COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

December 1, 2023

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

Dear Senator Fields:

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

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

Attached is the Accountable Care Collaborative annual report for FY 2022–23. As required by the legislation, this report provides information on program enrollment, program performance, program costs and value, access to services for members in rural and frontier counties, efforts to coordinate with Long-Term Services and Supports, information on advisory committees and other stakeholder engagement, future areas of program development and efforts to reduce waste and inefficiencies through the Accountable Care Collaborative. It also provides information about how the program supported the Department's strategic pillars during FY 2022–23.

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

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2023 Accountable Care Collaborative Implementation Report

Cc: Senator Joann Ginal, Vice Chair, Senate Health and Human Services Committee
Senator Janet Buckner, Senate Health and Human Services Committee
Senator Sonya Jaquez Lewis, Senate Health and Human Services Committee
Senator Lisa Cutter, Senate Health and Human Services Committee
Senator Kyle Mullica, Senate Health and Human Services Committee
Senator Janice Rich, Senate Health and Human Services Committee
Senator Jim Smallwood, Senate Health and Human Services Committee
Senator Perry Will, Senate Health and Human Services Committee
Legislative Council Library
State Library
Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Rachel Reiter, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

December 1, 2023

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

Dear Representative Michaelson Jenet:

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

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

Attached is the Accountable Care Collaborative annual report for FY 2022–23. As required by the legislation, this report provides information on program enrollment, program performance, program costs and value, access to services for members in rural and frontier counties, efforts to coordinate with Long-Term Services and Supports, information on advisory committees and other stakeholder engagement, future areas of program development and efforts to reduce waste and inefficiencies through the Accountable Care Collaborative. It also provides information about how the program supported the Department's strategic pillars during FY 2022–23.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2023 Accountable Care Collaborative Implementation Report

Cc: Representative Mary Young, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Brandi Bradley, House Public & Behavioral Health & Human Services Committee
Representative Regina English, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
Representative Eliza Hamrick, House Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, House Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, House Public & Behavioral Health & Human Services Committee
Representative Tammy Story, House Public & Behavioral Health & Human Services Committee
Legislative Council Library
State Library
Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Rachel Reiter, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

December 1, 2023

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

Dear Senator Zenzinger:

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

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

Attached is the Accountable Care Collaborative annual report for FY 2022–23. As required by the legislation, this report provides information on program enrollment, program performance, program costs and value, access to services for members in rural and frontier counties, efforts to coordinate with Long-Term Services and Supports, information on advisory committees and other stakeholder engagement, future areas of program development and efforts to reduce waste and inefficiencies through the Accountable Care Collaborative. It also provides information about how the program supported the Department's strategic pillars during FY 2022–23.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2023 Accountable Care Collaborative Implementation Report

Cc: Representative Shannon Bird, Vice-chair, Joint Budget Committee
Representative Rod Bockenfeld, Joint Budget Committee
Senator Jeff Bridges, Joint Budget Committee
Senator Barbara Kirkmeyer, Joint Budget Committee
Representative Emily Sirota, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Mark Ferrandino, Director, Office of State Planning and Budgeting
Noah Straayer, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Rachel Reiter, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Accountable Care Collaborative FY 2022–23

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

Dec. 1, 2023

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

COLORADO
Department of Health Care Policy & Financing

Table of Contents

I. Executive Summary 3

II. Introduction: The Accountable Care Collaborative 7

III. Member Health Quality Performance Indicators 9

IV. Member Health Initiatives 18

V. Care Access 29

VI. Operational Excellence and Customer Service 41

VII. Health First Colorado Value 45

VIII. Priorities for FY 2023-24 52

I. Executive Summary

This report from the Department of Health Care Policy and Financing (HCPF) provides an update on the Accountable Care Collaborative (ACC) for FY 2022–23 (July 2022 through June 2023). Since 2011, the ACC has served as the core vehicle for delivering and managing member care for Health First Colorado (Colorado's Medicaid program) as authorized by Section 25.5-5 Part 4, C.R.S. Most full-benefit Health First Colorado members are enrolled in the ACC.

The ACC was designed to provide cost-effective access to quality health care services while improving member health. It integrates managed fee-for-service physical health care and managed behavioral health care. The ACC's regional model allows it to respond to unique community needs while implementing the key components of member support and care coordination, ranging from health promotion to high-risk case management.

This fiscal year marked 11 years since HCPF launched the ACC. This year's accomplishments demonstrate fidelity to the original goals of the ACC as well as the model's ability to evolve and adapt to a dynamic health care market and changing consumer, provider, stakeholder, fiscal and federal demands. Below are some key accomplishments from this year:

- **Enrollment Changes**. The unique structure of the ACC allowed HCPF to adjust to the rapid increase in Health First Colorado members, reflected in ACC enrollment. This represented about 500,000 additional ACC members from 2020 to 2023, due to federal continuous coverage enrollment rules in place during the COVID-19 public health emergency (PHE). With the end of the PHE in May 2023, the ACC took the lead in helping members and providers understand the need to renew or transition to other forms of coverage, such as employer-sponsored insurance or Medicare.
- **Member Health.** Improving member health is, and always will be, a key goal of the ACC. As a measure of performance against this program goal during this past fiscal year, all the ACC's Regional Accountable Entities (RAEs) earned incentive payments for related member engagement in substance use disorder (SUD) treatment and for behavioral health engagement for people released from prison. Most RAEs also earned incentive funds for the percentage of members with complex needs who received extended care coordination. Further, the RAEs developed population health strategies in key focus areas, including diabetes, maternal health and complex condition management. In addition, the RAEs partnered with HCPF on efforts to meet the needs of people experiencing housing instability, supporting transitions for people who

are reentering the community from prisons and jails, and children and youth receiving child welfare services and residential care.

- **Access to Care and Services.** Access to care and services is a key goal of the ACC. From March 2020 through June 2023, the total number of providers enrolled with HCPF increased by 49%. During the same three-year period, more than 3,000 behavioral health practitioners were added to the Medicaid network[1]. HCPF partnered with the RAEs to integrate several new provider types, including behavioral health secure transportation, mobile crisis response, qualified residential treatment programs, pre-licensed clinicians and peer support. RAEs also worked to improve the experience of providers by making enrollment and claims processing more efficient. Across RAEs, the percentage of adjudicated behavioral health claims paid within 30 days was 98.9%. Most behavioral health claims are paid faster; on average, 90.5% of clean claims were paid in 14 days or less. From a call center perspective, calls were answered in an average of less than 1 minute for all but one RAE/MCO. In the 2023 Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, most members reported being able to get needed care (78.3% for adult care and 80.4% for children) and receive care quickly (78.9% for adults and 85.0% for children). Most members also reported satisfaction with care coordination (81.1% for adults and 83.6% for children) and satisfaction with their medical provider's communications (92.7% for adults and 93.7% for children).
- **Value.** HCPF continues to innovate its payment structures to reward improved outcomes. The payment strategies described in this report, including the capitated behavioral health benefit, alternative payment models as well as incentive payments, are designed to respond to system challenges. These strategies help to better manage rising health care costs to protect access to Medicaid coverage, benefits and provider reimbursements, while driving improvements in quality and health equity.

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

- Improve quality care for members

[1] The five behavioral health provider types include: Psychiatric Residential Treatment Facility, Community Mental Health Center, Licensed Psychologist, Licensed Behavioral Health Clinician, and Substance Use Disorder - Clinics.

- Close health disparities and promote health equity
- Improve care access
- Improve the member and provider service experience
- Manage health care costs to protect access to Medicaid coverage, member benefits, and provider reimbursements

In addition, the following efforts are planned for FY 2023–24:

- HCPF, RAEs, providers, counties and stakeholders will continue to collaborate, under HCPF's leadership, to achieve the shared goal to Keep Coloradans Covered[2] through the end of the PHE. This includes helping eligible Coloradans renew their Health First Colorado or Child Health Plan *Plus* (CHP+) coverage, while connecting disenrolling members to other forms of coverage, such as employer-sponsored insurance, Medicare or individual coverage and related federal subsidies through Connect for Health Colorado.
- The RAEs will continue to work with HCPF and the Behavioral Health Administration (BHA) to improve the behavioral health system and safety net in Colorado. Senate Bill 23-174 will also be implemented, giving members under age 21 access to mental health services before their condition becomes a clinical diagnosis. HCPF will also continue its efforts to increase behavioral health access and payments to independent providers in collaboration with RAEs to achieve shared goals of increasing behavioral health access and utilization, implementing integration grants to Primary Care Medical Providers (PCMPs) to improve care access, and implementing modernizations that hold safety net providers more accountable for seeing those with serious mental illness.
- HCPF will continue to partner with BHA and other state agencies to leverage opportunities for federal match, and to share where appropriate resources and systems for behavioral health operations. This includes collaboration with BHA to identify opportunities for efficiencies and a better member and provider experience through alignment between the RAEs and BHASOs going forward. It also includes joint review and sharing of available technologies used for data collection and analysis, claims processing, social programs, learning management systems, and other initiatives to improve patient outcomes and equity, federal match dollars and other shared goals.
- Collaboration with Colorado's Office of eHealth Innovation on the development of Phase II of the Prescriber Tool, also called the Social Health Information

[2] Link: https://hcpf.colorado.gov/keepcocovered

Exchange (SHIE), will continue. This platform will be designed to securely share social health information to refer Health First Colorado members to programs. Long-term, these include state programs like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), RAE programs like prenatal care or diabetes care and support, or social determinants of health —the life circumstances that support or undermine good health— supports like community foodbanks, homeless shelters or housing vouchers. All of these programs are intended to improve whole-person care, access, equity, quality and affordability.

- Work on the Find-a-Doctor tool will continue, giving members access to information about care quality, patient experience and ultimately costs at hospitals and other facilities.
- The eConsult platform will be implemented, allowing PCMPs to submit asynchronous clinical questions to specialty providers. The platform will increase efficient access to specialty care insights, enhance care that can be provided in the primary care setting, reduce member specialty appointment no-shows, improve quality, close disparities and improve affordability.
- Projects to transform care for people with disabilities or long-term care needs will continue, funded by the federal American Rescue Plan Act (ARPA). These include more than 60 initiatives identified through collaborative stakeholder engagement and with approval from both the Joint Budget Committee and the Centers for Medicare and Medicaid Services (CMS).
- HCPF will continue to implement Value-Based Payments (VBP) to achieve the CMS goal of 50% of Medicaid payments through VBP by 2025. This includes the evolution of the Hospital Transformation Program; rewards to physicians for being part of the prescription drug affordability solution through the active use of the Affordability Module within the Prescriber Tool Phase I; value-based contracts with drug manufacturers to hold them more accountable for their clinical promises, especially in the area of specialty drugs; maternity bundled payments; and, partial and full capitation to PCMPs through the Alternative Payment Model (APM) 2 program.
- HCPF will continue to invest in health equity and closing disparities by implementing its Health Equity Plan with focus areas of prevention, behavioral health and maternal health. Concurrently, HCPF is focusing efforts on improving its quality scores determined by CMS's Adult and Child Core Measure Set.

II. Introduction: The Accountable Care Collaborative

A. Regional Accountable Entities

The ACC balances the efficiency of a single statewide program with the agility to meet the unique needs of Colorado's diverse regions. Its fundamental premise is that regional organizations are in the best position to deliver programs in response to geographic community differences. For this reason, the ACC does not use one central administrative organization, but instead uses managed care entities called Regional Accountable Entities (RAEs) to manage care in each of the state's seven regions. Figure 1 shows the current ACC region map with the following vendors that serve as RAEs for each region: Rocky Mountain Health Plans (RMHP) in Region 1; Northeast Health Partners (NHP) in Region 2; Colorado Access (CoA) in Regions 3 and 5; Health Colorado, Inc. (HCI) in Region 4; and, Colorado Community Health Alliance (CCHA) in Regions 6 and 7.

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

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

In compliance with state law, two physical health managed care capitation plans (Managed Care Organizations, or MCOs) also participate in the ACC. RMHP PRIME (C.R.S. 25.5-5-415) is operated as part of the Region 1 RAE contract. Denver Health Medical Plan (C.R.S 25.5-5-402) delivers physical health care in the Denver metro region and subcontracts with the RAE in Region 5 to administer the capitated behavioral health benefit. Both are designed to maximize the integration of behavioral health and physical health services for enrolled members.

