procedures that prevent regional entities from realizing efficiencies and reducing waste within the Medicaid system; and

(III) Any other efforts by regional entities or the state department to ensure that those who provide care for Medicaid clients are aware of and actively participate in reducing waste within the Medicaid system.

Executive Summary

The Accountable Care Collaborative is on the core components of the state's Medicaid program. Launched in 2011, the Accountable Care Collaborative represents an innovative way to accomplish the Department's goals. The fundamental premise is that regional communities are in the best position to deliver the programs that will improve member health and reduce costs.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that to meet our members' complex health needs, progress must be iterative to keep pace with the dynamics of an evolving and changing health care system and macro environment.

Medicaid Cost Control

The affordability of health care continues to be one of the most significant challenges facing the Department, the state and the nation. Governor Polis and Lieutenant Governor Primavera have made it a top priority to ensure all Coloradans have access to affordable, quality healthcare. The Office of Saving People Money on Health Care published a *Roadmap to Saving Coloradans Money on Health Care,* providing short- and long-term action steps toward reducing patient costs while investing in long-lasting changes to improve the health system overall. The Department is a key player in these broader state efforts as the largest payer in the state providing health care coverage to about 1 in every 4 Coloradans, dedicated to a mission of service, and housing a wealth of health care experts called upon to drive innovative change.

The Accountable Care Collaborative is an important part of the Department's alignment with the Health Care Affordability Roadmap that includes the following strategies:

1. **Cost Transparency and Management**: In partnership with other health care thought leaders, the Department has focused on research, analytics and reporting that identifies the drivers of rising health care costs and alternatives to address them. The Department published two reports during FY 2019-20: "Reducing the Cost of Prescription Drugs" and "Colorado Hospital Cost Shift Analysis." These two areas of costs represent the major drivers of rising costs

2. **Benefit Design and Management**: The Department's Cost Control and Quality Improvement Office continued to develop tools to more effectively analyze Medicaid cost expenditures so the Department could review and revise benefit policies and procedures as appropriate.
3. **Statewide approach to addressing member health**: The Department is implementing a statewide approach to address the health care needs of members based on a clinical and data-driven analysis of the Medicaid population that has identified those members where the Accountable Care Collaborative is most likely to positively influence member health and program costs.

Accountable Care Collaborative

One entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions. In order to promote comprehensive and coordinated care for members, the RAEs contract with a network of Primary Care Medical Providers (PCMPs) to serve as our members' central point of care. The RAEs also provide and arrange for the delivery of mental health and substance use disorder services as the administrators of the Department's capitated behavioral health benefit. Integrating the care coordination for physical and behavioral health through one entity in each region improves the member experience and member health by establishing one point of contact and clear accountability for treating the whole person. This successful integration is the product of a decade of focus and execution by the Department, in alignment with directives from our federal partners including a SIM grant of more than $65 million, and parallel strategies employed in the commercial market in Colorado and across the nation.

The RAEs have leveraged this integration platform and approach to more effectively address the full range of our members' needs. Instead of just focusing on a member's physical health needs, they are able to screen for problems with mental health or substance use and more readily and consistently connect a member to follow-up services when necessary. In addition, the RAEs have established relationships with many community organizations to link members to essential services, such as food, housing, and transportation. For example, when working with a pregnant woman, the

RAEs will screen members for depression, connect them with smoking cessation programs when needed, link them to parenting and other related programs, and help the member access food and other essential services. In doing so, the RAEs are able to increase the likelihood of a healthy pregnancy and the subsequent delivery of a healthy baby.

The Accountable Care Collaborative also provides the platform for the Department to pursue both targeted and structural approaches to controlling Medicaid costs in alignment with state priorities. Specifically, the unique design of the Accountable Care Collaborative provides a flexible delivery system within which the Department can innovate and expand efforts to improve the affordability of healthcare. For example, the RAEs have a primary role in the regional implementation of the Department's new statewide approach for clinical management of members with complex health needs and members with one of the Department's targeted health conditions. Through care coordination, leveraging existing community-based programs, and the delivery of preventive and supportive services, the Department expects to reduce utilization of services that do not improve member health, prevent disease progression, promote members' ongoing health, or reduce costs.

Enrollment in the Accountable Care Collaborative

The Department implemented mandatory enrollment into the Accountable Care Collaborative for all full-benefit Medicaid members, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). In FY 2019-20, average monthly enrollment in the Accountable Care Collaborative was 1,161,545. This enrollment number includes members participating in the Accountable Care Collaborative limited managed care capitation initiatives: Rocky Mountain Health Plans Prime (37,624 members) and Denver Health Medicaid Choice (86,975 members). FY 2019-20 enrollment reflects a decrease from FY 2018-19 of 38,537 (3.2%), reflecting our #1 economy in the nation and a booming economy during that period that helped Coloradans gain employment - and with that - employer-sponsored health care coverage.

Program Performance

The Accountable Care Collaborative aims to improve health outcomes and the health care experience for all Medicaid members. One primary tool for the Department to measure and monitor program performance is the Pay-for-Performance Program. The RAEs are able to earn financial incentives for achieving performance and programmatic objectives through three components: Key Performance Indicators, the Performance Pool, and the Behavioral Health Incentive Program. The following are highlights of performance results:

- Nearly 19% of members received a behavioral health service; this was an increase of greater than 2% from the previous year.
- For 64% of newborn deliveries, the mother received a prenatal care visit during pregnancy. This was an 8.7% increase from the previous year.
- On average, 61% of members who received inpatient treatment for a mental health condition during FY 2018-19 received follow-up within 7 days following discharge.
- The RAEs and their provider networks were able to increase member engagement in substance use disorder treatment by 1.4% during FY 2018-19 from a statewide average baseline.
- The number of members who received a mental health service after a positive depression screen increased by 2.3% from the statewide average baseline during FY 2018-19.
- For the first time in many years, the ACC reported a 1.3% increase in emergency room visits. The reason for the increase is unclear, but may be propelled by the initial impact of COVID19. Our promptly implemented telehealth policy has addressed that since as members are adapting to this emerging and innovative alternative. Increasing ER/ED visits may also be the result of the increasing number of standalone ER/EDs that have been constructed across the front range over the last number of years. On the latter, the Department is using multiple strategies to decrease emergency visits as part of the Governor's Office's Wildly Important Goals for FY 2020-21. One such strategy includes collaborating with hospital systems who own most of these standalone ER/ED sites to reverse this inefficient delivery system trend by repurposing such sites to provide valued services such as primary care and behavioral health care. A value-based incentive has been

established as part of the Hospital Transformation Program to do just that, which is a systemic complement to our comprehensive attribution approach, and the RAE outreach and education to high utilizers of ER/ED services.

Financial Performance

Program costs for the Accountable Care Collaborative include administrative costs and all expenses for benefits and services provided during FY 2019-20, including capitations, pharmacy, inpatient, outpatient, emergency room, Long-Term Services and Supports (LTSS), home health, and professional claims. For this report, the Department performed a straight comparison of FY 2019-20 expenditures to FY 2018-19 expenditures for all full-benefit Medicaid members, excluding those enrolled in PACE.

The total amount paid for the Accountable Care Collaborative in FY 2019-20 was $8.15 billion – a 3.8% increase from the previous fiscal year. Total costs are divided by total member months to yield an average program cost PMPM for the fiscal year. In FY 2019-20, the average paid PMPM was $564. This was a 7.2% increase from FY18-19, when the average paid PMPM was $526. The primary increases in total costs included:

- An increase of $40,640,506 in administrative costs based on the timing of Pay-for-Performance payments and distributing funds for a full 12 months of performance instead of only 6 months of performance during FY 2018-19.
- The behavioral health capitation payments increased by $50,190,043 (or 8.47%) based on a 2% legislative appropriation to increase salary reimbursement for community-based behavioral health providers, as well as increased utilization partially driven by the RAEs' efforts to increase member access to behavioral health services.
- Fee-for-Service benefits and services saw increases from FY2018-19 as a result of both changes in caseload and an increase in utilization of services. The largest increases in costs continued to occur in Long-Term Services and Supports, Pharmacy, and Home Health and Private Duty Nursing.

For this year's annual report, the Department evaluated whether member engagement with a PCMP, a pillar of the Accountable Care Collaborative, had an impact on costs. To conduct the evaluation, the Department compared the expected per member cost in FY 2019-20 to their observed cost. The Department is able to estimate the expected

annual costs for members using an assigned risk score produced by IBM that takes into account a member's diagnoses, eligibility category, and demographics. The analysis found that members who engaged with a PCMP in either FY 2018-19 or FY 2019-20 were less costly than expected. While there may be differences among those who do and do not use primary care, **when accounting for the difference between the expected and observed annual costs in FY 2019-20, the Department saved up to $43.6 million for members who engaged with a PCMP.**

The analysis of PCMP engagement indicates that the Accountable Care Collaborative's model and focus on and support for member engagement with a PCMP results in cost savings for the Department. While the RAEs have limited ability to influence costs in some of the Department's primary cost drivers, such as Long-Term Services and Supports and new high cost, specialty prescription drugs, they are able to move the needly within their PCMP and behavioral health networks to control costs and improve member health. Examples of effective RAE activities include:

- RAEs have instituted quality-based payment tiering structures that offer higher administrative payments to PCMPs who demonstrate improved management of member health.
- RAEs have established processes and community relationships to help address members' social determinants of health as a critical first step to addressing members' health care needs.
- Formal and informal assessments of members' behavioral health needs have been integrated into many of the RAEs' and PCMPs' interactions with members to help connect members more quickly to behavioral health services when members can benefit from such care and support.
- RAEs have implemented a variety of strategies to ensure members have the supports and resources they need to access community-based services and to prevent inpatient admissions and readmissions for both physical and behavioral health conditions.

