Accountable Care Collaborative FY 2020-21

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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

Contents

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Executive Summary

This report summarizes the work of the Accountable Care Collaborative (ACC) from July 2020 to June 2021, a year shaped overwhelmingly by the effects of the COVID-19 pandemic, which continues to overshadow all areas of life. It was a year of unpredictability and uncertainty that impacted health care and economics, both of which affect Medicaid programs. While this report includes data that the Department of Health Care Policy and Financing (the Department) shares every year — everything from enrollment to utilization to costs was affected by the pandemic. For example, access and quality measures were trending upward until the pandemic arrived; only now is the Department starting to see recovery in both areas. Therefore, it is important to note that the data are not necessarily comparable to past years or helpful as signposts for future decisions.

Despite these limitations, there is much to learn from this report, including promising advances made this fiscal year. The core values of the ACC program, (e.g., regionality, focus on medical homes, and use of performance measurement) were critical to helping the state navigate and nimbly respond to the multi-faceted disruption and ripple effect the pandemic created. As a result, the Department experienced decreased per-member, per-month costs; pursued data-driven innovation, including regionally strategic and population health-specific COVID-19 vaccination outreach; supported expanded utilization of telemedicine; implemented a new inpatient and residential substance use disorder (SUD) benefit; created new care management programming; and experienced behavioral health provider network growth. Each are detailed in depth throughout the report. The comprehensive work of the program highlighted demonstrates why coordination and innovative payment models paired with regional flexibility constitute an approach worth fostering in Colorado.

Accountable Care Collaborative: Overview, Budget, and Performance

The ACC is at the core of the state's Medicaid program. Launched in 2011, its fundamental premise is that regional communities are in the best position to deliver the programs that will improve member health and reduce costs. For this reason, the program uses Regional Accountable Entities (RAEs) to manage care for each of the seven regions of the state. The program is authorized by Section 25.5-5 Part 4 C.R.S.

The ACC has four core components:

- Regional Accountable Entities (RAEs), one for each of the state's seven regions.

- Primary Care Medical Providers (PCMPs). Each member has a PCMP, which serves as a medical home. PCMPs are paid fee-for-service for the health care they provide and receive a per-member-per-month payment from the RAEs for their medical home services.
- Comprehensive community-based system of mental health and substance use disorder services. RAEs receive a per-member-per-month (PMPM) capitation payment to provide all covered behavioral health care and services to members.
- Data and analytics. The Department, RAEs, PCMPs, and partners have access to actionable data and information.

Enrollment

Most Medicaid members are enrolled in the ACC. In FY 2020–21, average enrollment in the program was 1,343,597, an increase from the previous two fiscal years. This enrollment number includes members in the two managed care initiatives: Rocky Mountain Health Plans Prime and Denver Health Medicaid Choice. Average enrollment hovered around one million before the pandemic began in March 2020, but the pandemic increased enrollment as unemployment rose and more people experienced economic instability. In addition, the federal government temporarily required Medicaid programs to keep members enrolled even if their financial situation improved. Enrollment continuous coverage requirements will expire at the end of the federally declared public health emergency.

Budget and Financial Performance

Program costs include administrative costs and all expenses for benefits and services provided during FY 2020–21, including capitations, pharmacy, inpatient, outpatient, emergency room, Long-Term Services and Supports (LTSS), home health, and claims.

The total amount paid for the ACC in FY 2020-21 was $8.9 billion, a 10.5% increase from the previous fiscal year. The primary driver for the increase in total costs was the growth in member enrollment. Average PMPM costs <u>decreased</u> from $564 PMPM in FY 2019–20 to $557 PMPM in FY 2020–21.

Program Performance

One tool the Department uses to measure and monitor program performance is the Pay-for-Performance Program. RAEs can earn financial incentives for achieving performance and programmatic objectives through Key Performance Indicators, the Performance Pool, and the Behavioral Health Incentive Program.

The pandemic led to lower utilization in many services, especially emergency department visits and preventive services. However, utilization rates for both behavioral health engagement and prenatal engagement did not decrease as much or, in some cases, were maintained at pre-pandemic levels, which may be due in part to the program's efforts to connect members to these services.

Response to COVID-19

In FY 2020–21, the program demonstrated the power of its regional model. RAEs adapted to the rapidly emerging threats caused by the pandemic both to members and to the health care system itself. RAEs and MCOs identified and supported at-risk members, responded to system threats, and supported providers at risk for temporary or permanent closure.