Figure 1. Accountable Care Collaborative regional map

RAEs and MCOs play an important role in addressing emergencies and challenges that arise in their region. Regional flexibility helped the RAEs to provide services to more than 500,000 new members during the COVID-19 public health emergency (PHE) and is helping members adjust to the end of the PHE in 2023. RAEs helped identify and ensure access to services for members at high risk of severe COVID infection and identify members who were potentially homebound and needed access to vaccines. They also worked closely with HCPF to identify and address disparities to promote vaccination efforts for all members. After several mass shootings between 2018 and 2022, and the Marshall fire in December 2021, the RAEs mobilized to rapidly identify and respond to community needs, coordinated services for affected Health First Colorado members, and often developed community response plans to streamline responses to future tragedies.

B. Enrollment in the ACC

Most full-benefit Health First Colorado members are enrolled in the ACC. HCPF uses a formula to attribute new members to a PCMP, though members can select a different PCMP at any time. Based on the geographic location of the PCMP, the member is assigned to a RAE.

ACC enrollment increased during the COVID-19 pandemic when the federal government temporarily required Medicaid programs to maintain health care coverage

for all medical assistance programs regardless of changes in a member's eligibility status, referred to as **continuous Medicaid eligibility**. As federal stimulus dollars entered the state, vaccines became more widely available, and the economy recovered. With that, ACC enrollment growth continued but at a slower rate. In FY 2022–23, Health First Colorado enrollment increased but at a lower rate than in the previous year, averaging 1,594,150 members compared to 1,489,511 in FY 2021–22.

Table 1. Average enrollment in the ACC by population, FY 2022–23

Population	Average Enrollment FY 2022-23	Percent of Total Enrollment
Children without disabilities	596,720	37%
Adults without disabilities, eligible due to the Affordable Care Act expansion	626,558	39%
Adults without disabilities, eligible before the Affordable Care Act expansion	274,660	17%
Children and adults with a disability, including Medicare-Medicaid members	96,212	6%
TOTAL	**1,594,150**	

In 2022, HCPF, the RAEs and the MCOs intensified planning for the eventual end of the federal COVID-19 PHE and the corresponding elimination of continuous Medicaid eligibility. These efforts, referred to as "Keep Coloradans Covered," included outreach and communication strategies to inform members and providers about potential coverage changes, upcoming renewal dates and member and provider responsibilities. When the federal government officially notified Colorado that the PHE would end in May 2023, HCPF and the RAEs/MCOs immediately implemented these communications strategies and began messaging members and providers. HCPF created video tutorials to educate members about renewing their benefits and updating their address in PEAK, and RAEs/MCOs provided additional outreach about alternate health coverage options for members determined to be over the income limit. Monthly PHE unwind meetings with RAEs and MCOs will continue throughout FY 2023–24. HCPF also met with insurance carriers and employer organizations to engage their help in connecting disenrolling members to related coverage, while coordinating outreach and escalation efforts with care providers, counties and advocates.

III. Member Health Quality Performance Indicators

HCPF uses several sets of health quality performance indicators to measure ACC program support for member health. These include key performance indicators (KPIs),

Behavioral Health Incentive Program (BHIP) indicators and Performance Pool incentive measures.

HCPF withholds a portion of the RAE administrative PMPM payments to fund the KPI and performance pool incentives. There is a separate funding pool for the BHIP measures. See the Health First Colorado Value section of this report for an overview of incentives and information about how RAE payments were broken out for FY 2022-23. MCOs have separate metrics and incentives and are not eligible for KPI or performance pool funds.

HCPF works with the RAEs annually to set performance targets for each indicator based on previous performance, changing priorities and other factors. HCPF intentionally sets high standards for achievement of performance metrics, requiring RAEs to achieve a certain percentage growth or reduction, depending on the target. In some cases, the lack of an incentive payment is reflective of the high standards RAEs have already reached and the difficulty in achieving further improvement. That said, and as noted below, there is clearly important work to do to improve the establishment of these quality indicators, related performance measures and the payout of related RAE incentives.

Specifically, the COVID-19 pandemic dramatically affected the member health quality performance indicators for the RAEs. Initially, the pandemic disrupted health care utilization, which impacted performance metrics. Because HCPF also sets baselines and performance targets using utilization information from previous years, the pandemic has impacted performance against goals and payouts for several consecutive performance years. Accordingly, many of the performance targets in the following three sections were difficult to set and in hindsight, difficult to achieve, as they reflected pre-pandemic goals. Now that the PHE has ended, HCPF is working with RAEs and stakeholders to set more appropriate post-pandemic goals for performance metrics that also align better with current RAE resources.

During the height of the pandemic, RAEs sometimes struggled to meet established performance targets; this was concurrent with a shift in needed RAE focus based on pandemic risks and threats to member health, safety and well-being. HCPF invested unearned performance dollars to support RAEs and providers to address the changing COVID environment and thereby protect member health, safety and well-being. As an example, these investments were critical in the RAEs' ability to establish vaccine distribution sites and outreach members to receive the COVID-19 vaccine; this refocus also helped to eliminate vaccine disparities for Health First Colorado members of color, a key revised priority for HCPF and the RAEs.

With the end of the PHE in May 2023, HCPF began returning to more normal, traditional operations. Unearned performance incentive dollars in 2023 were reverted to the General Fund.

As HCPF learned from previous phases of the ACC, it is clear that the nation's – and Colorado's – health care affordability, access, equity and quality challenges are complex, especially for low-income Coloradans and individuals with disabilities. To address those complexities and achieve shared goals going forward under ACC Phase III, RAEs and providers need improvements in technology, programs and payment methodologies, while strategies to improve quality outcomes and reduce health disparities, such as value-based payments and member incentives, need to be more focused and aligned. Discussed further in the following section, HCPF will be implementing national validated and benchmarked quality measures and standard targets that ensure all members are supported by RAEs that have the same high standards across the state.

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

A. Quality Measure Alignment

HCPF's goal for quality measurement is to measure performance and value while reducing data collection burden on providers. To that end, HCPF is working to align indicators across programs, drawing primarily from Centers for Medicare and Medicaid Services (CMS) Core Measure Sets for adults and children; the Universal Foundation Measure Set; indicators established for the Multi-Payer Collaborative with Colorado Division of Insurance; and indicators used for Making Care Primary, a Center for Medicare and Medicaid Innovation (CMMI) initiative.

HCPF is implementing standard, nationally recognized metrics for these programs to align with mandatory quality performance measure reporting to CMS. This change will allow HCPF to continuously monitor performance on these metrics in relation to national benchmarks, so performance may be compared to the rest of the country. This will also allow HCPF to identify early if a measure should be retired, when performance indicates it is no longer a priority area for improvement. Future program indicators will also be intentionally aligned with indicators identified as priorities in HCPF's Health Equity Plan. The ACC's indicators may be adjusted in future years to reflect this alignment.

B. Key Performance Indicators

The KPIs provide insight into physical and medical health care utilization. RAEs can earn a part or all of the PMPM withhold amount if they reach KPI performance targets. The following eight KPIs were used in FY 2022-23:

1. **Emergency department visits**: Number of emergency department visits per 1,000 members per year.
2. **Behavioral health engagement**: Percentage of members who received at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit.
3. **Prenatal engagement**: Percentage of members who had at least one prenatal visit within 40 weeks prior to the delivery and are Medicaid enrolled at least 30 days prior to the delivery.
4. **Oral evaluation, dental services**: Percentage of enrolled children under age 21 who receive a comprehensive or periodic oral evaluation within the measurement year.
5. **Child and adolescent well visits**: Percentage of child and adolescent members who had the appropriate minimum number of well visits based on their age and according to HEDIS standards. (This is a composite indicator that comprises two HEDIS measures, one for children 0 to 30 months, and one for children and adolescents aged 3 to 21 years.)
6. **Well child visits 0-15 months:** Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.
7. **Well child visits 15-30 months:** Percentage of children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
8. **Risk-adjusted PMPM**: Measures whether a RAE's risk-adjusted per-member-per-month cost was less than the ACC average risk-adjusted PMPM cost of $468.85 or reduced from a set baseline. This was previously a performance pool measure but became a KPI in FY 2022–23.

Table 2. KPI performance by RAE for the 12-month period from April 2022 to March 2023

RAE	ED (per 1000 members per year)	Behavioral health engagement	Prenatal engagement*	Oral evaluation, dental services	Child & adolescent well visits	Well-child visits: first 15 months	Well-child visits: 15-30 months
2021 HEDIS Medicaid Average	*NA***	*NA*	*NA*	*NA*	*46%*	*53%*	*71%*
1 (RMHP)	520.1	21.0%	57.7%	49.6%	42.0%	64.3%	66.3%
2 (NHP)	618.0	14.7%	63.9%	48.2%	35.3%	56.0%	59.2%
3 (CoA)	566.6	16.7%	62.6%	52.0%	42.2%	58.5%	64.5%
4 (HCI)	490.0	18.3%	66.5%	48.4%	37.2%	58.1%	59.2%
5 (CoA)	619.5	20.1%	71.2%	55.7%	49.7%	60.7%	67.8%
6 (CCHA)	485.3	18.2%	60.9%	51.2%	39.5%	56.2%	59.8%
7 (CCHA)	640.8	16.7%	71.3%	49.6%	33.2%	56.7%	57.4%

Key:

Green = Met Tier 2 Goal
Yellow = Met Tier 1 Goal
White = No Goal Met

* In the reporting of this measure, some global billing codes may be missing due to differences between the delivery date and the date of service on the claims. This is being resolved by moving to a standardized measure and certified reporting system beginning in FY 2023-24.

**Indicators noted as *NA* are Colorado-specific metrics with no national benchmark available for comparison.

COLORADO
Department of Health Care Policy & Financing

Table 3. Risk-adjusted PMPM by RAE for the 12-month period from April 2022 to March 2023 (compared to ACC average risk-adjusted PMPM of $468.85)

RAE	Risk-adjusted PMPM
1 (RMHP)	$448.43
2 (NHP)	$403.77
3 (CoA)	$491.58
4 (HCI)	$437.26
5 (CoA)	$473.30
6 (CCHA)	$479.86
7 (CCHA)	$489.63

Key:
Green = Met target

Refer to language regarding the impacts to performance at the start of the Member Health Quality Indicators section on pages 11 and 12.

C. Behavioral Health Incentive Program Indicators

The Behavioral Health Incentive Program (BHIP) indicators provide insight into how ACC members access and utilize behavioral health care. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, funds distributed to the RAEs in FY 2022–23 were for the RAEs' performance during FY 2021–22. BHIP indicators included:

1. **Engagement in outpatient SUD treatment**: Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
2. **Follow-up within 7 days after an inpatient hospital discharge for a mental health condition**: Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.
3. **Follow-up within 7 Days after an emergency department visit for a SUD**: Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour

treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.

4. **Follow-up after a positive depression screen**: Percent of members engaged in mental health service within 30 days of screening positive for depression.
5. **Behavioral health screening or assessment for foster care children**: Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment. This metric was intended to incentivize collaboration between counties and RAEs. It is not a reflection of all behavioral health assessments for children in foster care, and many external factors affect it. Statewide RAE performance has improved by more than double since the metric was created in FY 2017–18.

Table 4 shows the percentage of members in each RAE who received the service described in each performance indicator. While not all RAEs received incentives, the ACC overall and each individual RAE has shown year-over-year improvement.