Responding to COVID-19

The Department leveraged the flexible nature of the Accountable Care Collaborative and the RAEs to respond to the coronavirus (COVID-19) pandemic that emerged in early 2020. The RAEs implemented outreach and engagement activities for members

identified as being most at risk for serious health consequences if they contracted COVID-19, along with other member outreach, education, and support services. The Department and the RAEs also partnered to provide both financial and practice support to primary care and behavioral health providers to help them adjust to the rapid changes in delivering health care services. Examples of efforts included:

- The Department reallocated earned pay-for-performance funds for immediate distribution to support struggling providers through the sudden and dramatic COVID19 impact.
- RAEs partnered with and provided financial support to community organizations to propel the provision of housing and wraparound services for homeless individuals and other vulnerable populations, including help accessing food.
- For members who received Long-Term Services and Supports, the RAEs collaborated closely with their regional partner agencies on outreaching members identified as being at high-risk for poor outcomes from COVID-19.
- RAEs provided a variety of operational, technical, and practice support to their network providers to support the transition to telemedicine and other virtual care models.
- RAEs established alternative funding strategies available under the capitated behavioral health program to support Community Mental Health Centers (CMHCs) in creatively meeting Medicaid members' needs.

FY 2019-20 General Operations

In FY 2019-20, the Department worked with the RAEs to implement and refine the statewide approach to addressing member health. With the onset of COVID-19, the last four months of the fiscal year were focused on activities to ensure members were informed about COVID-19 and could remain safe, while also supporting providers to make changes in how they delivered clinical care. Some of the highlights of RAE activities during FY 2019-20 include:

- Before COVID-19, the RAEs implemented a number of strategies to increase member and provider access to behavioral health services using telehealth. Following the onset of COVID-19, the RAEs expanded the utilization of telehealth services in their regions by training providers, offering software

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platforms and other resources to providers, and making phones, tablets, and internet access more readily available to members.

- In addition to telehealth, the RAEs promoted access to care in rural and frontier counties by collaborating with community agencies for outreach to members and resource referrals.
- RAEs increased collaboration with Long-Term Services and Supports providers by including representatives in regional advisory committees, hiring liaisons, and creating an incentive program to target collaborative efforts.
- The Department continued to leverage the RAEs' oversight for both behavioral health and physical health to reduce duplicative and inappropriate service utilization.

Advisory Committees and Stakeholder Engagement

The Accountable Care Collaborative has been committed to staying connected to its members and being responsive to the input of stakeholders. The Program Improvement Advisory Committee (PIAC) was the program's main forum for stakeholder engagement and feedback. In FY 2019-20, the PIAC focused on providing recommendations to improve performance measurement for both the Accountable Care Collaborative and Alternative Payment Model, creating alignment between the Colorado Crisis Service System and the Accountable Care Collaborative, examining member access to specialty care, understanding provider needs for practice transformation, and exploring care coordination models and chronic disease management strategies. In addition, each RAE hosted a regional program improvement advisory committee to identify community-level needs and develop solutions. All RAEs operated Medicaid member advisory councils to incorporate the member perspective into program operations.

Looking Forward

Controlling costs for Health First Colorado will be even more critical in the months and years ahead given the economic downturn and the resulting impact on the state budget, of which Health First Colorado is a major portion. Below are some initiatives that will move the Accountable Care Collaborative and the Department forward in improving the affordability of Medicaid now and in future years.

- The Department is implementing RAE condition management strategies to improve members' health and reduce costs for members with prevalent conditions identified by the Department where member education, care coordination and case management strategies are most likely to improve member health and reduce claim costs.
- A prescriber tool will be implemented in FY 2020-21 that will give prescribers the tools and resources to encourage utilization of clinically appropriate and cost-effective prescriptions. It will also include an opioid module to battle the inappropriate overprescribing of opioids, which reduces addiction and improves member health and outcomes.
- Beginning with maternity, the Department is developing bundled payment strategies that create specialist accountability for patient outcomes while rewarding innovations that improve quality and keep the total cost of care low for targeted episodes of care.
- The Department will continue to support innovation in primary care by evolving existing alternative payment methodologies and implementing new models as part of the Accountable Care Collaborative.
- Beginning January 1, 2021, the Department will add residential and inpatient substance use disorder services as a Medicaid covered benefit in accordance with House Bill 18-1136.
- The Department is working on eConsult and Centers of Excellence systems and reporting that will increase care delivered at the primary care level and also increase referrals to delivery systems that are proven to improve quality outcomes and reduce costs specific to the specialty care required.
- The Department is evolving and refining its PCMP analytics to help these critical partners understand their opportunities to better improve quality and reduce costs based on their patient population, referral patterns and care management programs.
- The Department is working with federal partners to submit a proposal to import prescription drugs from Canada.

The Department has taken a significant step to improve health outcomes and bend the cost curve by integrating the administration of physical health and behavioral health under the RAEs. Effectively leveraging this infrastructure in tandem with other

Department initiatives will begin to generate greater improvements in member health, member experience, and cost containment.

I. Introduction

The Accountable Care Collaborative is one of the core components of the state's Medicaid program. Launched in 2011, the Accountable Care Collaborative represents an innovative way to accomplish the Department's goals. The fundamental premise is that regional communities are in the best position to deliver the programs that will improve member health and reduce costs.

The Accountable Care Collaborative represents an innovative way to accomplish the Department's goals. It differs from a capitated managed care program by blending capitated behavioral health services with a managed fee-for-service physical health program. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The Accountable Care Collaborative relies on four core components:

- Seven regional organizations (called Regional Accountable Entities or RAEs), each accountable for the program in a different part of the state.
- Primary Care Medical Providers (PCMPs), which are medical homes for members.
- Comprehensive community-based system of mental health and substance use disorder services.
- Data and analytics, to give the Department, RAEs, and PCMPs actionable information on individual members and the program population as a whole.

The Accountable Care Collaborative was designed with a long-term vision in mind, and the understanding that to meet our members' complex health needs, progress must be iterative to keep pace with the dynamics of an evolving and changing health care system and macro environment. The program provides the platform from which other health care initiatives, such as medical homes, health information technology and payment reform, can thrive as they better serve members and create value.

II. Background and Overview

A. Accountable Care Collaborative Model

One entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions. The RAE contracts with a network of PCMPs and functions as a Primary Care Case Management Entity

with accountability for member health outcomes and fee-for-service physical health costs. In addition, the RAE administers the Department's capitated behavioral health benefit through a contracted network of behavioral health providers.

Figure 1. Map of Accountable Care Collaborative Regions

PCMPs are a core component of the Accountable Care Collaborative model. They serve as the member's central point of care and promote comprehensive and coordinated care for a positive member experience and better health outcomes. All members are attributed to a PCMP upon their enrollment into the program; members can select a different PCMP at any time.

The RAEs are responsible for distributing administrative payments to their contracted PCMPs to incentivize the delivery of comprehensive, cost effective, team-based, quality care as well as improvements in member health. All RAEs have implemented quality-based, tiered payment structures that have been

instrumental in preparing providers for participation in more complex value-based payment arrangements being designed by the Department and the Centers for Medicare and Medicaid Services (CMS). These payment strategies also help ensure members have access to high quality services by incentivizing continued quality improvement among PCMPs.

In addition to the RAEs, the Department operates two physical health limited managed care capitation initiatives as part of the Accountable Care Collaborative: Denver Health Medicaid Choice and Rocky Mountain Health Plans Prime. These initiatives are authorized by C.R.S. 25.5-5-415. Rocky Mountain Health Plans Prime is operated as part of the Region 1 RAE contract, while contracting for Denver Health Medicaid Choice changed in accordance with House Bill 19-1285 on January 1, 2020. This legislation resulted in a Department contract directly with Denver Health. Denver Health is partnering with the RAE in Region 5 to administer the capitated behavioral health benefit for its members. Both initiatives are to be administered in a manner that maximizes the integration of behavioral health and physical health services for enrolled members. While these initiatives are operated as part of the Accountable Care Collaborative, detailed reporting of the initiatives were provided in a separate report due April 15, 2020 as required by C.R.S. 25.5-5-415 (4) (a).

Effective management of the Department's capitated behavioral health benefit is also critical to the success of the Accountable Care Collaborative. The capitated behavioral health benefit offers an array of mental health and substance use disorder services for all members. The RAEs leverage the full continuum of mental health services covered by the capitation to provide a safety net for some of the Department's most vulnerable members who experience serious and persistent mental illness and serious emotional disturbance. The capitated behavioral health benefit has historically been credited with directly decreasing the length and number of psychiatric hospitalizations. As administrator of the capitated behavioral health benefit, the RAE has primary accountability for promoting optimized behavioral health and wellness for all members and providing or arranging for the delivery of medically necessary mental health and substance use disorder services.

The RAE is responsible for ensuring timely and appropriate access to medically necessary services offered by the full range of Medicaid providers in the Health Neighborhood, including specialty, hospital, and home-based care, to meet the health and functioning needs of members. The RAE is charged with establishing infrastructure and promoting provider access and utilization of tools and resources that will enable them to serve members with complex conditions, obtain brief specialty consults, and make appropriate, timely, and coordinated referrals for members requiring more intensive specialty care.