RAEs and MCOs played a critical role in getting members vaccinated, especially in identifying and reaching out to unvaccinated members. The program focused on increasing vaccination rates for two priority populations: members of color and members who are potentially homebound. By the end of September 2021, the RAEs, in collaboration with their partners, met their vaccination disparity reduction goals of vaccinating over half of all Medicaid members and nearly 83% of members who are homebound. Section 2.A highlights the RAEs' comprehensive strategy in reaching 100% of homebound members, who were not already vaccinated. Their collective, proactive efforts led to connecting with approximately 32,000 individuals in total.

The pandemic posed a particular risk to older members and those with chronic conditions. Using its data and care coordination infrastructure, the program rapidly identified high-risk members and reached out to them to provide information about COVID prevention, symptoms, and vaccinations. RAEs also shared lists of high-risk members with PCMPs and supported expanded telemedicine services for them.

RAEs also supported the expansion of telemedicine during the pandemic by providing training, software platforms, and other resources. RAEs implemented programs that made phones, tablets, and internet access more readily available to members. Fee-for-service telemedicine visits increased from less than one percent of visits before the pandemic to a high of 32.2% of visits in the first week of April 2020 and hovered around 15% for this fiscal year. (These visits do not include most behavioral health services.) Behavioral health providers adopted telemedicine at high rates throughout the pandemic. In the first two months of 2020, prior to the pandemic, average telemedicine utilization for capitated behavioral health was 0.9% of total utilization. It grew to 50.4% by April 2020. From March 2020 through March 2021, the statewide average telemedicine utilization rate for behavioral health visits was 40.3%.

Behavioral Health Care

RAEs administer the capitated behavioral health managed care benefit for their region, a model that has several advantages for members. It helps to ensure that all behavioral health services are coordinated and allows the state to offer specialized benefits for people with serious mental illness that would not be available under a fee-for-service model. These services, referred to as “B3 services,” offer members a way to connect with peers, develop life skills, and prevent isolation. A managed care model gives the state the ability to track progress on metrics and adjust policies or practices when the state is not getting the most value for its health care dollars. Its structure also allows the Department to respond quickly and flexibly to emerging needs, such as the need for behavioral health telemedicine during the pandemic.

This fiscal year, the Department continued to work with the RAEs to ensure that members can access the full range of behavioral health services they need. In FY 2020–21, 18.2% of members accessed capitated behavioral health services, including substance use disorder (SUD) services. As a point of comparison, the behavioral health penetration rate for Medicaid nationally was approximately 14% at the end of December 2020 (not including substance use disorder services) according to the National Committee for Quality Assurance. These figures provide a rough indicator that member access to behavioral health is near the national average and may be above it, given that penetration rate only reflects capitated services.

Maintaining a robust network of behavioral health providers continues to be increasingly important to meet the needs of increased membership and the behavioral health challenges resulting from the pandemic. Despite workforce challenges, the RAEs have continued to increase the total number of contracted behavioral health providers over the last fiscal year.

On January 1, 2021, Medicaid expanded its SUD benefit in accordance with House Bill 18-1136 to include residential and inpatient services as part of the behavioral health capitated managed care. RAEs put systems in place for the benefit and developed provider networks to deliver the services. From January to June 2021, 664 members accessed residential treatment and 4,225 members accessed withdrawal management services.

Condition Management and Complex Care Coordination

Since its inception, one of the ACC’s functions has been to help manage chronic and complex conditions among Medicaid members. The Department chose three conditions for the RAEs to focus on this year: maternity, diabetes, and complex care coordination. Diabetes was selected because of its prevalence and potential for serious but preventable health problems. Members with complex needs (four or more chronic conditions) need coordination between multiple services and providers. Maternal health was selected because Medicaid covers more than 42% births in the state each year, and high preterm birth rates and racial and ethnic disparities persist in Colorado's maternal health outcomes.

The RAEs use a population management framework to assess their population and identify which groups require high-cost, complex care. They then administer condition management programs that include culturally competent specialized care teams; facilitation of access to appropriate medical services, resources, and community programs; delivery of evidence-based/informed interventions; and program measurement and reporting on target outcomes. Condition management programs started in the middle of the fiscal year; formal evaluation will be available next year.

Services for Populations with Unique Health Challenges

RAEs are instrumental in meeting the needs of members who face specific health challenges. This year, the program focused on justice-involved members, members in the child welfare system, and members experiencing homelessness.

Justice-involved individuals often experience barriers to receiving needed care after release from prison. The Department has established data-sharing agreements with the Department of Corrections and the Judicial Branch to get a roster of Medicaid-eligible individuals who have been released from prison or are on probation that RAEs use for outreach. From April 2020 to April 2021, RAEs reached out to justice-involved individuals to increase their rate of engagement with behavioral health services within 14 days of release from just over 10% to 17.06%.