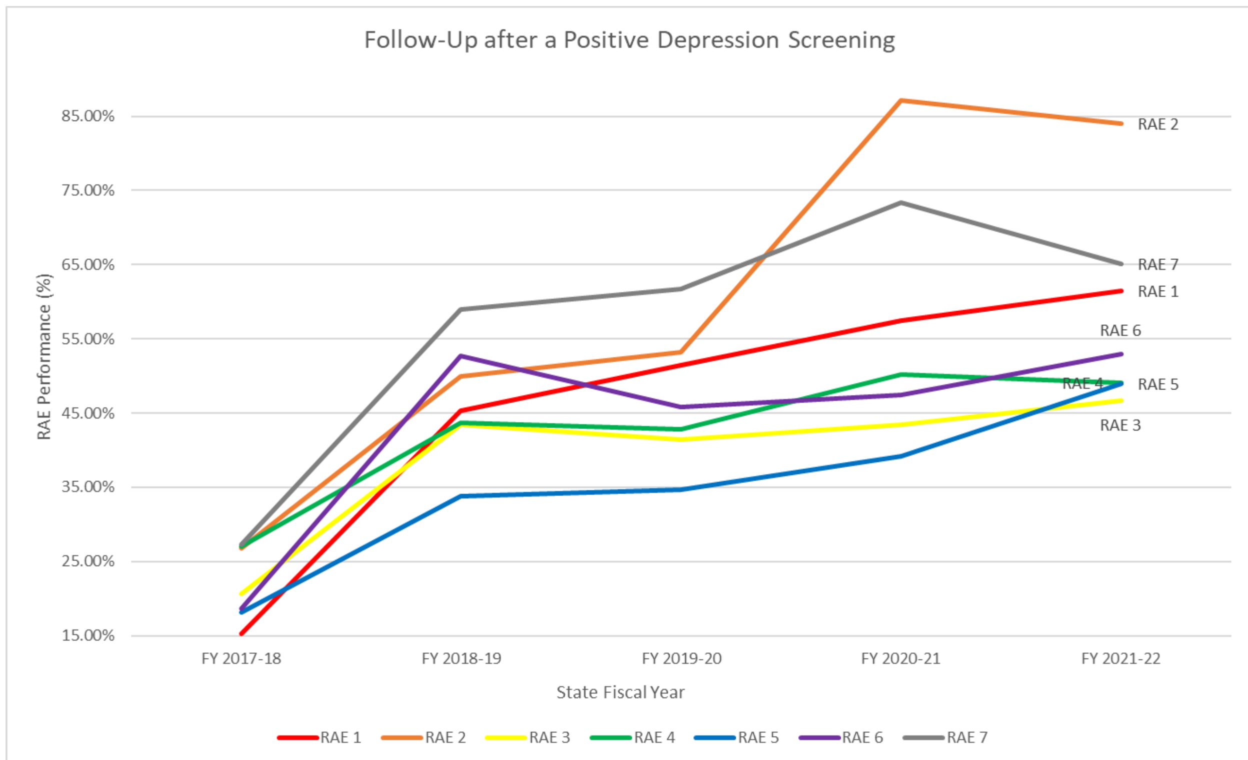
Table 4. Behavioral Health Incentive Program performance by RAE, FY 2021-22

RAE	Outpatient SUD	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD	Follow-up within 30 days of positive depression screen	BH assessment for children in foster care
1 (RMHP)	53.7%	50.8%	35.9%	61.4%	13.1%
2 (NHP)	54.8%	53.6%	30.9%	84.0%	16.6%
3 (CoA)	51.5%	46.8%	26.3%	46.7%	14.9%
4 (HCI)	55.6%	66.2%	32.5%	49.0%	27.1%
5 (CoA)	49.3%	49.5%	30.2%	49.0%	28.9%
6 (CCHA)	45.4%	58.1%	31.9%	53.0%	18.1%
7 (CCHA)	61.3%	32.6%	32.0%	65.1%	16.1%

Key:
Green = Met target. HCPF works with each RAE annually to set appropriate targets for each indicator based on previous performance and other factors.

Performance on many of the BHIP indicators has increased steadily over time. For example, Figure 2 shows that follow-up after a positive depression screening has steadily increased since FY 2017–18, despite the utilization challenges during the pandemic.

Figure 2. Follow-up after a positive depression screening by RAE, FY 2017–18 to FY 2021-22



Refer to language regarding the impacts to performance at the start of the Member Health Quality Indicators section on pages 11 and 12.

D. ACC Performance Pool

The Performance Pool is funded with money not disbursed for KPI performance incentives. It is often used to respond flexibly to timely needs and priorities. The reported results are from FY 2021–22 rather than FY 2022–23 due to the time it takes for the data to be collected and processed. The performance pool measures are described below.

1. **Extended care coordination**: Percentage of members with complex care needs who received extended care coordination as an intervention, which includes a care plan and bi-directional communication with the member through face-to-face conversations, phone or text.
2. **Premature birth rate**: Percentage of premature births (gestation less than 37 weeks) per total live births during the measurement period.
3. **Behavioral health engagement for members releasing from state prisons**: Percentage of members releasing from a Department of Corrections facility with at least one billed behavioral health capitated service or short-term behavioral health visit within 14 days. This was especially salient during the

COLORADO
Department of Health Care Policy & Financing

pandemic, when many individuals with low criminogenic risk were released to decrease the COVID risk for this vulnerable population.

4. **Asthma medication ratio**: Percentage of patients aged 5–64 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the performance year. (When asthma is controlled, patients should take more controller medications than emergency rescue medications.)
5. **Antidepressant medication**: The percentage of members 18 years of age and older who had a diagnosis of major depression, were treated with antidepressant medication and remained on that medication treatment during the acute phase (12 weeks) and continuation phase (at least six months).
6. **Contraceptive care for postpartum women**: Percentage of women aged 15–44 who had a live birth and were provided with either a most effective method of contraception (sterilization, implants, intrauterine devices or systems) or a moderately effective method (injectables, oral pills, patch, ring or diaphragm) within three to 60 days of delivery.

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

Table 5. Performance pool measures by RAE, FY 2021-22

RAE	Extended care coordin-ation	Prematur e birth rate	Behavioral health engagement for people releasing from prison	Asthma medica-tion ratio	Anti-depressant medication management: acute and continuation	Contraception post-partum
2021 HEDIS Medicaid Average	*NA**	*NA*	*NA*	*66%*	*57%* *42%*	*NA*
1 (RMHP)	77.9%	9.5%	25.8%	48.2%	68.5% 46.3%	32.0%
2 (NHP)	58.6%	12.2%	26.4%	46.5%	63.6% 41.1%	33.2%
3 (CoA)	19.6%	9.9%	15.4%	46.5%	68.4% 45.2%	31.5%
4 (HCI)	19.6%	9.5%	22.7%	41.3%	65.0% 40.9%	41.9%
5 (CoA)	25.9%	10.6%	19.5%	44.8%	61.9% 38.6%	39.7%
6 (CCHA)	36.2%	10.2%	20.4%	48.0%	70.0% 48.6%	29.6%
7 (CCHA)	38.2%	11.5%	21.5%	48.9%	67.0% 45.2%	27.4%

Key:
Green = Met target
*Indicators noted as *NA* are Colorado-specific metrics with no national benchmark available for comparison.

Refer to language regarding the impacts to performance at the start of the Member Health Quality Indicators section on pages 11 and 12.

IV. Member Health Initiatives

HCPF uses a population management framework to stratify the Health First Colorado population to promote wellness, prevent disease progression and provide additional resources to improve the health of individuals with complex and chronic care needs. A data-driven population health framework also helps reduce the total cost of care by

COLORADO
Department of Health Care Policy & Financing

keeping people healthier and maintaining their conditions. A key ACC strategy is to work with the RAEs on programs that improve Health First Colorado member health and control costs for conditions that commonly affect the Medicaid population, including maternity, diabetes, hypertension, congestive heart failure/coronary artery disease, chronic obstructive pulmonary disease, anxiety, depression and chronic pain.

HCPF continues to evolve condition management strategies used in the ACC program. HCPF collaborated with the RAEs to improve the accuracy and consistency of condition management data when HCPF transitioned to the Healthcare Effectiveness Data and Information Set (HEDIS) measures. This will allow the ACC to track progress over time and compare Colorado's program to that of other states. Implementation of this reporting will continue in FY 2023–24.

The sections that follow provide further information on the ACC's five focus areas for member health: diabetes, maternity, complex conditions, social determinants of health and services for children and youth.

A. Diabetes

Diabetes requires complex monitoring and management by members and their providers to prevent complications such as blindness, kidney failure, heart disease, stroke and lower-limb amputations. As a result, it is an expensive chronic condition to manage. All RAEs developed or used programs that met minimum HCPF standards, including cultural relevance, data use and use of evidence-based programs, to better manage diabetes in the region. Examples include:

- RAE 1 (RMHP): Partnered with Healthy.io to send at-home uACR tests kits to members identified as high-risk for kidney disease, including members with diabetes. Members use an app to generate and share test results with their PCMP. RMHP also used automated calls to contact members with gaps in diabetes-related care that allowed members to connect with their PCMP to schedule an appointment.
- RAE 2 (NHP): Continued using diabetes programs like Diabetes Self-Management Education & Support and the Diabetes Prevention Program to meet the needs of members with diabetes. One community introduced a new program, Be Well with Diabetes, for adults over age 60 and their caregivers. This evidence-based program developed by Stanford University is a six-week workshop that addresses the social and psychological adjustments associated with living with diabetes in addition to teaching to self-management strategies.
- RAE 3/5 (CO Access): Partnered with DarioHealth to provide members with app-based tools in multiple languages to manage diabetes, hypertension,

weight management and behavioral health. Members receive access to digital programming, coaching, a blood pressure cuff and a blood glucose monitor. Preliminary evaluations indicate improvements related to weight, A1c levels and blood pressure among high-risk members.

- RAE 4 (HCI): Hosted a diabetes work group for PCMPs quarterly to share best practices and problem-solve barriers to care. The group aims to improve quality of life for members by improving A1C, evaluating and addressing gaps in care, increasing awareness of resources and sharing best practices and workflows.
- RAE 6/7 (CCHA): Implemented a pilot with Project Angel Heart, which delivered medically tailored meals to members with diabetes. The pilot was successful and shows promise for reducing health care costs. The program will be integrated into regular operations and considered for other health conditions. In addition, providers in the region expanded gestational diabetes care and pursued Diabetes Self-Management Education & Support accreditation.

B. Maternity

Maternal health equity continues to be a key focus for the ACC. This fiscal year, HCPF released its second annual report on maternal health outcomes[3]. Covering calendar year 2020, the report uses data that links the birth certificate of the newborn with the Health First Colorado ID of the birthing parent to track outcomes across three stages of pregnancy: prenatal, labor and delivery, and postpartum. It provides a window into the lived experience of members that cannot be captured by claims data alone. The stories in the report are from members of the Maternity Advisory Committee (MAC), a group of Health First Colorado members established in 2021. HCPF also partnered with the RAEs to complete a series of listening sessions to share region-specific data and hear about local opportunities and challenges related to maternity.

Since 2020, RAEs have been required to have programs supporting pregnant and postpartum members that meet minimum HCPF standards, including cultural relevance, data use and use of evidence-based programs. Below are highlights from each RAE's maternity program:

---

[3] Link: https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Maternal%20Health%20Equity%20Report_April%202023.pdf

- Denver Health MCO: Recently made connections with sister agency Denver Public Health that have improved care coordination and referrals to SNAP/WIC teams.
- RAE 1 (RMHP): Works with multiple postpartum programs focusing on infant and maternal wellness, including SimpliFed (lactation support for members) and a comprehensive doula program at two Federally Qualified Health Center (FQHC) locations.
- RAE 2 (NHP): Offers the Taking Care of Baby and Me program, which provides culturally appropriate content about the postpartum period in English and Spanish.
- RAE 3/5 (CO Access): Supports pregnant members of color through doula programs for people of color and the Kente Village Resource Center. Healthy Mom Healthy Baby (HMHB) improves maternal and child health outcomes through texts and interactive modules.
- RAE 4 (HCI): Works with San Luis Valley Health to offer innovative prenatal and postpartum programming to support all pregnant members, especially high-risk members and those with substance use disorder. They are a critical care partner in the Integrated Care for Women and Babies pilot program. HCI also has dedicated OB/GYN care managers reach out to pregnant members.
- RAE 6/7 (CCHA): Currently developing promising initiatives to engage pregnant members with behavioral health needs and connect them to services. They also collaborated with Special Connections program providers for bidirectional referrals for members needing additional support and treatment for substance use disorders.

C. Complex Conditions

Complex conditions put a person at risk for serious health outcomes. These conditions are often chronic and usually require specialized care. Since 2020, RAEs have been required to have programs supporting complex members that meet minimum HCPF standards, including cultural relevance, data use and use of evidence-based programs. Below are some highlights from each RAE's strategies to support members with complex conditions.

- RAE 1 (RMHP): RMHP uses data to identify members in need of care coordination and categorize them for outreach based on a population management strategy. Transitions of care, such as hospital admission or discharge and transfers, also prompt a care coordination intervention. Care coordination teams make and receive referrals, facilitate follow-up and coordinate care with local community resources and partners. Local physical

COLORADO
Department of Health Care Policy & Financing

health, behavioral health and social resource networks are integrated with RMHP care coordination teams and technology platforms. Groups with similar needs or conditions receive customized care coordination designed to address unique circumstances (e.g., foster care, justice-involved, housing instability).