The RAE uses their expanded scope to promote the population's health and functioning, coordinate care across disparate providers, interface with Long-Term Services and Supports (LTSS) providers, and collaborate 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 a cohesive network of providers that work together effectively to provide coordinated health care services to members. Having one entity improves the member experience by creating one point of contact and clear accountability for treating the whole person.

B. Medicaid Cost Control/Healthcare Affordability

Medicaid Cost Control

The affordability of health care continues to be one of the most significant challenges facing the Department, the state and the nation. Governor Polis and Lieutenant Governor Primavera have made it a top priority to ensure all Coloradans have access to affordable, quality healthcare. The Office of Saving People Money on Health Care published a *Roadmap to Saving Coloradans Money on Health Care,* providing short- and long-term action steps toward reducing patient costs while investing in long-lasting changes to improve the health system overall. The Department is a key player in these broader state efforts as the largest payer in the state providing health care coverage to about 1 in every 4 Coloradans, dedicated to a mission of service, and housing a wealth of health care experts called upon to drive innovative change.

The Accountable Care Collaborative is an important part of the Department's subset of Health Care Affordability Roadmap that includes the following strategies:

1. **Cost Transparency and Management**
2. **Benefit Design and Management**
3. **Statewide approach to addressing member health**

Each of these focus areas are explained below.

1. Cost Transparency and Management

In partnership with other health care thought leaders, the Department has focused on research, analytics and reporting that identifies the drivers of rising health care costs and alternatives to address them. The Department published two reports during FY 2019-20: "Reducing the Cost of Prescription Drugs" and "Colorado Hospital Cost Shift Analysis." These two areas of costs represent the major drivers of rising costs.

- **Reducing the Cost of Prescription Drugs:** The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid, Child Health Plan Plus (CHP+) and all health plans. In December 2019, the Department released this report laying out a set of comprehensive changes that would favorably impact prescription drug costs and the out-of-pocket costs for families covered by commercial insurance, while achieving a meaningful reduction in the total cost of prescription drugs for the Department. This report is being updated for a December 2020 release.

- **Colorado Hospital Cost Shift Analysis:** While Colorado is fortunate to have strong health outcomes and health coverage, Colorado's hospital prices are some of the highest in the country with wide variance between hospitals in the prices for individual procedures, inpatient and outpatient care. The Colorado Hospital Cost Shift Analysis published by the Department in January 2020 provided a thorough analysis of the price, costs and profits across the hospital industry in Colorado The Department is leveraging the insights from this report, as well as the emerging insights from Department bills on financial transparency and not-for-profit hospital community investments to drive improved hospital affordability policy to the betterment of Coloradans, their employers, the state and taxpayers.

Hospitals are a critical component of the health care delivery system, as well as a significant cost expenditure. The Department is implementing several initiatives to monitor and control costs, while improving member health.

- The Department began collaborating with the Colorado Hospital Association to implement cost and quality analytics tools that help identify potentially avoidable costs and complications, enabling hospitals to improve member health and control costs by procedures.

- The Department is collaborating with the Attorney General's Office and the Colorado Hospital Association and CIVHC to create reports that identify centers of excellence which will enable patient referrals that result in better outcomes and lower costs.

- The Hospital Transformation Program is a five-year hospital reform initiative that builds upon the hospital supplemental payment program to incorporate value-based purchasing strategies into existing hospital quality and payment improvement initiatives. Several of the Hospital Transformation Program measures are also RAE performance measures, while other measures require hospitals to share member-level information with the RAEs. Having aligned incentives and data sharing between hospitals and the RAEs is expected to improve communication and coordination among the entities and result in better member health and experience.

2. Benefit Design and Management

The Department's Cost Control and Quality Improvement Office continues to develop tools to more effectively analyze Medicaid cost expenditures. Through this work, the Department is identifying benefits that warrant enhanced management and policy review. As an example, the Department has begun work to implement prior authorization requirements for adults requiring long-term home health services and a private duty nursing assessment tool for adults in an effort to ensure services are appropriate and medically necessary. In addition,

the Department is incentivizing the RAEs to increase the delivery of targeted care coordination for members receiving long-term home health.

At the same time, the Department is reviewing its benefits to identify any potential gaps in the care continuum. Such gaps in the availability of lower-cost, evidence-based treatments could accelerate disease progression and/or drive members to higher-cost treatment services.

3. Statewide Approach to Addressing Member Health

The Department has begun implementing a statewide approach to address the health care needs of members based on a clinical and data-driven analysis of the Medicaid population and a review of the RAEs' existing care management and coordination efforts. Utilizing a Clinical Risk Stratification Dashboard, the Department has looked across all populations to identify those members where the RAEs and their provider networks are most likely to positively influence member health and program costs. The Population Management Framework features three primary strategies to target the RAEs resources where they are most likely to have the greatest impact.

- **Complex Care Management**: For the state's most vulnerable members with the highest acuity of conditions, the Department and the RAEs remain focused on identifying and implementing best practices that can streamline coordination of care delivered by multiple systems, improve member health and basic functioning, efficiently utilize health care resources, and reduce overall costs.

- **Condition Management**: The Department's analysis of the prevalence, comorbidity, and cost of the top conditions present across the Medicaid population resulted in a selection of conditions for the RAEs to target. The RAEs are accountable for ensuring specific condition management programming is available for the evidence-based management of these conditions, such as maternity, diabetes, cardiovascular disease, anxiety, and substance use disorders. RAEs will focus their resources on conditions that are of highest prevalence or need in their region.

- **Prevention and Wellness**: While the majority of Medicaid members do not require complex care or condition management, they are often at high-risk for poor health and social outcomes. As a result, the Department is committed to partnering with the RAEs and providers in delivering preventive and supportive services that promote members' ongoing health and reduce the risk of the development of chronic and complex conditions.

- **Evolving System Delivery**. The Department is evolving eConsults and centers of excellence insights and reporting to increase capacity and support for PCMPs and to help PCMPs refer their patients to health system specialty care sites that delivery higher quality outcomes and lower costs – improving both member health and affordability.

As the delivery system for nearly all full-benefit Medicaid members, the Accountable Care Collaborative impacts and is impacted by all the initiatives the Department is implementing to control health care costs. Its design provides a flexible delivery system within which the Department can innovate and expand efforts to improve affordability. In addition, the RAEs provide a valuable resource to disseminate, train, and educate providers about any new tools the Department makes available to providers, such as the planned release of a prescription tool.

C. COVID-19 Public Health Emergency

The novel coronavirus (COVID-19) pandemic that emerged in early 2020 had an unprecedented impact on the health care sector, the economy, and our most vulnerable Coloradans. Following the declaration of a public health emergency on January 31, 2020, by the U.S. Department of Health and Human Services Secretary, the Department worked to modify its programs and benefits to ensure members had access to medically necessary treatment while protecting both providers and members from the spread of COVID-19.

In the initial weeks of the public health emergency, the state and the federal government passed a number of policy changes related to provider enrollment, payment, prior authorization, telemedicine and care delivery. The Department anticipates that some of these changes will be reversed, but others – in whole or

in part – may evolve into a permanent policy. The Department is actively studying emerging best practices in an effort to drive "a new normal in healthcare" to the betterment of the health and well-being of Coloradans and the affordability of our safety net programs and the cost of healthcare to all Coloradans.

At the same time, the Department leveraged the Accountable Care Collaborative and the RAEs to respond to the emergency. The RAEs implemented outreach and engagement activities for members identified as being most at risk for serious health consequences if they contracted COVID-19, along with other member outreach, education, and support services. The Department and the RAEs also partnered to provide both financial and practice support to primary care and behavioral health providers to help them adjust to the rapid changes in delivering health care services. Examples of efforts included:

- RAEs provided a variety of operational, financial, technical, and practice support to their network providers, including assistance with securing Personal Protective Equipment (PPE), thermometers, and other resources essential to providing clinical care during the pandemic.
- RAEs established alternative funding strategies available under the capitated behavioral health program to support Community Mental Health Centers (CMHCs) in creatively meeting Medicaid members' needs.
- The Department reallocated pay-for-performance funds for immediate distribution to support struggling providers.
- The Department supported the RAEs and community partners in utilizing Medicaid services to support members who test positive for COVID-19 while experiencing homelessness.
- RAEs partnered with and provided financial support to community organizations to support the provision of housing for homeless individuals and other vulnerable populations, and to help with food security.
- RAEs supported their network providers in the transition to telemedicine and other virtual care models.

COVID-19 has changed the way patients seek care and how that care is delivered. It has also exposed systematic limitations as well as opportunities. The

public health crisis and the secondary and tertiary crises that followed are the largest factors shaping the Department's FY 2020-21 priorities.

The Department's strategy has adjusted to recognize the emerging "new normal in healthcare," with a focus on sustaining and driving positive changes to the system. For example, telemedicine visits have increased and inappropriate emergency room visits have decreased as Coloradans avoid unnecessary interactions that increase the risk of COVID-19 transmission. By driving a new normal in healthcare, the Department can also leverage telemedicine services to reduce barriers to care like transportation, while also addressing traditional care access concerns for people with disabilities, older adults and rural Coloradans.

III. Accountable Care Collaborative Enrollment

This section describes the process for enrolling members into the Accountable Care Collaborative and provides data on the number of members enrolled for FY 2019-20.