- RAE 2 (NHP): NHP's model identifies high-need members and prioritizes member and family engagement as a standard of care. NHP creates processes for clinical and community care communication that encompass closed-loop referrals for services and facilitating collaboration with other community providers serving the member. For children with complex conditions, families are central to the care team, so NHP care coordinators complete a needs assessment for both child and family. Care coordinators look at the full range of social, behavioral, environmental and health care needs, and facilitate access to medical and social services across a variety of systems, including culturally appropriate community resources, to avoid duplication of services, reduce costs and improve outcomes.
- RAE 3/5 (CO Access): Colorado Access created a pediatric-specific definition of a complex member based on age-appropriate conditions and health-related social needs. The definition continues to be refined with feedback from providers and other stakeholders. They prioritized complex members for coordination and outreach to help them renew enrollment due to the end of the PHE continuous enrollment.
- RAE 4 (HCI): HCI separated its care coordination model into three distinct competencies to clarify and standardize these activities. **Care navigation** focuses on members at moderate risk of poor outcomes and utilization, and unnecessary cost of care by addressing condition specific gaps in care. **Care management** focuses on the most complex members and involves a hands-on approach, supporting members by ensuring they get the care they need and are engaged with the care process to improve health outcomes. **Low-risk care coordination** is a short-term level of service for members identified by HCI or referred for care coordination who do not meet criteria for care management. Based on its belief that care coordination is best provided at the local level, HCI delegates care coordination and management to multiple provider groups across the region.
- RAE 6/7 (CCHA): Building on the model piloted in Region 7, CCHA expanded its Emergency Department Outlier Outreach in Region 6 and trained care coordinators. CCHA expanded its health needs assessment, dashboards and mobile apps that identify nonmedical needs, and continues to look for

opportunities to align care coordination activities with member priorities and cultural values.

D. Social Determinants of Health/Health-Related Social Needs

A focus on the social determinants of health (SDOH)—the life circumstances that support or undermine good health—has been a part of the vision for the ACC since its inception. Health-related social needs are the nonmedical needs, such as food and housing, that impact health. With their regional focus, RAEs are uniquely positioned to make the necessary connection between health care and nonmedical drivers of well-being. Below are highlights of work done during FY 2022–23 to address SDOH.

1. Colorado Blueprint to End Hunger

During the past fiscal year, ACC program staff and the RAEs were active in implementation of the Colorado Blueprint to End Hunger through the Cross-Program Alignment Workgroup, which also includes other state departments, local governments and community groups. Its goal is to improve Health First Colorado member enrollment in food assistance programs like SNAP and WIC. This fiscal year, the Blueprint's focus was on providing education and support as the COVID-19 PHE ended, affecting both Medicaid and food assistance benefits. They supported efforts to raise awareness about benefit redetermination and the end of maximum SNAP allotments.

2. Justice-Involved Members

Individuals returning to the community after incarceration have many needs, including access to health coverage and continuity of care. This care is especially important because people releasing from the justice system have a disproportionately high rate of serious mental illness, SUD, infectious diseases and chronic health conditions. Mortality among post-carceral members reentering society is higher after release, when overdoses, suicides and homicides are more likely to occur. This exacts a high cost in human life and health care dollars, and in some studies, a lack of behavioral health care is associated with increased rates of recidivism.[4] Black and low-income individuals are overrepresented in the justice system, and therefore disproportionately face health and social challenges associated with incarceration and reentry.[5]

---

[4] Wallace, D., & Wang, X. (2020). Does in-prison physical and mental health impact recidivism? *SSM - population health*, *11*, 100569. https://doi.org/10.1016/j.ssmph.2020.100569

[5] Feinberg, R., Esenstad, A., Cannon, R., Staatz, E., Peris K., Bokota, L., Luca, D. L., & Stein, J. (2023) Health Care Transitions for individuals returning to the community from a public institution: promising practices identified by the Medicaid reentry stakeholder group. U.S. Office of the Assistant Secretary for Planning and Evaluation.

3. Post-Release Services

To address the health needs of those releasing from state prisons, HCPF hosts monthly meetings with the RAEs, the Department of Corrections (DOC) and community partners to problem-solve and share best practices. A data-sharing agreement gives the RAEs access to a list of members releasing from DOC facilities so they can coordinate post-release services.

One area of improvement was the percentage of members receiving behavioral health services within 14 days of release, which increased from 10% in January 2020 to over 26% by March 2023. During that same time, the percentage of members receiving medication-assisted therapy (MAT) for SUD within 14 days of release more than doubled from just under 2% to over 5%. RAEs also restarted in-person outreach in prisons and established agreements with providers to outreach members and provide post-release care. In compliance with House Bill 23-1300, HCPF will seek federal authority by April 1, 2024, to expand continuous eligibility for those releasing from a DOC facility.

This fiscal year, HCPF continued its data-sharing agreement with the Colorado Judicial Branch to support members on probation. Work began on an automated data-sharing process in FY 2022–23 that would enable RAEs to reach out to members on probation. Implementation is expected in FY 2023–24.

The most challenging (and largest) group to serve is people in county jails. Coordinating with jails is complex due to shorter, less predictable stays and management inconsistencies: the 50 county jails have different contacts, processes, sizes and needs. The ACC has been focusing primarily on care coordination for enrolled members, but work is ongoing to establish processes for enrollment and post-release care coordination. A stakeholder meeting in April 2023 identified this as an issue. The meeting also identified the need for HCPF to facilitate coordination between jails and RAEs. HCPF is working on an update to the Criminal-Justice Involved Populations Toolkit for Counties, originally published in 2016, to clarify roles and responsibilities and establish processes for Medicaid enrollment prior to release.

4. Pre-Release Services

Colorado Senate Bill 22-196 requires HCPF to determine whether the state should seek an 1115 waiver from CMS to provide a set of benefits immediately prior to release from incarceration. CMS recently approved a similar waiver in California

---

https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf

that allows the state to offer care coordination services 90 days prior to release and in April 2023 released guidance on how states can be approved for this expansion. The bill required HCPF to prepare a report analyzing the potential to cover behavioral and physical health assessments, screening, brief intervention, care coordination and case management, medication assisted treatment (and associated counseling) and prescribed medications, 90 days before release from jail, prison or juvenile justice facilities. The report, submitted in October 2023, identified that this program would be beneficial to the state's criminal justice-involved population and cost-neutral due to additional federal funding, but would require state budget authority. This report is available on HCPF's [Legislator Resource Center](https://hcpf.colorado.gov/legislator-resource-center)[6].

For juveniles, Section 5121 of the Consolidated Appropriations Act of 2023 (federal omnibus budget bill) requires the expansion of a limited set of benefits 30 days prior to release, post adjudication, effective January 1, 2025. The criminal justice reentry report outlines a program that meets this requirement.

5. Community Investment Grants

Community investment grants are an opportunity for RAEs to grant funds to local community organizations, public health departments, health care providers and others to support innovative projects that support health and address barriers to care, such as transportation and access to mental health care. Funded by incentive payments, the grants are meant to support health neighborhoods and communities to improve the overall quality of care, health, wellness and life outcomes for members while reducing expenditures.

Annually, RAEs grant a total of approximately $20 million to more than 160 community recipients throughout Colorado. RAE-funded projects include mobile health clinics, culturally inclusive food pantries, integrated wraparound care for older adults and lifestyle coaching and technology for diabetes management.

6. Permanent Supportive Housing

Housing instability is a health-related social need, a group of factors that may account for as much as 50% of health outcomes.[7] Permanent Supportive Housing (PSH) is an intervention that combines housing and wraparound services for

---

[6] Link: https://hcpf.colorado.gov/legislator-resource-center

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

COLORADO
Department of Health Care Policy & Financing

individuals with a disability, including those whose disability is related to a behavioral health diagnosis and a history of homelessness.

In December 2022, HCPF launched the Statewide Supportive Housing Expansion (SWSHE) pilot project with the Colorado Department of Local Affairs, through funding made available by Section 9817 of ARPA. The pilot identified members with a behavioral health diagnosis who met defined service utilization criteria, and provided them with pre-tenancy and tenancy supportive services, including housing navigation, tenancy support, case management, peer connection and transportation assistance. These services were in addition to covered behavioral health services such as therapy and SUD treatment.

As of June 30, 2023, 529 Health First Colorado members were enrolled in the pilot and receiving wraparound services. Of these, 317 had been previously homeless but were able to secure a housing voucher in the prior months, and 212 secured housing as part of the program.

Through agency partnership agreements, RAEs had the option of working with the Continuum of Care program in their region. These programs manage the statewide Homeless Management Information System and the referral process that connects eligible individuals to a PSH provider and a housing voucher. These partnerships ensured that members with behavioral health diagnoses and other chronic conditions have been appropriately prioritized and connected to the appropriate programs. For example, one RAE that had an agency partnership agreement with the region's Continuum of Care successfully referred 72 members with complex needs and a history of homelessness to PSH during the pilot. The SWSHE pilot will continue through Sept. 30, 2024, at which time it will be evaluated by the Urban Institute to study its impact on Medicaid utilization.

E. Services for Children and Youth

Children and youth are among the most vulnerable Coloradans, especially those in the child welfare system or who require residential treatment. They often need multiple services from different agencies, each with its own complex system subject to different federal and state regulations. State agencies must be proactive in working together to avoid service gaps, delayed access to essential care and service duplication. To this end, HCPF participates in several collaborative efforts with Colorado Department of Human Services (CDHS), BHA, RAEs, hospitals, counties, providers, advocates and families that focus on fixing technical systems issues and on serving members with many complex needs.

RAEs often partner with local and state government agencies and community organizations to address issues in their region that affect children and youth. For example, RAE 4 (HCI) has been working with the Colorado Partnership for Thriving Families to reduce fatalities and maltreatment of children under the age of 5. It has also been collaborating with partners to prevent lead poisoning among children who live near a Superfund site in the region.

Below are examples of collaborative initiatives in FY 2022-23 related to children and youth that involved HCPF and RAEs.

1. *Residential Treatment Programs*

As of October 2021, Colorado was required to demonstrate compliance with the federal Family First Prevention Services Act of 2018 (FFPSA), which overhauled financing of child welfare services and created a new out-of-home provider type, Qualified Residential Treatment Programs (QRTP). Many child-serving residential facilities transitioned their programming and business models to enroll as a QRTP provider to meet FFPSA requirements and provide services to youth in child welfare custody.

HCPF has previously worked with CDHS, BHA, and child-serving residential providers to identify solutions that met the requirements of FFPSA service standards as well as individual provider needs. HCPF supported three of Colorado's larger facilities to convert into Psychiatric Residential Treatment Facilities (PRTF) to expand services for the highest acuity youth. HCPF also reviewed the daily reimbursement rate for PRTFs and significantly increased it to appropriately support services in this setting.

FFPSA requires the use of an Independent Assessment to determine the need for QRTP level of care for children who are child welfare- or juvenile justice-involved. HCPF collaborated with the Behavioral Health Administration (BHA), CDHS and county child welfare agencies to align child welfare and Medicaid authorization processes for QRTP level of care. RAEs are now required to ensure that members requesting QRTP level of care receive an independent assessment if the RAE does not have enough information to approve an authorization request. The RAE must then consider the assessment recommendation when determining whether QRTP is medically necessary. HCPF continues to work with stakeholders on increasing alignment and improvement of this process.

2. *Step-Down Facilities and Respite Programs*

Some children and youth need behavioral health care in a residential setting that is a step down from a hospital, but the state does not have enough facilities and beds to meet the need. As a result, children and youth are placed in facilities out

of state. To limit out-of-state placement, HCPF is using federal ARPA funds to support in-state QRTP and Child Habilitative Residential Program (CHRP) providers who serve Health First Colorado members with complex behavioral health conditions and/or an intellectual or developmental disability. These funds are designed to collect data and fund projects to increase capacity for residential services to better meet the needs of these members.

3. High Fidelity Wraparound Services and Systems of Care

During FY 2022–23, HCPF continued working on a high-fidelity wraparound benefit for children and youth at risk for out-of-home placement. This benefit is an evidence-based model that formalizes care coordination across child-serving systems, supports community-based treatment and helps families strengthen their own natural supports. RAEs will receive an enhanced administrative PMPM payment to provide wraparound and family support services for eligible children and youth: comprehensive assessment, development and facilitation of the Child and Family Team, an individualized care plan and follow-up activities to ensure successful implementation and completion of the individualized care plan. The RAEs will also provide parent/caregiver and youth peer support if families require additional assistance.

4. Statewide Standardized Utilization Management Guidelines

In FY 2022-23, HCPF worked with the RAEs to create uniform statewide utilization management standards for assessing the most appropriate level of care for children and youth referred for residential treatment. The Statewide Standardized Utilization Management (SSUM) guidelines have information related to residential services through QRTPs and Psychiatric Residential Treatment Facilities (PRTFs). These guidelines were developed as a companion to national utilization management standards used by the RAEs to authorize behavioral health services. RAEs were required to use these guidelines in their utilization management processes starting July 1, 2023.