A. Enrollment Numbers

In FY 2019-20, average annual enrollment in the Accountable Care Collaborative decreased based on gradual decreases in Medicaid enrollment for the first nine months of the fiscal year. Medicaid enrollment grew over the last three months of the fiscal year based on federal policies associated with COVID-19 and the economic recession. Individuals who have become unemployed during the pandemic have begun enrolling in Medicaid, and the Department is currently prevented from disenrolling members during the Public Health Emergency in accordance with the Families First Coronavirus Response Act (P.L. 116-127).

The average Accountable Care Collaborative enrollment in FY 2019-20 was 1,161,545, a decrease of 38,537 (3.2%) from FY 2018-19. This enrollment number includes members participating in the Accountable Care Collaborative limited managed care capitation initiatives: Rocky Mountain Health Plans Prime (37,624 members) and Denver Health Medicaid Choice (86,975 members).

Table 1 shows Accountable Care Collaborative average enrollment by population.

Population	Number of Accountable Care Collaborative Members	Percent of Total Accountable Care Collaborative Members
Children without disabilities	478,912	41.23%
Adults (without disabilities) **eligible after** the Affordable Care Act expansion	374,080	32.21%
Adults (without disabilities) **eligible before** the Affordable Care Act expansion	219,903	18.93%
Children and adults with a disability, including Medicare-Medicaid members	88,650	7.63%
TOTAL	**1,161,545**	

B. Accountable Care Collaborative Enrollment Process

All full-benefit Medicaid members are mandatorily enrolled into the Accountable Care Collaborative, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly. As the Accountable Care Collaborative serves as the delivery system for Medicaid, members do not have a choice to opt out. That said, members do retain choice of their PCMPs and providers for all fee-for-service physical health benefits and can opt-out of the limited managed care capitation initiatives and choose, or be assigned, a PCMP.

A foundational principle of the Accountable Care Collaborative is that every member has a central point of care through a PCMP or limited managed care capitation initiative. To ensure that every member began with a central point of care, the Department established a two-step enrollment process that is active the day the Department receives notification of a member's Medicaid eligibility:

1. Members are first attributed to a PCMP or limited managed care capitation initiative (if they met the geographic and eligibility requirements for one of those initiatives).
2. Members are then assigned to a RAE based on the location of the member's PCMP or limited managed care capitation initiative.

Attribution to a PCMP (step 1 above) was based on the following process:

1. Members with claims history with a PCMP during the previous 18 months are attributed to that PCMP.
2. Members without any claims history are attributed to either a PCMP of a relative living in the member's household or a PCMP located close to the member.

Members are notified by mail when they are attributed to a PCMP or limited managed care capitation initiative and assigned to a RAE. The notification includes information on how a member can select or change their PCMP at any time or how they have 90 days to opt out of the limited managed care capitation initiative and select a PCMP. Member choice always takes priority over system assignment.

IV. Program Performance

The Accountable Care Collaborative aimed to improve health outcomes and the health care experience for all Medicaid members. One primary tool for the Department to measure and monitor program performance is the Pay-for-Performance Program. The Accountable Care Collaborative's Pay-for-Performance Program enables the RAEs to earn financial incentives for achieving performance and programmatic objectives. It consists of three components:

1. **Key Performance Indicators:** The Key Performance Indicators (KPIs) are designed to assess the overall health of the ACC program and reward RAEs for improvement of the regional delivery system as a whole. The Department selected measures that highlight the RAEs progress toward building a coordinated, community-based approach to meet member health needs and reduce costs.

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2. **Performance Pool:** Funds for the Key Performance Indicators that did not get distributed to the RAEs went into a pool of funds available for additional performance and programmatic incentives. Annually, the Department identifies the performance and programmatic priorities that align with state and Department initiatives.
3. **Behavioral Health Incentive Program:** The Department monitors the performance of the behavioral health system and rewards RAEs for performance improvement utilizing the Behavioral Health Incentive Program.

For this report, the performance data includes updates on FY 2018-19 performance measures not available for last year's annual report and performance during the first nine months of FY 2019-20 (July 1, 2019-March 31, 2020). The reason for the differing time frames for reporting performance results is because at least three months are required following the end of a performance period to allow sufficient time for the submission and payment of claims, and then time is needed to calculate the measures and validate the results. The claims runout period is longer for calculating the Behavioral Health Incentive Program. As a result, the performance data presented does not reflect the RAEs' complete performance for FY 2019-20.

A. Key Performance Indicators

For the second phase of the Accountable Care Collaborative, 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 ($4) of the RAE's Per-Member Per-Month (PMPM) administrative fee is withheld for KPIs. The RAEs can earn quarterly (sometimes annual or semi-annual) KPI incentive payments equaling all or part of the $4 PMPM by achieving certain performance levels on the KPIs identified by the Department.

The following reflects the statewide performance on the KPIs during FY 2019-20[1]:

1. **Potentially Avoidable Costs:** The Department has been utilizing the PROMETHEUS tool with the RAEs that compares a standard cost of an

[1] The data included in this report reflects the RAE performance for the 12-month period ending March 31, 2020. The full year's performance could not be reported due to claims run-out and data validation.

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episode of care to actual costs. Performance payments were based on process measures regarding the RAE's implementation of this tool into their cost control operations and management.

2. **Emergency Department Visits:** Number of emergency department visits, per 1,000 members per year risk-adjusted. FY 2019-20 was the first time in many years that the Accountable Care Collaborative reported a 1.3% increase in emergency room visits from the previous fiscal year, as discussed above.
3. **Behavioral Health Engagement:** Percent of members who access behavioral health services. On average, nearly 19% of members received at least one behavioral health service during FY 2019-20; this was an increase of greater than 2% from FY 2018-19.
4. **Well Visits:** Percent of members who receive a well visit during the 12-month evaluation period. There was an average increase of 1.33% of members who received a well visit during FY 2019-20, for a total of 30.39%.
5. **Prenatal Engagement:** Percent of deliveries where a woman received a prenatal care visit during pregnancy. For 64% of newborn deliveries, the mother received at least one prenatal care visit during pregnancy. This was an 8.7% increase from FY 2018-19.
6. **Dental Visit:** Percent of members who received professional dental services. Dental visits increased by nearly 6% from FY 2018-19 to a statewide average of approximately 42%.
7. **Health Neighborhood:** This KPI is comprised of two components that reflect connections and referrals between specialty care and primary care providers. One component monitors how many PCMPs established or renewed care compacts with specialty care providers to facilitate referrals and the coordination of care for members over the previous 12 month period. In FY 2019-20, the number of PCMPs with care compacts decreased from 320 to 313. The other component is a claims-based measure looking at indications that a specialist visit resulted from a referral from a PCMP. The RAEs' performance on this component remained approximately the same as the previous fiscal year. The Department is committed to ensuring appropriate utilization of specialty care resources and continues to work with the RAEs to

identify other potential methods to effectively monitor the RAEs efforts to reduce unnecessary utilization of specialty care.

Table 2 provides individual performance data for each of the RAEs.

Table 2: FY 2019-20 RAE KPI Performance[2]

RAE	ED (per 1000 per year)	BH Engage	Well Visits	Prenatal Engage	Dental Visits	Care Compact	Health Neighbor Claims
1	609	16.19%	32.79%	54.59%	42.48%	53.47%	1.74%
2	614	17.21%	25.43%	63.23%	41.42%	0.00%	3.08%
3	669	17.05%	35.40%	60.74%	44.41%	26.32%	1.64%
4	541	19.56%	25.33%	70.33%	37.68%	3.54%	3.08%
5	645	21.46%	33.39%	74.91%	45.02%	22.73%	2.01%
6	588	21.09%	31.41%	60.58%	41.20%	53.91%	1.91%
7	723	18.87%	29.01%	65.95%	39.90%	62.63%	1.40%

B. Performance Pool

Utilizing Pay-for-Performance Program funds that were not distributed for achieving Key Performance Indicator targets, the Department incentivized the RAEs to implement strategies to address the Department's identified complex populations and top chronic conditions. This included:

- RAE activities to increase the percentage of Department identified high-cost members receiving care coordination.
- Utilization and collaboration with perinatal/maternity programs available in the region.
- Utilization and coordination of programs in the RAE's region addressing the Department's identified top chronic conditions, including member communications on the programs, the percent of members participating, and the number of providers for each program.

[2] The data included in this table reflects the RAE performance for the 12-month period ending March 31, 2020. The full year's performance could not be reported due to claims run-out and data validation.

- Collaboration with institutions for mental diseases to improve processes, procedures, and reimbursement for members who require inpatient mental health treatment.

In response to the COVID-19 pandemic, the Department decided to leverage the Performance Pool to indirectly support PCMPs. The Department was able to distribute $7.6 million to RAEs to proactively support providers during the public health emergency ($3.7 million was distributed in May 2020 and $3.8 was distributed in August 2020). RAEs attested to distributing 100% of that funding to PCMPs in their network to alleviate the financial impact of the COVID-19 pandemic. The amount of financial support received per PCMP ranged from about $5,800 to $15,000, with a median amount per PCMP of $11,460.

C. Behavioral Health Incentive Program

The Behavioral Health Incentive Program was developed in collaboration with the Office of Behavioral Health and the previous Behavioral Health Organizations in 2017 and is based on standard performance measures collected by the agencies. Payment is based on annual performance and is not finalized until 6-9 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 2019-20 were for the RAEs' performance during FY 2018-19.