5. HCPF, RAEs, CDHS and Counties Forum

HCPF continued to facilitate the HCPF, RAEs, CDHS and counties (HRCC) forum for child welfare issues. In addition to the QRTP assessment work, the HRCC's work this fiscal year included:

- Monthly workgroup meetings to create ways to use data to assess the effectiveness of the ACC program for youth involved in the child welfare system. The workgroup gathered, presented and evaluated data from HCPF

and CDHS that prompted additional work to refine the research questions, gather relevant data and draw conclusions.

- Updates and resource-sharing for projects such as the adoption negotiation tool and the placement vs. treatment workgroup.

- Regional meetings between each RAE and county child welfare staff to build relationships, identify areas for improvement and develop solutions.

HCPF also held a voting position on the Delivery of Child Welfare Services Task Force and co-chaired the Medicaid Subcommittee that has been working for three years to identify opportunities to improve access to Medicaid services for youth in child welfare. The Task Force moved forward a set of recommendations to HCPF and other state entities, and HCPF provided a formal response in October 2022.

In addition to these efforts, HCPF developed a set of recommendations for the Colorado's Child Welfare System Interim Study Committee[8]. These recommendations were developed with the Behavioral Health Task Force Child and Youth Subcommittee in collaboration with multiple state agencies, county governments, advocates, families and providers. The committee is drafting proposed legislation for the 2024 legislative session based on these recommendations.

V. Care Access

Access to care for all members is an ongoing goal for the ACC. HCPF monitors access and works continuously to improve member access to high-quality care. This section describes how the ACC is expanding access to both behavioral and physical health care.

A. Behavioral Health Transformation

Access to behavioral health care is essential for a person's health and well-being. Providing needed behavioral health care is a challenge nationally and a particular challenge for Medicaid programs, which cover more people with severe mental illness and substance use disorders than commercial insurance,[9] and deliver care in large geographic areas with both urban and rural populations. Behavioral health system transformation is necessary to address these challenges and meet community needs.

---

[8] Link: https://leg.colorado.gov/committees/colorados-child-welfare-system-interim-study-committee/2023-regular-session

[9] Saunders, H. & Rudowitz, R. (2022). Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. *KFF*. https://www.kff.org/mental-health/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

As the largest payer of behavioral health services in the state, Medicaid policies and payment strategies directly impact Health First Colorado members, but also drive and influence change across Colorado.

To do this work, HCPF partners with BHA on many initiatives described in this report. HCPF and BHA work together to engage behavioral health providers and other stakeholders to increase access to behavioral health care, improve systems of payment and reporting, adjust licensing and provider enrollment requirements when needed, and support the behavioral health workforce.

As part of system transformation, and in compliance with House Bill 22-1302, HCPF offered short-term grant funding for physical and behavioral health care providers looking to implement or expand access to care and treatment for mental health and substance use disorders using an evidence-based integrated care model. Funds were awarded after the opportunity was posted in FY 2022–23. Funded organizations began work in FY 2023–24.

This year, BHA and HCPF also worked together to establish Behavioral Health Administrative Service Organizations (BHASOs), which will consolidate substance use disorder treatment services and crisis services, and include services offered by Community Mental Health Centers (CMHCs). Although RAEs and BHASOs are similar, there are differences between populations served and function. HCPF and BHA are collaborating to identify commonalities and opportunities for alignment between RAEs under ACC Phase III and BHASOs. The shared goals are to improve services to Coloradans, improve coordination and efficiencies across the system and create consistency for providers while reducing administrative burden. BHASOs will be implemented by July 2025.

B. Behavioral Health Safety Net

HCPF and BHA are collaborating with stakeholders to improve the performance and accountability of the behavioral health safety net, to better meet the needs of the communities they serve.

1. Definition of "Safety Net" and "Safety Net Provider"

To support and expand the state behavioral health safety net, HCPF and BHA are establishing new definitions for **safety net** in compliance with Senate Bill 19-222. These definitions will ensure that the criteria for a safety net provider simultaneously reduces administrative burden while incentivizing provider participation in the safety net system. This work stream is underway and will be complete by July 1, 2025. In addition, House Bill 22-1278 modernized the definition of safety net providers and associated safety net services. The first set of these rule adjustments are expected to be effective by Jan. 1, 2024.

2. Rate Setting for Behavioral Health Safety Net Providers

To increase clarity and transparency on rate setting for CMHCs, HCPF released new cost report templates for the CMHCs in May 2022. Starting November 2022, CMHCs were required to submit their cost information to HCPF using these new reports, which will continue to be updated based on new safety net requirements in 2024.

3. Alternative Payment Models (APMs) and Value-Based Payments (VBPs)

HCPF is working with stakeholders and BHA to develop new reimbursement methodologies for safety net providers that create greater accountability to the community and reward improved member outcomes. See the Health First Colorado Value section of this report for more details.

4. Universal Contract Provisions

Two state laws (House Bill 22-1278 and House Bill 22-1302) require HCPF and BHA to work together to develop universal contract provisions that will define expectations for state-contracted behavioral health providers. This will standardize contract expectations around data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission and billing for procedures. HCPF and BHA developed an initial draft in FY 2022-23 and will seek stakeholder feedback during the summer and fall of 2023. The final provisions are expected to be included in FY 2024–25 contracts.

5. Investments to Increase Behavioral Health Provider Rates

About $600 million in additional funding has been provided to RAEs since FY 2018-19 to increase provider reimbursements and enhance behavioral health services and coverage. HCPF increased RAE behavioral health budgets by approximately 6% in FY 2021-22 (about three times the across-the-board increase provided to all Health First Colorado providers that year) and sustained that funding during FY 2022–23.

C. Short-Term Behavioral Health Services

Members can receive short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's PCMP site. About 46% of the 17,728 members who used the short-term behavioral health benefit in FY 2022–23 had not accessed behavioral health through the capitated benefit in the previous year, suggesting that this benefit may be expanding access to behavioral health care.

D. Behavioral Health Crisis Services

Traditionally, emergency medical services and law enforcement have been relied upon to respond to behavioral health emergencies. New crisis behavioral health

services, however, give members access to behavioral health professionals in an emergency. In FY 2022-23, HCPF collaborated across state agencies to address a behavioral health crisis. Specific activities are described below.

1. Behavioral Health Secure Transportation Benefit (BHST)

Traditionally, urgent behavioral health transportation has been provided by law enforcement or emergency medical services, which can be stigmatizing or traumatizing to the individual in crisis. Utilizing this high level of care can also be costly to the system and may lead to unnecessary interaction with law enforcement. Due to the nature of emergency medical transportation, members must often go to the emergency department prior to being routed to a behavioral health treatment facility. In FY 2022-23, HCPF worked with CDPHE and BHA to establish a new benefit to provide secure transportation for those in a behavioral health crisis so they can go to the best place for treatment in a less traumatizing manner. HCPF continues to shape the benefit so that it aligns with other policies. For example, HCPF intends to integrate BHST, which is currently a fee-for-service benefit, into the capitated behavioral health benefit.

2. Mobile Crisis Response

In FY 2022-23, HCPF and BHA worked to develop the Mobile Crisis Response benefit which standardizes services across the state. The updated benefit allows teams to provide a trauma-informed, community-based crisis response at any time to anyone in Colorado experiencing a behavioral health crisis in wide variety of community-based settings, regardless of age, insurance status, residency or prior utilization. HCPF reimburses for members only, while BHA covers costs for all others. These services can be accessed through the Colorado Crisis Line, which connects people directly to behavioral health professionals as a trauma-informed alternative to calling police or going to an emergency room. This program was designed to reduce unnecessary hospital visits and arrests. Providers are required to connect members to post-crisis health care and community support services.

HCPF provided ARPA funds to response teams through an interagency agreement with BHA to help providers adjust to these updated standards. The providers are implementing staff training, increasing their capacity for 24/7 response, purchasing equipment and harm reduction tools and improving technology. Funds are also being used to create more culturally responsive and person-centered equitable access mobile crisis services in Colorado.

3. Crisis Hotline Support

The Colorado Crisis Line provides immediate, anonymous, confidential emergency telephone support to anyone in need of assistance, information or referrals

regarding a behavioral health crisis. It provides services 24/7 to people of all ages regardless of insurance or ability to pay, and includes a hotline, warm-line and texting. The service is funded primarily by BHA and is provided by Rocky Mountain Crisis Partners. RAEs contributed $1 per member for FY 2022-23 to Rocky Mountain Crisis Partners to support use of this service by members.

E. Medication-Assisted Treatment/Opioid Treatment Program

Medication-assisted treatment (MAT) refers to the use of medication together with other therapies to treat SUD. MAT is a required service under Colorado's federal 1115 SUD waiver as well as state legislation. Any provider credentialed to prescribe MAT is permitted to do so under the fee-for-service model and does not need to contract with a RAE to receive reimbursement. However, RAEs do contract with many MAT service providers.

There are many medications used to assist in withdrawal management and abstinence maintenance. All prescribers, in accordance with their licensing, may provide MAT as a service to members. MAT is commonly used to help members manage alcohol use disorder as well as opioid use disorder. Some of the most common opioid use disorder treatments include methadone, buprenorphine and naltrexone. Opioid treatment programs (OTPs) are licensed by BHA in accordance with federal Substance Abuse and Mental Health Services Agency and Drug Enforcement Agency standards. OTPs are the only type of provider that is permitted to prescribe, dispense and administer Methadone in an outpatient setting. In addition to Methadone, OTPs may also provide all other MAT medications, such as buprenorphine and naltrexone.

The use of MAT to treat opioid use disorder increased during this fiscal year. New federal guidelines have reduced barriers and removed obstacles for all prescribers to meet more basic requirements to prescribe buprenorphine. In addition, more OTP providers are now licensed and enrolled; there are now 35 across the state, making it easier for people to find OTP services closer to home. RAEs continue to provide education about MAT to primary care providers, including OB-GYNs and pediatricians. In the upcoming fiscal year, they will explore how to expand OTP networks with the addition of mobile MAT services supported by BHA.

In addition, Phase I of the Prescriber Tool included the release of OpiSafe, a module released in January of 2021, including the provision of 5000 free licenses to providers to adopt and use the module, which mitigates overprescribing of opioids and benzodiazepines to patients, including Health First Colorado members. In the first year of the release of this module, the prescribing of opioids to Health First Colorado members dropped by 16%, preventing addiction and protecting individuals and families all across Colorado from its consequences.

F. Behavioral Health Network Provider Expansion

HCPF is committed to building provider networks so that all members can access the care they need. Federal and state managed care regulations require strict monitoring of provider access and adequacy to ensure members' needs are met. This includes provider-member ratios as well as distance and travel time, appointment wait times, cultural/linguistic competency and disability services.

HCPF monitors behavioral health network adequacy through annual network adequacy reports and quarterly reports on network development, which include contracting efforts and a quantitative analysis of where members live in relation to provider locations and services. Reports include a qualitative analysis of whether contracted providers are accepting members and their capacity to provide care for the member population in the region. All network data submitted to HCPF is validated and reviewed for accuracy by a third-party external quality review organization.

Expanded access to behavioral health care depends on increasing the number of providers who can deliver services. In regions where providers are limited due to national workforce shortages, RAEs have adopted innovative strategies to build the capacity of their networks so they can deliver comprehensive behavioral health services. They may contract with new providers from other state systems (e.g., child welfare or criminal justice), establish new service modalities (e.g., telehealth), create value-based payments, recruit new providers or help existing provider practices expand their capacity to serve new populations or offer new services.

In FY 2022–23, the ACC collaborated on behavioral health system transformation to address access challenges caused by an insufficient number of providers and lack of participation in both Medicaid and commercial insurance plans. Higher reimbursement rates helped to increase the number of participating providers. In FY 2022-23, all RAEs increased reimbursement rates for behavioral health providers, with a specific focus on expanding the independent provider network (IPN), or providers outside the CMHC network. In addition, HCPF and the RAEs worked together to put policies in place to expand the use of pre-licensed clinicians working under supervision as Medicaid providers. The ACC added over 3,000 contracted behavioral health practitioners in FY 2022–23, including licensed psychologists and licensed behavioral health clinicians. Practitioners were added in every quarter of this fiscal year in all regions.