The following are the performance measures and the statewide results for the FY 2018-19 performance period:

1. **Engagement in Outpatient Substance Use Disorder (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. The RAEs and their provider networks were able to increase member engagement in substance use disorder treatment by 1.43% from the FY 17-18 statewide average baseline.
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. On average, 61% of members who received inpatient treatment for a mental health condition during FY 18-19 received follow-up within 7 days following discharge. This was an increase of 1.65% from the FY 17-18 statewide average baseline.

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. During FY 2018-19, performance improved by 1.33% from the statewide average baseline.
4. **Follow-up after a Positive Depression Screen:** Percent of members engaged in mental health service within 30 days of screening positive for depression. Follow-up after a positive depression screen increased by 2.3% from the statewide average baseline.
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. Assessments and screening of children in foster care increased by an average of 2.16% during FY 2018-19 from the statewide average baseline.

Table 3 provides individual performance data for each of the RAEs.

Table 3: FY 2018-19 RAE Behavioral Health Incentive Program Performance

Metric	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
SUD Engagement	41.91%	37.24%	36.96%	35.69%	34.03%	35.36%	47.02%
MH Follow-up	65.00%	70.20%	54.04%	76.68%	60.86%	42.96%	62.95%
SUD Follow-up	37.58%	37.64%	31.29%	45.62%	36.03%	37.03%	30.61%
Depression Screen	25.05%	36.64%	33.28%	37.74%	30.00%	26.56%	49.94%
Foster Care	13.03%	17.30%	10.36%	17.59%	34.85%	13.38%	18.65%

D. Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) Survey

The Department contracts with the Health Services Advisory Group, Inc. (HSAG) to annually administer a standardized survey to members receiving services through Health First Colorado and report the results. This year, HSAG administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) Survey to 37 program practices (19 pediatric and 18 adult). The goal of the PCMH Survey is to give practices and RAEs feedback that will help them improve member services. A total of 3,638 parents/caretakers (19% response rate) returned a completed survey on behalf of their child, and 3,311 adult members (18.44% response rate) returned a completed survey.

Results varied widely across practices surveyed, but overall, the majority of parents/caretakers and adult members were satisfied with their providers and their overall care. 72% of parents/caretakers rated all of their child's health care as a 9 or 10, and 61% rated their child's provider as a 9 or 10 for providing comprehensive child safety and healthy lifestyle information and resources.

55.8% of adults rated all of their health care as a 9 or 10, and 51% rated their medical home as a 9 or 10 for providing comprehensive services. The full results are available at www.colorado.gov/hcpf/client-satisfaction-surveys-cahps.

V. Financial Performance

During FY 2019-20, the Accountable Care Collaborative operated as both a Primary Care Case Management Entity, in which medical services were paid fee-for service, and a Prepaid Inpatient Health Plan, in which covered behavioral health services were paid through a capitated payment to the RAEs. Under this model, RAEs were paid a PMPM administrative fee for most members and a PMPM capitation payment.

As part of the Accountable Care Collaborative, 124,599 members were enrolled with a limited managed care capitation initiative rather than a PCMP. The RAEs did not receive a PMPM administrative fee for these members, instead, the limited managed care capitation initiatives receive a capitation for covered medical services.

As described in Section IV, the Accountable Care Collaborative also includes a Pay-for-Performance Program that enables the RAEs to earn financial incentives for achieving performance and programmatic objectives.

A. Accountable Care Collaborative Total Program Costs

Program costs include all expenses for benefits and services provided during FY 2018-19, including capitations, pharmacy, inpatient, outpatient, emergency room, Long-Term Services and Supports, home health, and professional claims. Capitations included in the program costs include the PMPM capitated payments to the RAEs for covered behavioral health services for all members, the PMPM administrative fees to the RAEs, and the PMPM capitated payments for members enrolled with a limited managed care capitation initiative.

For this report, the Department performed a straight comparison of FY 2019-20 expenditures to FY 2018-19 expenditures for all full-benefit Medicaid members, excluding those enrolled in PACE.

The total amount paid for the Accountable Care Collaborative in FY 2019-20 was $8.15 billion – a 3.8% increase from the previous fiscal year. Total costs are divided by total member months to yield an average program cost PMPM for the

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fiscal year. In FY 2019-20, the average paid PMPM was $564. This was a 7.2% increase from FY18-19, when the average paid PMPM was $526

Table 4. Accountable Care Collaborative Program Costs for FY 2019-20.

Financial Transaction	FY 2019-20 Expenditures
Administrative Costs	
Administrative PMPM Payments	$142,010,648
Earned Key Performance Indicator Payments	$20,885,010
Earned Performance Pool Payments	$24,710,660
Behavioral Health Incentive Program	$22,587,965
Total Administrative Costs	**$210,194,283**
Benefits and Services	
Behavioral Health Capitation PMPM Payments	$642,553,403
Limited Managed Care Capitation Initiative PMPM Payments	$420,077,353
Benefits and Services (not included in the capitation payments)	$6,880,684,075
Total Benefits and Services Costs	**$7,943,314,831**
TOTAL ACC EXPENDITURES	**$8,153,509,114**

Administrative Costs

The total administrative costs for the Accountable Care Collaborative consist of the administrative PMPM payments, the earned Key Performance Indicator payments, the earned performance pool payments, and the earned behavioral health incentive program. The $210,194,283 total administrative fees and costs represent an increase of $40,640,506 from FY 2018-19 administrative costs. The

increase in administrative costs are based exclusively on the timing of pay-for-performance payments.

1. **KPI and Performance Pool Payments:** FY 2019-20 payments reflect a full 12 months of performance payments. As FY 2018-19 was the first year of operation for the RAEs, the Department was only able to report on KPI and Performance Pool payments for 6 months of the fiscal year based on the time required for claims runout and data analysis.
2. **Behavioral Health Incentive Program Payments:** As discussed in the Program Performance section, payment for the behavioral health incentive program is made during the subsequent fiscal year and is therefore calculated as part of that fiscal year's expenses. No payments were made to the RAEs for the behavioral health incentive program during FY 2018-19 as it was the first year the RAE's administered the behavioral health program. Therefore FY 2019-20 reflects the first year payments were made for the behavioral health incentive program as part of the Accountable Care Collaborative.

Capitated Benefits and Services

The Department saw increases in costs for both the behavioral health capitation and the limited managed care capitation initiatives. Increased enrollment was a primary driver for cost changes for the limited managed care capitation initiatives.

Cost increases for the behavioral health capitation of $50,190,043 (or 8.47%) were driven by the following changes in policy and utilization of services.

- During the 2019 legislative session, the Colorado General Assembly appropriated to the Department a 2% increase in funds for the capitated behavioral health benefit to increase salary reimbursement for community-based behavioral health providers. The funding was incorporated into the managed care rates and passed through in its entirety by the RAEs to behavioral health providers to address workforce issues.
- The RAEs used various strategies to increase member access to services including contracting with more independent behavioral health providers. As

a result, the RAEs successfully increased the percentage of members that were able to access medically necessary behavioral health services.

- While performance varied across the RAES, some of the RAEs experienced increased utilization of inpatient services and other high-cost treatments. These trends were factored into the rate setting process and drove an increase in costs.
- The RAEs also implemented fewer traditional sub-contracted relationships with providers, particularly the Community Mental Health Centers. This created payment arrangements more similar to fee-for-service and offered less incentive at the provider level to effectively manage care and costs.

The Department is working with the Cost Control and Quality Improvement Office and Finance Office to improve tools for monitoring behavioral health utilization trends. Consistent with the history and philosophy of the Department's capitated behavioral health benefit, the Department wants to ensure the RAEs are utilizing cost-effective, community-based services to care for members in order to reduce the need for higher-cost treatments.

Fee-for-Service Benefits and Services

Fee-for-Service benefits and services saw increases from FY2018-19 as a result of both changes in caseload and an increase in utilization of services. For the first three quarters of FY 2019-20, the Department continued to see declines in enrollment for people who tended to be healthier and had lower costs than those people that remained on Medicaid. As a result, per capita expenditures continued to rise. However, the COVID-19 pandemic's impact on health care delivery in the state resulted in a lower than expected last quarter of the fiscal year. In the initial stage of the pandemic, the Stay-At-Home order and the postponement or cancellation of non-essential medical services had a large impact on utilization of services among Health First Colorado members. Some services were more impacted than others. The services with the largest impacts during the COVID period were dental, outpatient hospital visits, emergency department use, professional services (including visits to provider offices, FQHCs, RHCs, and IHS) and transportation. The Department is monitoring how services have rebounded over the course of the pandemic. Based on total spend, most services have rebounded to pre-pandemic levels of utilization. The exceptions are emergency

department, transportation, and FQHC/RHC/IHS (excluding dental). However, when adjusted for the increase in caseload, the majority of services have not returned to pre-pandemic levels.

Simultaneous to changes in the utilization of different benefits, Health First Colorado has experienced an increase in our enrollment in the last quarter of the Fiscal Year. First, Coloradans who became unemployed during the pandemic and were newly qualified for Health First Colorado joined the rolls. In addition, the federal government has prevented states from disenrolling members through the end of the public health emergency.

The large swings during the last quarter of the fiscal year mean that analyzing benefits by their overall contribution to trend is no longer meaningful or comparable to past reporting. Instead, table 3 reports the top five benefit groups by total paid amount and the change in their paid amount from FY2018-19.