Table 6. Number of RAE-contracted behavioral health practitioners added each quarter, FY 2022–23

RAE	Q1 (Jul-Sept)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
1 (RMHP)	18	30	20	40
2 (NHP)	97	175	273	200
3 (CoA)	199	109	146	260
4 (HCI)	97	176	274	200
5 (CoA)	203	109	150	257
6 (CCHA)	154	244	268	427
7 (CCHA)	154	244	268	427

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

Table 7. Number of RAE-contracted behavioral health practitioners at the end of FY 2022–23

RAE	Behavioral Health Practitioners as of July 2023
1 (RMHP)	4,064
2 (NHP)	3,480
3 (CoA)	8,300
4 (HCI)	3,480
5 (CoA)	8,302
6 (CCHA)	7,421
7 (CCHA)	7,421

1. Residential SUD Service Providers

There are now 61 enrolled residential providers across the state offering all levels of adult residential SUD services. Adolescent services are currently limited to withdrawal management, as there are no adolescent residential SUD providers enrolled with Medicaid and very few licensed in Colorado. Effective July 2023, payments have been increased for adolescent SUD residential providers in hopes of increasing provider participation in offering these services. In FY 2022–23, more than 8,000 members received residential SUD treatment services. Denials for residential services decreased during this second year of the 1115 waiver demonstration and have stabilized at about 5%.

2. High-Intensity Outpatient Service Providers

This fiscal year, RAEs started work to build network capacity to address gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care. Each RAE was contracted to disperse ARPA funds to increase access to high intensity outpatient services through capacity building efforts.

3. Peer Support Service Providers

Peer support is an important part of recovery for members diagnosed with a behavioral health condition and learning to live with it in a manageable way. Peers can share their recovery journey, which often includes trauma, recovery from SUD and life with a mental health diagnosis. In partnership with BHA, HCPF created a new provider type this year to align with a new license type: the Recovery Support Services Organization (RSSO). These organizations employ peers and can bill Medicaid for peer services. This provider type started in August 2022. As of June 2023, two of these organizations have enrolled as Medicaid providers and contracted with one or more RAEs. In FY 2023-24, the ACC plans to build the RSSO network and include organizations that employ peers to support people experiencing homelessness.

G. Stakeholder Engagement with the Independent Provider Network

HCPF intensified stakeholder engagement with the behavioral health independent provider network (IPN) in FY 2022-23. The goal of this initiative is to identify potential barriers for behavioral health providers and create mutually agreeable action plans for addressing issues. The purpose of Phase I, which took place from April to June 2022, was to gather information from stakeholders and establish a safe space to share perspectives, build relationships and develop a foundation for a collaborative problem-solving process. This phase identified the shared interests of all parties, a summary of what is working in the system, a list of system issues by stakeholder group and the identification of 10 barriers.

The goal of Phase II, completed in June 2023, was to explore the barriers identified in Phase I and recommend mutually agreeable action plans to address them. Five action teams focused on these key areas: credentialing and contracting, billing and coding, payment and reimbursement, service quality and communications. The action teams followed a structured process improvement framework to develop recommendations and implementation plans. HCPF is now launching an ongoing IPN Collaboration Forum and Working Group with IPN, RAE, and HCPF staff to move these recommendations forward and provide ongoing space for collaboration.

In each project phase, independent behavioral health providers had the opportunity to give feedback on their interactions, key touchpoints and transactions with HCPF and the RAEs through an IPN satisfaction survey. The results of the survey, administered in 2022 and 2023, indicate improvement in satisfaction and service quality.[10] Overall, survey respondents indicated they are more satisfied with being a Health First Colorado provider and their relationships with the RAE improved in the one-year collaboration period. Improvement is also evident across all 11 indicators of interaction among providers, HCPF and the RAEs. The indicators include enrolling with HCPF as a Health First Colorado provider; contracting, credentialing and receiving service preauthorization through a RAE; coding, preparing and submitting claims to a RAE; coding, preparing and submitting claims to HCPF; resolving claim issues with a RAE; receipt of payment from a RAE; receipt of payment from HCPF; and responding to RAE audits.

H. Autism Spectrum Disorder

Through a budget request in FY 2022-23 (R-10, Children and Youth with Complex and Co-Occurring Needs), Colorado added autism spectrum disorder (ASD) as a covered diagnosis under the capitated behavioral health benefit for psychotherapy services. This change will remove barriers for members with ASD who have co-occurring conditions and increase access to services covered by the RAEs. ASD coverage takes effect Jan. 1, 2024.

I. Provider Directory Audit

RAE provider directories help members find network providers, so it is crucial that the information is accurate, updated and easy to locate and navigate, ensuring access to health care at the right time, the right place and the right setting. During the fiscal year, HCPF contracted with a vendor to audit these provider directories, identify potential deficiencies and make recommendations. Some recommendations that came out of the audit were to improve search parameter functionality, perform annual audits of the directories, maintain updated contact information for providers, ensure all provider type filters are operational, and regularly testing functionality and accessibility tools.

J. Care Coordination with Long-Term Services and Supports

The ACC coordinates with Long-Term Services and Supports (LTSS) entities to ensure access to comprehensive services for members with a range of needs, including those with physical disabilities, serious mental health needs and developmental or

[10] The IPN Satisfaction Survey is in the Phase II report. https://hcpf.colorado.gov/sites/hcpf/files/IPN%20RAE%20HCPF%20Collaboration%20Project_Phase%20II_Final%20Report_080423.pdf

COLORADO
Department of Health Care Policy & Financing

intellectual disabilities. In FY 2022-23, the ACC coordinated with LTSS entities to support members who need these services.

1. Private Duty Nursing

Private Duty Nursing (PDN) is a benefit for members to receive face-to-face skilled nursing that is more individualized and continuous than nursing care available under the home health benefit or provided in a hospital or nursing facility. This service is ordered by the attending physician, and a plan of care is developed and carried out by a home health agency.

This fiscal year, HCPF heard concerns regarding the prior authorization process for PDN. We wanted to ensure that members have timely access to care while also fulfilling the federal obligation to demonstrate medical necessity at the level approved for all authorized services. HCPF continues to work with RAEs and Denver Health to ensure that members who received PDN service denials get appropriate support to meet their needs. In FY 2022-23, HCPF hosted two trainings to ensure that RAE/MCO care coordination staff understand the PDN benefit as well as the responsibilities of the case management agency (CMA) and the RAE/MCO to support members who are denied PDN services. HCPF also created educational resources available on the PDN webpage[11] and an email address[12] for questions about the PDN policies and benefits. If the member is receiving waiver benefits and assigned a CMA, the RAE/MCO is expected to coordinate with the assigned CMA. The RAE/MCO must support the member by explaining the appeals process and connecting the member to alternative supports if needed.

Each week, HCPF sends a list of members who have received PDN denials, including the rationale for the denial and CMA information for each member, to the RAEs/MCOs, who then use this information for outreach and support. RAEs/MCOs submit monthly reports back to HCPF to confirm outreach and track support status. They also report summary data twice a year on the Care Coordination and Complex Management Report. In addition, HCPF clinical staff and RAEs communicate directly on cases that are clinically or administratively complex to ensure member needs are met.

2. Care Coordination and Case Management

HCPF used ARPA funds to increase communication, collaboration and cross-agency coordination for members receiving care coordination from a RAE and case management from a CMA. During this fiscal year, a contractor conducted individual and group interviews of stakeholders and subject matter experts,

[11] Link: https://hcpf.colorado.gov/private-duty-nursing
[12] Email address: HomeHealth@state.co.us

created a system map and compiled a report of best practices. In the upcoming fiscal year, these best practices will be used to connect core competencies with roles and responsibilities, inform rule and contract language, create and implement a cross-agency communication strategy, develop RAE and CMA trainings, and assess process improvement outcomes.

Work is also underway to plan for care coordination during the next iteration of the ACC. A Care Coordination Workgroup formed in January 2023 to plan care coordination improvements in ACC Phase III. The objectives of this work are to increase awareness and understanding of care coordination as a service, increase equitable access to care coordination, improve the quality, consistency and measurability of interventions and improve the member experience and outcomes by ensuring better coordination and data exchange between the various organizations that coordinate care for the same member, such as Medicare Advantage and Dual Eligible Special Needs Plans (D-SNPs), CMAs supporting members with LTSS and RAEs.

3. Hospital and Emergency Department Discharge Coordination for SUD

All RAEs and MCOs use admit, discharge and transfer health information exchange feeds for care coordination and discharge planning. RAEs coordinate with hospitals in different ways. For example, RAE 1 (RMHP) participates in the hub-and-spoke model for SUD in Larimer and Mesa Counties. Members who need SUD treatment are identified through hospital claims data or referrals from community partners. Care coordinators facilitate connections between regional hubs like SUD providers and providers who offer MAT services, and this coordination continues through the continuum of care 30 days after discharge. In another example, RAEs 3 and 5 (Colorado Access) pair hospital systems with high-volume PCMPs who serve the same members to improve care coordination and prevent hospital readmission.

4. Hospital Review for Care Coordination and Discharge Planning

As part of Senate Bill 18-266, HCPF was required to design and implement an inpatient hospital review program (IHRP) to help hospitals coordinate with the RAE for effective discharge planning and care coordination. HCPF launched an initial version of the program in 2019, but it was temporarily halted during the COVID-19 public health emergency. In FY 2022-23, HCPF redesigned the program, now called IHRP 2.0, to include pre-admission and post-admission reviews. Pre-admission reviews are on hold while HCPF works with hospital partners on the program, but post-admission reviews were implemented in May 2023. The reviews are required at hospital day six for neonatal stays, sepsis, cellulitis, pulmonary edema and respiratory failure, thoracic procedures and abdominal vascular procedures. Post-

admission reviews are also required on all hospital stays at day 30 and every 30 calendar days thereafter. Hospitals submit clinical documentation and other relevant information to HCPF's utilization management vendor, which is then shared directly with each RAE to assist with care coordination and discharge planning. A formal evaluation during the fall and winter of 2023 will inform process improvements to optimize the RAEs' relationships with hospitals and their role in discharge support.

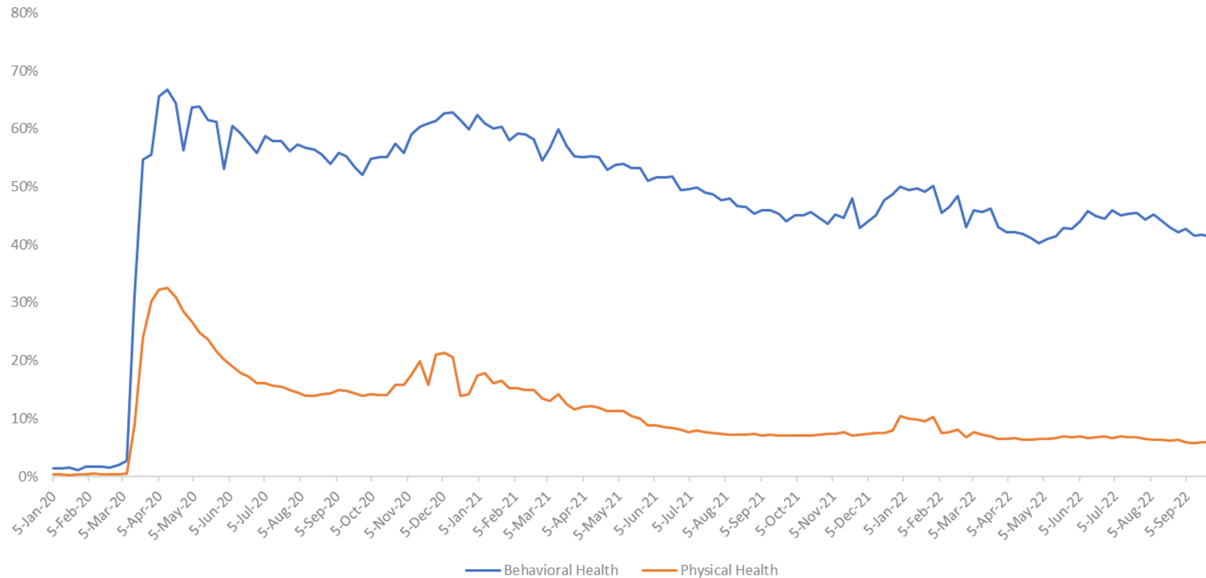
5. Coordination for Members Who Cannot Be Discharged

HCPF is collaborating with hospitals, RAEs and community organizations to support members who need to be discharged from hospitals and emergency departments but lack post-discharge care or a safe place to be discharged (e.g., members involved in child welfare). RAEs provide weekly updates about members who are struggling to find appropriate care to facilitate discharge. HCPF worked with hospitals to ensure they are notifying RAEs when members cannot discharge from the hospital. HCPF also collaborated with hospitals to develop a checklist with discharge roles and responsibilities. During the next fiscal year, HCPF will work with the hospitals to adopt this document.

K. Telehealth

HCPF continues to track and monitor telehealth utilization as required by Senate Bill 20-212. Telehealth may be either video or audio-only visits. Utilization has continued to stabilize since the start of the COVID-19 pandemic. As of the end of the first quarter of SFY 2022–23, 41% of all eligible behavioral health visits were conducted by telehealth and 6% of all eligible physical health visits were conducted by telehealth, compared to the height of in April 2020, when 67% of eligible behavioral health visits and 33% of eligible physical health visits were conducted via telehealth. Data are available only through September 2022 due to encounter data lag times.

Figure 3. Percentage of eligible telehealth visits, January 2020 to September 2022



Telehealth utilization varied by RAE region. RAEs in urban areas of the state had a higher percentage of tele-behavioral health use than RAEs in more rural areas. Telehealth use for behavioral health care ranged from 33% of behavioral health services in RAE 1 to 56% of services in RAE 6 during the first quarter of FY 2022–23.

VI. Operational Excellence and Customer Service

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

A. Member Experience

The ACC assesses member experience in a few different ways, one of which is the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey. The 2023 Health Plan Survey asked members (or their parents/guardians) questions about how they like their doctor, whether they were able to get needed care in a timely manner, provider communication, health plan customer service and coordination of care.

Ratings varied across RAEs for each factor, but most members reported being able to get needed care (78.3% for adult care and 80.4% for children) and get care quickly (78.9% for adults and 85.0% for children). They also reported satisfaction with care coordination (81.1% for adults and 83.6% for children) and how well their doctors communicate with them (92.7% for adults and 93.7% for children). Survey conclusions

indicate that the ACC should continue building provider networks and address provider barriers to ensure access to care.

Another way to measure experience is through the responsiveness of the call center. Members access help from both the HCPF Member Call Center and the RAE call centers. In FY 2022–23, the average speed of answer at the HCPF call center was 35 seconds, compared to last year's average of 40 seconds. The data for the RAE member call centers are in Table 8.

Table 8. RAE member call center data by RAE/MCO, FY 2022–23

RAE/MCO	Average member monthly call volume	Member response times (avg speed of answer)	Member call abandonment rate
Denver Health	1,605	63 seconds	1.43%
1 (RMHP)/RMHP PRIME	4,127	8 seconds	0.30%
2 (NHP)	391	15 seconds	3.06%
3 (CoA)	1,965	15 seconds	0.005%
4 (HCI)	391	15 seconds	3.06%
5 (CoA)	1,965	15 seconds	0.005%
6 (CCHA)	2,034	11 seconds	2.76%
7 (CCHA)	1,143	11 seconds	3.43%

B. Provider Experience

A positive provider experience depends on several factors, including smooth enrollment/contracting, timely processing of claims payments and timely responses to questions. As managed care entities for behavioral health, RAEs are responsible for contracting with providers and ensuring a good provider experience that will lead to better care and outcomes for members. RAEs also contract with PCMPs and work closely with other physical health providers in the region. RAEs are responsible for processing behavioral health claims that fall within the managed behavioral health benefit and paying providers the contracted rate. In compliance with federal regulations, HCPF requires that the RAEs adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party.

Providers submitting claims to their RAE must provide adequate documentation and adhere to the provider's contract with the RAE. Claims can be denied if they do not

meet medical necessity requirements. More often, they are denied due to inaccurate billing and documentation. Each RAE has a call center and provider relations staff to help providers with billing questions. They are required to respond to provider questions within two days.

Table 9. Performance on provider service requirements by RAE, FY 2022–23

RAE	% of clean claim payments within 30 days (standard: 90%)	Response to provider inquiries within two days (standard: 100%)	Credentialing and contracting within 90 days (standard: 90%)
1 (RMHP)	99.5%	99.7%	93.7%
2 (NHP)	99.8%	100%	92.7%
3 (CoA)	97.1%	100%	97.7%
4 (HCI)	99.9%	100%	93.9%
5 (CoA)	97.2%	100%	97.7%
6 (CCHA)	99.5%	100%	100%
7 (CCHA)	99.5%	100%	100%

Across RAEs, the percentage of adjudicated claims paid within 30 days was 98.9%. Most claims are paid faster; on average, 90.5% of clean claims were paid in 14 days or less.

A provider’s experience is better when they can get the help and answers to questions in a timely manner. Table 10 shows RAE provider call center response data for FY 2022-23.

Table 10. Provider call center data by RAE/MCO, FY 2022-23

RAE/MCO	Average provider monthly call volume	Provider response times (avg. speed of answer)	Provider call abandonment rate
Denver Health	1,100	12 minutes 29 seconds	36.71%
1 (RMHP)/RMHP PRIME	6,973	29 seconds	2.07%
2 (NHP)	355	16 seconds	2.31%
3 (CoA)	1,606	19 seconds	0.009%
4 (HCI)	355	16 seconds	2.31%
5 (CoA)	1,606	19 seconds	0.009%
6 (CCHA)	1,067	17 seconds	0.42%
7 (CCHA)	1,067	17 seconds	0.42%

Most physical health service claims are processed through HCPF's vendor, Gainwell. This fiscal year, Gainwell's call center average speed of answer was 39 seconds. Its medical claims processing average turnaround time was 3.5 days. Due to staffing shortages, Denver Health experienced longer provider response times. However, they expanded the call center capacity in August 2023 and experienced only a 3.83% provider call abandonment rate.

During this fiscal year, RAE 3/5 (CO Access) and RAE 1 (RMHP) migrated to new platforms for provider claims payment to improve functionality. To mitigate the risk of disruption, HCPF required enhanced service standards and substantial consequences for failure to meet those standards. HCPF and RAE staff met frequently to discuss system migration progress, and both RAEs continue to send regular status reports. As of July 2023, both RAEs have met most of the enhanced service performance standards, and the system migrations have not caused significant program disruptions. The RAEs have implemented interim workarounds and supports for providers and members to mitigate changes and impacts.

C. Member and Provider Engagement

The ACC has both a statewide Program Improvement Advisory Committee (PIAC) and regional PIACs to better inform programmatic decisions. The statewide PIAC is managed by HCPF and facilitated by two co-chairs. It includes representatives from various provider groups, advocacy organizations, members and other stakeholders. At regular public meetings, the statewide PIAC considers actions related to the ACC and provides formal recommendations to HCPF for program improvement. The PIAC also

utilizes three subcommittees that focus on behavioral health, provider and community experience, and performance measurement and member engagement. By contract, each RAE must also manage a regional PIAC process. These groups, composed of regional stakeholders, help RAEs identify local challenges and concerns as well as opportunities for improvement.

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

VII. Health First Colorado Value

A. ACC Budget and Value

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

The effectiveness of ACC cost control cannot be evaluated solely by an increase or decrease in costs year over year because these raw numbers are heavily influenced by the number of covered Coloradans. The overall program cost increased dramatically during the pandemic, leveled off in FY 2022-23, and will likely decrease as normal enrollment processes resume.

To evaluate the effectiveness of cost control, HCPF looks at the overall Medicaid claim cost trend, which is measured in several ways. One way is to look at the cost trend, or the rate at which health care costs are increasing. From July 2022 to June 2023, the per-member-per-month trend was 2.1%, while risk-adjusted trend was 3.7%. During the evaluation period, the approved across the board provider reimbursement increase, which has a direct impact on Medicaid cost trend, was 3%. The trend in total claims paid was 12.4%, which reflects membership growth of 10.1% due to the public health emergency (PHE). The ACC was part of a comprehensive Medicaid cost control strategy that controlled these cost increases during the PHE: after covering claims for the hundreds of thousands of additionally eligible Coloradans, HCPF was able to return $1.7 billion to the state General Fund through June 2023 of the additional 6.2% growth in federal matching funds.

HCPF strives to efficiently administer Health First Colorado, with a 4% administration allowance, meaning that 96% of the budget goes to reimbursing providers for their services to Health First Colorado members. This section describes the ACC's budget and summarizes ACC efforts in the past year to increase value and control costs. Costs for the ACC include:

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

Table 11. FY 2022-23 Budget for the Accountable Care Collaborative

Accountable Care Collaborative Budget Category	FY 2022-23 Expenditures
Payments for Services	
Fee-for-service payments	$9,471,079,075
Denver Health MCO capitation payments	$301,680,592
RMHP PRIME MCO capitation payments	$302,836,594
Behavioral health capitation payments	$1,172,103,419
Administrative and Incentive Payments	
Administrative PMPM payments	$207,337,012
KPI payments	$21,683,884
Behavioral health incentive payments	$17,116,868
Performance pool payments	$29,348,811
TOTAL ACC EXPENDITURES	**$11,523,186,255**

HCPF requires payment models that combine accountability for health outcomes with flexibility for providing care in the manner that best meets member needs. HCPF leverages a variety of aligned strategies that enable RAEs and providers to improve outcomes, reduce disparities and drive affordability. These are described below.

B. Hospital Transformation Program

The Hospital Transformation Program (HTP)[13] is a result of a state law that directed the Colorado Healthcare and Sustainability Enterprise (CHASE), acting with HCPF, to fund and support the implementation of a program for health care delivery system reform incentive payments (DSRIP) to improve health care access and outcomes.

The goal of the HTP is to improve the quality of hospital care by tying provider fee-funded hospital payments to quality-based initiatives. During the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure to improve quality, community engagement and health outcomes over time.

Through the HTP, hospital-led projects will achieve benefits not just for members but all Coloradans and their employers, including improved patient outcomes, better delivery system performance, lower Medicaid costs, improved hospital readiness for

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

value-based payments and increased collaboration between hospitals and other health partners.

During Program Year 1, hospitals completed 1,380 milestone activities on a range of initiatives. Many of these activities include collaboration between hospitals and the RAEs. Some examples that highlight the ongoing collaboration efforts within the state and the HTP's alignment with the goals of the ACC include:

- Melissa Memorial Hospital is identifying and testing process workflows for timely RAE communication to ensure a follow-up appointment with a clinician is made prior to discharge and notification to the RAE.
- Sky Ridge Medical Center is working on a process for documentation tracking and reporting so behavioral health screenings are done more often. This includes collaboratively developing and implementing a mutually agreed upon discharge plan and notification process with the appropriate RAEs for eligible patients with a diagnosis of mental illness or SUD who have been discharged from the hospital or emergency department.
- Centura St. Anthony North Hospital is creating a solution in the electronic health record to identify all pregnant and postpartum members on any hospital counter so the Edinburgh Depression Scale Screening can be done. Upon screening, positive screens for perinatal and postpartum depression and anxiety will be sent to the RAE, ensuring information is being shared between the hospital and RAE and the appropriate next steps are taken.
- Centura St. Mary-Corwin Hospital is working on implementing a standardized referral to clinicians by amending the electronic health record to document the appointment and abstract data to report on performance. This will ensure that a follow-up appointment with a clinician is made prior to discharge and notification of the RAE will occur within one business day.

Community Health Neighborhood Engagement (CHNE) is required of hospitals throughout their participation in the program. This ensures that hospitals continue to be responsive to community needs throughout the life of the HTP. Overall, more than 700 unique CHNE activities have been conducted; hospitals reported 548 consultations with key stakeholders, engaged with over 200 unique organizations and reported over 100 community advisory meetings.

C. Prescriber Tool

Phase I of the Prescriber Tool, launched in 2021, has two modules. The first, OpiSafe, was implemented in January of 2021 and the second, the Affordability Module, was implemented in June of 2021. The tool offers pharmacy benefit information at the point of care for members to improve prescription drug transparency and

affordability, improve member access and decrease the administrative burden for providers. The Prescriber Tool has four modules: electronic prescribing, real-time benefits inquiry (RTBI), electronic prior authorization and opioid misuse risk. HCPF will continue to work with care providers to implement innovative tools that help providers achieve shared goals in the areas of access, affordability, quality and equity, and earn shared savings and other value-based payment rewards for their performance. The Prescriber Tool is one such important and evolving tool.

Accordingly, Prescriber Tool adoption continues to be an important focus of the ACC. In FY 2022-23, RAEs helped promote prescriber tool use by identifying PCMPs who could use the tool, incentivizing use with administrative funding and troubleshooting by practice support teams. As a result, prescriber tool adoption has continued to increase: 10,742 providers (47% of Health First Colorado prescribers) are using the tool. The opioid risk module of the tool has been integrated with health information exchanges, including Quality Health Network (QHN) and Contexture, to make it more accessible. About 5,700 licenses have been allocated to providers for the opioid risk module by Opisafe.