Table 5: Top Five Benefits and Services by Paid Amount for FY 2019-20

Benefit Group contributing to cost increase	Total Paid Amount FY 2019-20	Paid Amount Change from FY 2018-19 to FY 2019-20
Long Term Services and Supports	$2,096M	8.1%
Pharmacy	$1,185M	5.8%
Inpatient	$848M	0.5%
Professional Services	$636M	-2.9%
Home Health and PDN	$532M	9.0%

The Department analyzed the cost trends and COVID impact on these services and made the following findings:

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Long-Term Services and Supports (LTSS): This category includes costs for Home and Community-Based Services (HCBS) waivers, nursing facilities, and hospice. The largest driver of trend (40%) in HCBS is due to the HCBS-DD waiver, which is partially due to increases in enrollment decided by the Legislature. Another sizeable portion of HCBS trend is due to spending on self-directed service delivery options. The Office of Community Living is currently implementing strategies to address trend such as implementation of Electronic Visit Verification (EVV), implementation of a utilization management program for self-directed care programs, development of a new long-term care assessment tool, and PACE rate redesign.

Pharmacy: Pharmacy expenses include prescription drugs – including generic, brand name, and specialty drugs – distributed through traditional pharmacies, as well as those administered by health care professionals. Overall spend (non-rebate adjusted) in this category continues to be driven by specialty drugs. Spending in this category increased 11.1% since last fiscal year.

A report on pharmaceutical costs was released by the Department in December 2019. The report – available here – identified cost drivers, prioritized strategies, and proposed solutions for reducing prescription drug spending in Colorado. An updated report will be released in December 2020.

Inpatient Hospital. The growth in inpatient spending was nearly flat between last year and FY19-20. Hospitals saw a large dip in services during the last quarter of FY19-20 due to the Governor's order to temporarily postpone or cancel non-essential medical services. However, recent data shows that even when adjusting for an increase in members, utilization has recovered to pre-pandemic levels in the first quarter of FY20-21.

Professional Services. This category includes services delivered by physicians in medical offices, Federally Qualified Health Centers, Rural Health Centers, and Indian Health Services. These services were greatly

impacted by the Stay-At-Home order and as a result, spending on these services was below the level of last year's spending. Many providers quickly adopted telemedicine to serve their members during the height of the pandemic and a percentage of these providers continue to use telemedicine into FY20-21. The Department publishes telemedicine utilization on a bimonthly basis to its public facing website here.

Utilization of telemedicine peaked during the first three months of the pandemic and has since leveled off. The Department continues to analyze the utilization of telemedicine and opportunities to continue this mode of health care delivery into the future. In early 2021, the Department will release a report summarizing its findings and recommendations.

Home Health and Private Duty Nursing: This benefit category experienced the largest growth in spend among the top five largest benefit categories. Increases in home health aide care by Certified Nurse Assistants accounted for most of the change in trend. In addition, providers in this benefit area have been one of the top utilizers of telemedicine during the pandemic to deliver physical, occupational, and speech therapy to clients. Home Health and Private Duty Nursing remain focus areas of the Department, with the Department providing training to RAEs on methods to support members transitioning from Private Duty Nursing to Home Health.

B. Additional Cost Analysis

For this year's annual report, the Department has included a more nuanced approach to evaluating the impact of the Accountable Care Collaborative model on costs. With all members now enrolled into the Accountable Care Collaborative, there is no ability to compare costs for members not enrolled in the Accountable Care Collaborative. Therefore, another method was needed to evaluate the cost impacts related to the Accountable Care Collaborative.

The Department used member engagement with one of the pillars of the Accountable Care Collaborative – the PCMP – as a method to evaluate savings in the program. A member's PCMP is their central point for accessing care and connecting to other parts of the health care system. The Department is using

engagement with a PCMP as a proxy for engagement with the Accountable Care Collaborative model.

For this analysis, engagement was defined as having at least one visit with any PCMP during either FY18-19 or FY19-20. Members were included in the analysis if they had close to continuous enrollment – meaning they had at least ten out of twelve months of enrollment in both fiscal years. To evaluate cost savings, the Department compared the expected per member cost in FY 2019-20 to their observed cost. The hypothesis was that costs for members who engaged with their PCMP would be lower than projected due to the value and coordination provided by the PCMP. The Department is able to estimate the expected annual costs for members using an assigned risk score produced by IBM that takes into account their diagnoses, eligibility category, and demographics. Risk scores are a standard method used by both private and public payers across the country to predict how costly a member will be compared to the average patient.

The analysis found that members who engaged with their PCMP in either FY 2018-19 or FY 2019-20 were less costly than expected. When accounting for the difference between the expected and observed annual costs in FY 2019-20, the Department saved $43.6 million for members who engaged with their PCMP. It should be noted that the COVID-19 pandemic had a large impact on all outpatient visits in the last quarter of the fiscal year. During the statewide Stay At Home Order, the Department was unable to determine any specific cost savings attributed to PCMP engagement.

C. Accountable Care Collaborative's Influence on Costs

The analysis of PCMP engagement indicates that the Accountable Care Collaborative's model and focus on and support for member engagement with a PCMP results in cost savings for the Department. While the RAEs have limited ability to influence or control costs in some of the Department's primary cost drivers listed above, such as Long-Term Services and Supports and new high-cost prescriptions, they are able to innovate within their PCMP and behavioral health networks to control costs and improve outcomes.

Examples of RAE activities that help control costs include:

- **Quality-based Payment Structures:** Almost all of the RAEs have implemented tiered administrative payment policies for their PCMPs. While the policies differ among the regions, payment is generally determined based on a combination of factors such as proven utilization of nationally recognized medical home processes and procedures and performance-based measures. So those practices that can provide more comprehensive services, such as patient registries and on-site care coordination, can earn higher administrative payments to support improved management of patients.
- **Focus on Social Determinants of Health:** The RAEs recognize that it is more challenging to connect member's with appropriate health services if the member does not have access to basic services such as food and safety. Therefore, the RAEs have built networks of community-based services that they and their PCMPs can access to help members meet their basic needs. As members' essential needs are met, the PCMPs and RAEs are able to more effectively support their members in addressing their health care needs.
- **Coordination of Behavioral Health:** A primary driver of increased medical costs is the presence of untreated behavioral health conditions. The RAEs' combined responsibility for physical and behavioral health has enabled them to interweave behavioral health into many of the RAEs' and PCMPs' interactions with members. So many more members are being formally and informally assessed for behavioral health needs and getting connected with follow-up behavioral health services administered by the RAE.
- **Treating Members in the Community:** The RAEs have implemented a variety of strategies to effectively reduce inpatient admissions for both physical and behavioral health conditions. The RAEs monitor and share with their provider networks hospital admission, discharge and transfer information so providers can quickly follow up with members to support their transition in care and help reduce readmissions. The RAEs are also engaged with the Department of Corrections to improve transitions in care for members being released from prison. These and other similar efforts are designed to ensure members have the supports and resources they need to access outpatient services and to prevent exacerbations of existing conditions.

VI. FY 2019-20 General Operations

In FY 2019-20, the Department worked with the RAEs to implement and refine the statewide approach to addressing member health. With the onset of COVID-19, the last four months of the fiscal year were focused on activities to ensure members were informed about COVID-19 and could remain safe, while also supporting providers to make changes in how they delivered clinical care.

Throughout the year, the RAEs also continued work in the following areas:

- Administering behavioral health and physical health
- Promoting access to services in rural and frontier counties
- Care management best practices
- Coordinating with Long-Term Services and Supports
- Reducing waste and inefficiencies
- Advisory committees and stakeholder engagement

A. Administration of Behavioral Health and Physical Health

One of the primary objectives of the second phase of the Accountable Care Collaborative is to combine accountability for physical health and behavioral health under each of the RAEs. The Department has promoted this accountability by establishing and improving the systems and tools for sharing member claims data with the RAEs. A primary goal is to ensure the RAEs have access to and can easily act upon the data they receive to improve member health and cost outcomes.

During FY 2019-20, the Department continued to improve and leverage two tools to more effectively support the RAEs in managing their populations.

- **Clinical Risk Stratification Dashboard:** Developed by the Department's Cost Control and Quality Improvement office, this tool clinically stratifies the population enrolled in the Accountable Care Collaborative. It provides the RAEs with member-level data to identify members who are most vulnerable so they can implement evidence-informed allocation of care coordination resources and condition management programming. The RAEs used the Clinical Risk Stratification Dashboard data to implement complex care management plans specific to their region to improve the cost and quality of

care for their targeted population during FY 2019-20. Using existing resources and other data tools, the Department has developed cost trend and quality outcome metrics and is leveraging staff oversight to support and monitor the performance of the RAEs in reducing costs for their targeted members.

- **Potentially Avoidable Cost Tool (PROMETHEUS):** Working with the vendor Optumas, the Department gave the RAEs, hospitals, and other providers access to PROMETHEUS to raise awareness of the opportunities for cost savings and help them develop interventions to reduce variations in care. PROMETHEUS is an industry-standard tool that uses detailed clinical algorithms to group fee-for-service claims and managed care encounter data into episodes of care and compares the services provided, outcomes, and associated costs against clinically determined best practices to identify any deviations that result in potentially avoidable costs. An example of a potentially avoidable cost would be a hospitalization for an individual with diabetes who did not participate in evidence-based, outpatient treatment. This information enables the RAEs and providers to improve their referral patterns towards more cost-effective, higher quality physicians and hospitals, and allows hospitals and providers to identify and self-correct inefficient, lower quality care delivery.

The RAEs also began to implement innovative programs to move toward more integrated care models. Almost all the RAEs focused their efforts on supporting primary care practices interested in more effectively managing and delivering behavioral health services to members within their clinic. One of the most common programs among the RAEs was the implementation of tele-behavioral health programs that enable primary care practitioners to access behavioral health consultative services, including consultations with psychiatrists. As an example, Colorado Access's Telehealth Program, the Virtual Care Collaboration and Integration (VCCI) Program, supports Colorado Access's contracted PCMPs with increased access to virtual behavioral health care through collaborative consultations and short-term telehealth treatment at no cost to all PCMPs. This and the other RAEs' tele-behavioral health programs have been essential during the COVID-19 public health emergency and have seen incredible expansion of utilization.

Other examples of ways the RAEs have improved administration of members behavioral and physical health needs include:

- Northeast Health Partners, the RAE for Region 2 has been able to more effectively support providers in the region with trainings, data, resources, and solutions for both physical and behavioral health issues.
- Colorado Access, the RAE for regions 3 and 5, developed a transparent provider incentive sharing model that includes both physical and behavioral health providers and metrics that provide for regional achievement and intentional community investments to support shared goals.
- Colorado Community Health Alliance, the RAE for Regions 6 and 7, implemented an integrated care coordination model, where teams are comprised of behavioral health specialists, social workers, nurses, peer support specialists and care navigators. The RAE also incentivizes integrated care through its Primary Care Integration Program, whereby eligible PCMPs receive an enhanced per-member per-month payment to support the delivery of integrated services.
- The RAEs and PCMPs have incorporated formal and informal means of assessing members' behavioral health needs during most visits. The RAE is then able to leverage its regional network of behavioral health providers to quickly respond to a member's identified need.

The RAEs have used this expanded responsibility to more effectively address the full range of their members' needs. Instead of just focusing on a member's physical or behavioral health needs, they are able to focus on helping address members' other needs that may be negatively impacting their health or ability to adhere to medical recommendations. The RAEs have established relationships with many community organizations and link members to essential services, such as food, housing, and transportation. As an example, a number of the RAEs are working to include staff who can enroll members into The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) enrollment programs, eliminating the need for members to schedule additional appointments to access essential support services.

Mental Health and Substance Use Disorder Parity. During FY 2019-20 the Department contracted with CedarBridge Group to conduct the Department's first

annual mental health and substance use disorder parity report required by House Bill 19-1269. Based on their review of Colorado Medicaid, the CedarBridge Group found that the Department's Medicaid managed care entities are in compliance with federal and state parity laws and that the Medicaid benefit, in its entirety, is in compliance with all federal and state parity laws. Stakeholder input was used to inform CedarBridge Group's analysis pursuant to C.R.S. 25.5-5-421(2) and included individual interviews with key stakeholders, as well as two virtual townhall meetings.

B. Promoting Access to Services in Rural and Frontier Counties

The rural and frontier regions of Colorado face unique challenges in ensuring access to health care. Colorado is a geographically diverse state with five of the seven RAE regions containing rural or frontier counties; region 3 (Adams, Arapahoe, Douglas, and Elbert) and region 5 (Denver County) are the two exceptions. Below are strategies the Accountable Care Collaborative used in FY 2019-20 to improve availability and accessibility of services in Colorado's rural and frontier counties.

Improved access to telehealth. While all of the RAEs had telehealth efforts in place prior to COVID-19, the pandemic has accelerated and expanded their efforts. For example:

- Rocky Mountain Health Plans offers its Accountable Care Collaborative and Child Health Plan Plus (CHP+) members access to an on-demand telehealth platform called EasyCare Colorado at no cost. RMHP has developed real-time connectivity between EasyCare Colorado and the member's primary care medical home.

- In Region 4, safety-net providers have used monies distributed by Health Colorado, Inc. to assist members with broadband, phones, tablets, and other resources in order to increase member access to telehealth services.

Access network adequacy. The RAEs regularly monitored their provider networks to ensure that each member has access to PCMPs and behavioral health providers within a reasonable distance from where they live. The RAEs

also tracked calls to customer service centers and solicited feedback from advisory councils to identify trends in member concerns about access to providers.

Recruit providers. RAEs worked to develop relationships with providers of all types in the community to build relationships and increase the size of the network.

Partner with public health and community-based organizations to deliver some services. Many of the RAEs leverage local organizations that members frequently utilize in their rural and frontier communities to improve outreach and engagement of members. These partnerships have been vital during COVID-19 to continue engagement with members while reducing the number of face-to-face visits members need to access physical and behavioral health care and care coordination resources. For example:

- Colorado Community Health Alliance has contracted with Rocky Mountain Rural Health and Aspen Mine Center to outreach Health First Colorado members in Park and Teller Counties, provide resource referral, and assist members with access to health care services.

- Rocky Mountain Health Plans collaborated with the Colorado Health Foundation to support approximately 20 community agencies with the purchase of tablets, laptops, phones and/or data plans for Members to access telehealth services.

C. Care management best practices

The Department also continued its participation on multiple statewide committees and collaborative efforts to establish best practices for the care and management of individuals with complex health needs. Most notably, the Department participated in the Behavioral Health Task Force, and the subcommittees, led by the Colorado Department of Human Services over the past year. The Task Force worked together to complete a Blueprint, a list of priorities and actions that Colorado needs to improve behavioral health. The Health Cabinet has identified implementation of this plan as a top priority for all

health agencies and the Department expects to partner closely with the Colorado Department of Human Services, which is leading this effort.

The Department also continued its work with the Department of Corrections, the RAEs, and behavioral health providers to improve care for members being released from state prisons. Activities included working with the Department of Corrections to align its approved behavioral health network with the RAE networks of contracted providers to facilitate smoother transitions and care coordination. The Department also created a performance metric for the Performance Pool that incentivizes improved engagement with behavioral health treatment for Health First Colorado-eligible members within 14 days of their release from state prisons.

Institutions for Mental Diseases

One particular area of work has been facilitating improved processes and procedures for the utilization management and reimbursement for members requiring inpatient behavioral health services at an Institution for Mental Diseases (IMD). Section 1905(a) of the Social Security Act and federal regulations at 42 CFR § 435.1008 and 441.13 preclude federal Medicaid funding for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to any individuals under the age of 21. In 2016, the federal Medicaid managed care regulations were revised to allow Medicaid agencies with a capitated managed care program to make monthly capitation payments for members receiving IMD services as an in lieu-of service for no more than 15 days during the month. Prior to this change in federal regulation, Colorado Medicaid was one of a few states that was able to allow reimbursement for IMD services under a 1915(b) waiver from the federal government, without a formal limit on the number of days.

The Department has worked extensively with the RAEs and IMDs to address payment, utilization management and implementation of the 15-day limit, while developing strategies to reduce any negative consequences for members. The Department and RAEs have also worked to reduce the financial risk for IMDs when members require stays longer than 15 days within a capitation month. Specific activities during FY 2019-20 included:

- **Value-based Payments.** The RAEs were instructed to use the flexibility of their managed care capitations to implement value-based payment arrangements that support the continued viability of the IMD business models so that inpatient services remain available in their regions. RAE payments to providers are substantially higher than the providers' actual reported costs per diem.
- **IMD Workgroups.** The Department contracted with Cole and Partners to facilitate smaller workgroups to address and document agreements for handling issues related to billing and reimbursement, admissions, discharge planning, and utilization management.
- **IMD Dashboard.** In order to monitor utilization patterns within the IMDs, the Department has created a dashboard using data provided directly by the RAEs to track admissions, denials, and length of stay.
- **Contractor Specific Oversight.** The Department worked directly with parties when it identified practices that didn't align with industry standards, or it become aware that parties were not able to satisfactorily resolve their operational challenges. For example, the Department set up weekly meetings with a RAE and IMD to review each of their weekly admissions and denial information and to resolve an outstanding conflict.

D. Coordinating with Long-Term Services and Supports

Colorado's system of Long-Term Services and Supports (LTSS) provides comprehensive services to people with many types of long-term care needs, including those with physical disabilities, serious mental health needs, and developmental and/or intellectual disabilities. Most people access the LTSS system through two types of entities: Single Entry Points (SEPs) and Community Centered Boards (CCBs). SEPs predominately serve as the entry point and 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 entry point and case management agency for individuals with intellectual and/or developmental disabilities and children with autism. There are 24 SEPs and 20 CCBs throughout the state.

It is important that the RAEs collaborate with the SEPs and CCBs to support members in accessing the full range of Medicaid services, while reducing the number of care coordinators working directly with a member. To facilitate improved collaboration, many of the RAEs have included SEP and CCB representatives on their regional advisory committees.

The RAEs have also pursued a variety of other activities to improve the coordination of care for members shared with the SEPs and CCBs.

- Colorado Access hired a dedicated staff member to serve as the point person for the coordination between the SEP and CCBs in its regions
- Health Colorado, Inc. increased its outreach and collaboration with SEPs and CCBs to more effectively support members during COVID-19. This effort has improved relationships and communication between organizations and has established a strong foundation for further collaborative care activities.
- Colorado Community Health Alliance implemented a SEP/CCB Incentive Program to further collaboration with the SEPs/CCBs and target collaborative efforts towards members who are complex and would benefit from additional RAE or case management support. The SEP/CCB Incentive Program components include a monthly complex case reviews and the sharing of hospital admission, discharge and transfer data to improve outreach workflows following an emergency department of inpatient visit.