An APM to incentivize uptake of the prescriber tool's RTBI module was launched in October 2023 to promote pharmacy benefit compliance and cost efficiency. This reduces administrative burden by providing real-time Preferred Drug List information for prescribers and electronic prior authorizations. HCPF piloted provider-facing dashboards in March 2023 that communicated data on the original performance indicators for the APM. Feedback from this pilot was used to adjust the APM design, including a change to the performance indicators. At least one RAE has a value-based primary care payment model that creates financial incentives to providers who adopt the prescriber tool.

D. Alternative Payment Models

Traditional fee-for-service payment models reward volume over health outcomes or quality performance. APMs incentivize care providers to control costs while ensuring good patient health outcomes. Colorado intends to have half of all Health First Colorado payments tied to these value-based arrangements by 2025.

RAEs are critical to the success of APMs. They are responsible for supporting providers in participating in APMs and meeting quality improvement goals. APM indicators are intentionally aligned with the RAE quality performance indicators and other identified national measure sets to reduce provider burden and ensure all entities work together to improve the health of all members. Together with the Prescriber Tool APM described in the previous section, these are the APMs RAEs supported in development or implementation stages during FY 2022–23.

1. Making Care Primary

To encourage participation and reduce the administrative burden for providers, Colorado is partnering with CMMI on their Medicare payment reform initiative, Making Care Primary. HCPF is working closely with both CMMI and the Colorado Division of Insurance to align Medicaid payment strategies and performance indicators with those of other payers. Aligning payment models across markets, including Medicare, Medicaid and commercial insurance, is a crucial step in improving health care quality, access and outcomes for all Colorado residents.

2. APM 1

In the current APM 1 program, HCPF modifies traditional fee-for-service (FFS) payments to reward improved quality of care while containing costs. Providers earn points by reporting on quality measures and demonstrating high performance or improvement, and the number of points earned determines the payment for that practice. Providers with 500 or more attributed members are automatically enrolled in this program, and providers with fewer members can participate voluntarily. In program year 2022, HCPF completed its first full quality score calculation process, which demonstrated that more than 95% of clinics are meeting the quality thresholds set by APM 1. High-performing clinics are encouraged to consider the voluntary APM 2 program that builds on the foundational values of APM 1.

FQHCs can participate in a version of the APM 1 program that works with their unique reimbursement model. As key providers of primary care services to Health First Colorado members, FQHCs are eligible for the enhanced rate through the APM 1 program, and often meet or exceed the APM 1 quality threshold, demonstrating commitment to quality and value-based care.

3. APM 2

For APM 2, participating providers may choose to receive some or all their revenue as PMPM payments to provide stable revenue and allow for increased investment in care improvement. They are also eligible to share in the savings that result from improved chronic care management by meeting episode cost reduction targets. Any provider currently participating in APM 1 is eligible to participate in APM 2. With the passage of the FY 2023–24 long bill[14], providers participating in APM 2 will be eligible to receive 100% of the Medicare rates for services covered under the model starting in July 2024. As with APM 1, FQHCs may participate in a modified version of the program that provides some flexibility to accommodate

[14] Link: https://leg.colorado.gov/bills/sb23-214

the federal payment requirements for FQHCs. Providers participating in APM 2 will be eligible to receive 100% of the Medicare rates for services covered under the model starting in July 2024. As with APM 1, FQHCs may participate in a modified version of the program that provides some flexibility to accommodate the federal payment requirements for FQHCs.

Total participation in APM 2 for FY 2022–23 exceeded the targets set for the model. Between FQHCs and non-FQHC providers, more than 30% of Health First Colorado members are attributed to participating primary care providers across more than 190 primary care locations. The program grew exponentially during this fiscal year, from a starting value of approximately 2% of members attributed to participating providers.

4. Payment Alternatives for Colorado Kids (PACK)

The PACK APM, which focuses on pediatric primary care, was in development this fiscal year in response to feedback from the pediatric stakeholder community that adult-focused quality and payment models do not meet the needs of pediatric primary care providers or recognize their unique outcomes. This APM is intended to incentivize quality care specific to the pediatric population. It will be implemented on July 1, 2024.

5. Maternity Bundled Payment Program

This program, HCPF's first episode-based payment program, aims to raise the quality and lower the cost of maternal care while advancing maternal health equity. It will cover all prenatal, labor and delivery and postpartum care for pregnant and birthing members. Providers participating in this voluntary program can receive incentive payments depending on their ability to manage the cost of each episode. Incentive payments allow providers to make choices about care delivery and related investments to improve quality and health equity outcomes. The program, now in its third program year, has eight participating providers that provide services for about 25% of all Health First Colorado births.

6. Behavioral Health Alternative Payment Model

As the behavioral health safety net system in Colorado undergoes significant transformation, HCPF is working with stakeholders to reform how behavioral health safety net services are funded. The goal is to emphasize value over volume of services by rewarding safety net providers for care coordination and quality outcomes.

In FY 2022–23, stakeholder workgroups that included independent practices, CMHCs, small SUD providers and RAE leadership advised on possible APMs. The goal

was to provide different models that emphasized accountability for outcomes at every level. Workgroups explored encounter-based models, in which providers are paid a single rate for an encounter with a patient rather than receiving reimbursement for each individual service provided. The outcome of this stakeholder process was prospective payment system (PPS) model, where payment is based on a predetermined, fixed amount for a given encounter. The PPS will include most services but has carve-outs for certain services and utilization management strategies outside of the rate structure, like quality incentives.

In the upcoming year, HCPF will work with stakeholders and subject matter experts, including the RAEs, to operationalize the PPS model, including billing mechanisms, budget authority, communication strategy, essential provider value-based structure, rate setting and quality measurement strategy. HCPF will work with BHA on defining essential and comprehensive safety net provider types that can participate in the APM. BHA will finalize the definitions of these providers by January 2024. During FY 2023–24, HCPF will finalize the model and offer provider training and technical assistance in advance of the implementation date of July 1, 2024.

VIII. Priorities for FY 2023-24

A. Public Health Emergency Enrollment - Keep Coloradans Covered[15]

RAEs and MCOs will continue their coordinated effort to remind members to complete their benefit renewal application now that continuous Medicaid eligibility has stopped with the end of the COVID-19 public health emergency in May 2023. RAEs will continue to raise awareness about renewals and provide direct reminders throughout FY 2023–24. Monthly meetings with the RAEs and MCOs will continue, as will regular reporting on outreach activity. The focus will continue to be on members who have not yet taken action on their renewals and high-risk members, for whom an interruption in coverage could pose serious health risks.

B. ACC Phase III

Current RAE contracts will end on June 30, 2025. HCPF is in the process of designing the next iteration of the ACC, referred to as Phase III, which will begin on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to improve care quality, service, equity and affordability. Stakeholders will have multiple opportunities in FY 2023–24 to provide input and voice their desires and concerns for ACC Phase III.

[15] Link: https://hcpf.colorado.gov/keepcocovered

HCPF is proposing several areas of change for ACC Phase III, including a reduction in the number of regions from seven to four to ensure sustainable investment in regional infrastructure and better leverage efficiencies of the RAEs, while also enabling RAEs to meet the unique needs of their communities. Another proposed change is an adjustment to how members are assigned to a PCMP and possible expansion of the provider types that can serve as PCMPs. Other changes include the use of value-based payments aligned with the provision of member incentives to achieve shared goals; a PCMP structure that evolves from a Primary Care Medical Home to an Accountable Care Organization (ACO)-like model, which rewards outcomes not just actions; the continuation of provider and member tool innovation, like cost and quality indicators, eConsults and Prescriber Tool Phase II (or the SHIE); and, advances in care coordination and program impact to improve quality, close disparities and drive affordability.

Clinical goals include improving engagement in treatment for mental health and substance use disorders; closing racial/ethnic disparities for childhood immunizations and well-child visits; improving care for people with diabetes and hypertension; achieving national averages in preventive screenings; and reducing maternal disparity gaps.

Proposed payment models will build on existing models. HCPF will continue the capitated behavioral health benefit to encourage the effective utilization of the full continuum of behavioral health services and provide avenues for addressing health-related social needs. Administrative payments will continue to be paid to the RAEs for care coordination, provider support and management of whole-person care. Incentive payments will continue to tie a portion of RAE funding to achieving established outcome targets. Use of alternative payment models will increase, as described in the Health First Colorado Value section of this report.

C. Behavioral Health

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

By the end of the next fiscal year, HCPF will also implement Senate Bill 23-174, which allows members under the age of 21 to access mental health services without a covered diagnosis. With this change, members under age 21 can access therapy (individual, family, group), prevention, education, and outreach services and evaluation, intake, case management and treatment planning. Services will be provided as part of the behavioral health capitated benefit.

D. Health Equity and Social Determinants of Health

1. Health Equity Plans

HCPF launched its first Health Equity Plan[16] in FY 2022-23. The plan focused on closing disparity gaps and disparity indicators in three areas: maternal health, prevention and population health (including COVID vaccinations), and behavioral health. The plan identified and measured the current state of health disparities in these focus areas, and the goal is for each region to allocate resources and support to address disproportionately poor clinical outcomes for our members. In the upcoming fiscal year, each RAE will create a health equity plan that identifies current work that is making an impact, priority populations, and ways to leverage what is already being done to reduce disparities. HCPF has begun to send each RAE member-level data files, by indicator, with demographic fields (age, county, disability, gender, language and race/ethnicity) that can be used to identify priority populations. Each RAE will choose its own priority populations for each indicator and calculate results for each priority population based on the needs of their region. Populations will be tracked by HCPF using system filters built into the Health Equity Dashboard.

2. Health Benefits for Colorado Children and Pregnant Persons

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

3. Prescriber Tool Phase II (Social Health Information Exchange or SHIE)

Collaboration with Colorado's Office of eHealth Innovation on the development of Phase II of the Prescriber Tool, also called the SHIE, will continue. This platform securely shares social health information to enable case management agencies, RAEs, care coordinators, community health workers, and health care providers to connect Health First Colorado members to programs. These include state programs

[16] Link: https://hcpf.colorado.gov/sites/hcpf/files/2022%20HCPF%20Health%20Equity%20Plan.pdf

like SNAP and WIC, RAE programs like prenatal care or diabetes care and support, or social determinants of health supports like community foodbanks, homeless shelters or housing vouchers. All of these programs are intended to improve whole-person care, access, equity, quality and affordability. Phase II of the Prescriber Tool is expected to be live before the launch of ACC Phase III in 2025.

E. Innovation to Improve Quality, Access and Affordability

1. Facility Cost and Quality Indicators

HCPF will continue to provide members and providers with information about the quality of care, cost and patient experience at hospitals and other health care facilities so they can make the most informed decision about where to access or refer care. HCPF is working to ensure that members can easily access this information through the Find-a-Doctor tool. There will be opportunities for stakeholder engagement in FY 2023–24 to improve the evolution of this important work, intended to improve Medicaid's quality outcomes as determined by CMS Core Measures, close disparities and drive affordability to achieve the shared goals of protecting provider reimbursements, program access, and member benefits.

2. eConsult

During FY 2023-24, HCPF and Safety Net Connect, the eConsult contractor, will implement the statewide Medicaid eConsult Platform, which will allow PCMPs to submit clinical questions to specialty providers without having to make a referral. This will allow PCMPs to leverage specialist expertise when they cannot provide needed specialty care during an appointment. The eConsult platform gives members better access to specialty care and will provide earlier diagnosis and health management of chronic conditions. Additionally, it allows providers to meet the needs of members without having to make unnecessary referrals and risk no-shows for specialty appointments. It will decrease health care expenditures by reducing the number of high-cost specialty visits and acute care episodes. A similar platform was implemented through RMHP PRIME in FY 2022-23. Design and development of the statewide platform is underway; it will go live in early 2024.

3. Implementation of Senate Bill 23-002: Reimbursement for Community Health Services

During the upcoming fiscal year, HCPF will hold four stakeholder meetings to solicit feedback on implementation of this law, which authorizes HCPF to seek federal authorization from CMS to reimburse for services provided by community health workers. Stakeholder feedback topics will include minimum qualifications for community health workers, patient monitoring and safety, reimbursement

COLORADO
Department of Health Care Policy & Financing

options and the role and scope of practice of community health workers in the ACC.

F. Continuing ARPA Work

HCPF received more than $550 million of stimulus funds through ARPA to implement lasting transformation for people with disabilities and long-term care needs. More than 60 initiatives[17] are designed to enhance, expand and strengthen home and community-based services in Colorado, including $138 million in programs that address behavioral health. Many projects are related to the ACC, as they aim to make care more equitable and sustainable, especially in rural regions of the state. These projects also aim to improve systems and processes so that care is coordinated, and systems of care are connected and member centered. This work will continue through the end of 2024.

[17] Link: https://hcpf.colorado.gov/arpa/project-directory