E. Reducing Waste and Inefficiencies

The Accountable Care Collaborative 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 Accountable Entities

As the umbrella organization within each region, the RAEs served as a single resource to help both providers and members navigate the Medicaid system of care. Based on practice needs, RAEs helped 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 helped explain Medicaid benefits, establish relationships with PCMPs, coordinate care with behavioral health providers and other Medicaid providers, address grievances, arrange non-emergency medical transportation, and connect members with community resources to address non-medical needs.

Each of the RAEs collaborated with local public health agencies, county human service departments, case management agencies, and other community partners within its region to align resources, improve coordination of services among different providers, and reduce waste and inefficiencies.

Utilization Management

The RAEs developed their own utilization management programs for behavioral health services to reduce waste and promote more efficient and cost-effective care.

- Rocky Mountain Health Plans has reduced acute behavioral health service utilization trends in three of four Community Mental Health Center catchment areas over the course of multiple, consecutive program quarters, resulting in enhanced, performance-based payments for Community Mental Health Centers that have exceeded performance on specified utilization under risk-sharing agreements.
- Colorado Community Health Alliance's Special Investigations Unit monitors billing trends by contracted behavioral health providers and compares those to national billing trends through internal data mining. Due to this practice, multiple instances of potentially wasteful billing practices by providers were identified. The Colorado Community Health Alliance outreaches these providers to ensure they are aware of Medicaid billing policies, and then monitors claims for any changes in billing habits, positive or negative.

F. Advisory Committees and Stakeholder Engagement

In FY 2019-20, the Accountable Care Collaborative 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 Accountable Care Collaborative. Membership includes Medicaid members, physical and behavioral health providers, LTSS providers, RAEs, oral health providers, local advocacy organizations, and member advocates. Meetings were open to the public.

The PIAC leveraged the following subcommittees to provide more detailed guidance on future activities: behavioral health and integration strategies, provider and community experience, and performance measurement and member engagement. In FY 2019-20, the PIAC focused on providing recommendations to improve performance measurement for both the Accountable Care Collaborative and Alternative Payment Model, creating alignment between the Colorado Crisis Service System and the Accountable Care Collaborative, examining member access to specialty care, understanding provider needs for practice transformation, and exploring care coordination models and chronic disease management strategies.

Regional Program Improvement Advisory Committees and Member Advisory Councils

Each RAE established a regional performance advisory committee, with meetings held monthly or quarterly. This provided each region a forum for stakeholder participation on program improvement activities at the local level. These meetings helped the RAEs understand the unique needs within their community and design and implement solutions that best addressed the needs. The regional committees focused on issues such as care coordination efforts, member support services, RAE performance review, and establishing polices for distributing earned Pay-for-Performance Program payments.

All the RAEs formed advisory councils specifically for Medicaid members, which focused on understanding the member's perspective regarding how they access health care services in order to drive changes on policy and program decisions as well as member communications.

Some highlights of the RAE stakeholder engagement activities included:

- Rocky Mountain Health Plans facilitates Deaf advocacy groups, called Bridging Communications, representing Larimer County and Western Colorado. The Bridging Communications groups gave trainings to health care providers about the Deaf culture and the needs of the Deaf community when accessing health care, and have been instrumental in advocating for the continued funding of the Rural Interpreting Services Project that provides American Sign Language/English interpreting services for rural Coloradans at no cost to the provider or the deaf consumer.
- Northeast Health Partners hosts a bi-monthly Quality Improvement Committee of regional providers and stakeholders. This group reviews performance data and develops strategies to address areas of high cost and potential cost containment. Focus areas during FY 2019-20 included addressing complex pregnancy issues and c-sections; as well as developing a diabetes registry to ensure standardized treatment of members.
- Colorado Access created a Community Innovation Pool Steering Committee in response to COVID-19. The Committee helped Colorado Access review 69 applications and ultimately selected 19 innovation projects ($1.8 million) for funding in the focus areas of Health Equity and Telehealth.

VII. FY 2020-2021 Strategies

Controlling costs for Health First Colorado will be even more critical in the months and years ahead given the economic downturn and the resulting impact on the state budget, of which Health First Colorado is a major portion. The Department has taken a significant step to improve health outcomes and bend the cost curve by joining the administration of physical health and behavioral health under the RAEs. Effectively leveraging this infrastructure in tandem with other Department initiatives will begin to generate greater improvements in member health, member experience, and cost containment. Below are some initiatives that will move the program and Department forward in improving the affordability of Medicaid now and in future years.

A. Statewide Approach to Addressing Member Health

With the implementation of the Department's new statewide approach and Clinical Risk Stratification Dashboard, the Department now has the opportunity to

refine and focus the Accountable Care Collaborative to target members with complex health needs and identified high-cost conditions.

The Department has begun holding the RAEs accountable for ensuring specific condition management programming is available for the evidence-based management of the Department's identified 10 conditions. In FY 2020-21, in alignment with the Governor's Office's Wildly Important Goals, the Department and the RAEs will specifically focus on the implementation of condition management programs for maternity, diabetes and complex care members. The Department has set expectations around five universal characteristics of all condition management programming and is developing individualized clinical components for each condition.

The 5 universal characteristics for the Department's condition management programming are:

1. Member identification and risk stratification
2. Culturally-competent specialized care teams
3. Facilitated access to appropriate medical services, resources and community programs
4. Delivery of evidence-based/informed interventions and/or local evidence-based programs or local promising initiatives
5. Program measurement and reporting toward target outcomes will be used to guide evolution of programming in the region

The Department will monitor RAE performance and guide continuous improvement regarding the targeted populations and chronic conditions by introducing cost and additional health outcome metrics into the Performance Pool program. With fewer than 5% of members contributing over 50% of claim costs, a focused approach for managing care should result in lower costs and improved outcomes.

B. Prescription Drug Costs

The high cost of prescription drugs, especially specialty drugs, is a challenge for Medicaid and all health plans. The Department diligently utilizes cost control

initiatives to manage generic and brand name drugs such as a preferred drug list, prior authorization requirements, quantity limits, review of member drug utilization, and value-based contracts.

Senate Bill 19-005 authorized a Drug Importation Program as a means to control prescription costs for the state. With the recent release of a Final Rule from the Department of Health and Human Services for the Importation of Prescription Drugs, the Department is finalizing its application to begin importing prescription drugs from Canada. To that end, the Department will conduct robust stakeholder engagement, consult with experts in U.S. importation law, and embark on the procurement of supply chain partners.

In addition, the Department is scheduled to implement a prescriber tool in 2021. The tool will be a multifunctional platform accessible through electronic medical records. The tool will include an opioid module, furnished by OpiSafe, which will provide prescribers with patient-specific opioid risk metrics and medication monitoring. The opioid module is intended to give prescribers the tools and resources to prevent the misuse and abuse of opioid medications in the state and to improve member health and outcomes. The prescriber tool will also include a real-time benefit check module which will provide prescribers with patient-specific pharmacy benefit and drug price information. The Department is in the process of procuring a vendor for that module. The prescriber tool is intended to be a flexible platform and will be expanded in the future to provide decision support for other medications, such as prescriptions for behavioral health conditions. By making it easier for prescribers to identify the most efficacious and cost-effective medications, the Department hopes to improve the quality of care and reduce prescription drug expenditures for the Department.

C. Implementation of Alternative Payment Models

One important way the Department seeks to control costs is by implementing alternative payment models that pay for value over volume. The Department will be leveraging the following three strategies in the coming months and years.

Bundled Payments: The Department is developing bundled payment strategies that create specialist accountability for patient outcomes while rewarding innovations that improve quality and keep the total cost of care low for targeted

episodes of care. The Department’s voluntary maternity bundled payment episode went live on November 1, 2020 and gives obstetric care providers a single, comprehensive payment covering services within an episode of care such as a pregnancy and birth. The program promotes collaboration between providers to improve the quality and coordination of care for the patient and their baby. The Department has plans to implement two other high-value voluntary bundles on July 1, 2021.

Alternative Payment Methodology 1 (APM 1): The Department continues to evolve this pay for performance model which rewards PCMPs with financial incentives for meeting quality goals. High quality primary care has been shown to improve health outcomes in a low-cost setting and reduce unnecessary acute care utilization which lowers overall spending for the Department.

Alternative Payment Methodology 2 (APM 2): APM 2 is designed to pay primary care providers part of their historical Health First Colorado revenue as a capitation payment, with the opportunity to earn extra reimbursement for meeting quality goals. This is modeled after Medicare’s Comprehensive Primary Care (CPC) Track 2 program. Having stable revenue allows primary care providers to innovate their care delivery to improve member outcomes while decreasing unnecessary acute care utilization. The extra reimbursement will be tied to a primary care physician’s ability to reduce unnecessary acute care utilization.

D. Residential and Inpatient Substance Use Disorder Treatment

The Department is working to implement House Bill 18-1136 which adds residential and inpatient substance use disorder services to Medicaid’s covered benefits. While not a cost-containment strategy, the addition of these services will ensure members needing treatment for a substance use disorder have access to the full continuum of care available in the state.

The Department has applied to the Centers for Medicare & Medicaid Services to implement a Section 1115 Substance Use Disorder Demonstration Waiver beginning January 1, 2021. The proposed demonstration will complete the service continuum for Medicaid members by authorizing the state to draw down a federal match on inpatient and residential services, including withdrawal

management, delivered in Institutions for Mental Diseases (IMD). The RAEs will have primary responsibility for administering the new benefit to complement the current substance use disorder early intervention, outpatient treatment, and recovery services available to members.

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