Children in the child welfare system require services from multiple agencies, all of which are subject to complex regulations that make it difficult to braid funding for member-centered care. This year, the Department created a forum co-chaired by the Department, the RAEs, Colorado Department of Human Services (CDHS), and the counties to collaborate on meeting children's needs. The Department is partnering closely with CDHS to implement the Family First Preventions Services Act of 2018 (FFPSA), which prioritizes family settings over group settings. Finally, the Department worked with counties and providers to expand the Psychiatric Residential Treatment Facility (PRTF) benefit to meet the needs of high-acuity children and avoid out-of-state placement. This year, additional beds were allocated to meet the needs of high-acuity children; over 100 beds will be available by December 2021.

This year, the Department began using Medicaid application data to identify members who may be experiencing homelessness. The Department is also working on a data-sharing agreement with the Department of Local Affairs, Division of Housing to coordinate benefits between the agencies. RAEs and MCOs continue to form relationships with homeless shelters and supportive housing service providers to share data, make and receive service referrals, and coordinate care.

Advancements in Data Collection and Use

During FY 2020–21, the Department focused on sharing its internal data products with RAE partners to support condition management programming and track progress on key performance indicators. The Department and RAEs improved data use and data transparency for maternity outcomes, diabetes care, members experiencing homelessness, emergency department utilization, and behavioral health utilization. In addition, the Department is working to refine data on race and ethnicity and include it in data dashboards so the program can identify and address health disparities.

Priorities for FY 2021–22

Cost control for Health First Colorado continues to be a priority, and the ACC has a central role to play in ensuring quality of care, access to care, and good health outcomes while controlling costs. This is especially important given the cost implications of the pandemic. Below are initiatives that will move the program forward in its mission now and in the future.

- **Behavioral Health**. This year, the Colorado Department of Human Services is required to establish a Behavioral Health Administration (BHA). The Department will support the formation of the BHA and strengthen the behavioral health safety net, reduce barriers for providers, focus on outcomes-based payments while supporting appropriate projects associated with the 19 priorities identified through the Behavioral Health Task Force. In addition, the Department and the RAEs are engaged in the Behavioral Health Transformational Task Force, which will decide on how to invest $450 million in American Rescue Plan Act (ARPA) dollars to transform the behavioral health industry across Colorado. The RAEs are critical to improving the current, fragmented behavioral health landscape, and will play a vital role in realizing BHA-led reforms at the local and regional levels, especially in ACC Phase III.
- **Hospital Transformation Program (HTP)**. This program is designed to improve the quality of hospital care provided to members by tying provider fee-funded hospital payments to quality-based initiatives. RAEs will have an important role to play in facilitating transitions of care, sharing data on social determinants of health, developing readmissions programs, and more to ensure hospitals can

continue to meet the needs of the community as hospitals implement the program.

- **Prescription Drug Costs**. The high cost of prescription drugs, especially specialty drugs, continues to be a challenge. The RAEs are working with providers to educate them on the prescriber tool and will work with providers to support their participation in a new alternative payment model designed to incentivize increased utilization of the prescriber tool and medications on the Preferred Drug List. This will help the program reach one of the Department's Wildly Important Goals: Increase savings on pharmacy costs by 83% through pharmacy cost control initiatives, from $12 million in FY 2020–21 to $22 million by June 30, 2022.
- **Value-based Payments**. The Department will continue to explore cost control by implementing alternative payment models that pay for value over volume. The Department plans to leverage the following three strategies in the coming months and years: bundled payments, which create specialist accountability for episode of care outcomes and reward innovation that improve quality; Alternative Payment Methodology 1 (APM 1), a pay-for-performance model that rewards PCMPs with financial incentives for meeting quality goals; and Alternative Payment Methodology 2 (APM 2), which would pay primary care providers part of their historical Medicaid revenue as a capitation payment, with the opportunity to earn extra reimbursement for meeting quality goals. The Department is also engaging providers on the development and rollout of Providers of Distinction and the value-based payments that reward referrals from PCMPs to those providers who are proven to have superior outcomes and more affordable costs.
- **Expanded Use of Telemedicine and eConsults**. The Department will assess and set policy for Electronic Health Entities (eHealth Entities), providers that operate predominately with telemedicine. Concurrently, the Department will explore policies to codify use of eConsults, or electronic consultations. eConsults support PCMPs in operating at the top of their capability while reducing unnecessary specialty visits. They also will serve to help our PCMPs refer necessary specialty visits to Providers of Distinction. RAEs will continue to build infrastructure to support remote care.
- **Health Equity**. The Department will use improved race and ethnicity data to understand more about equity gaps and address them with a health equity framework applied to all policies. The Department priorities in addressing health disparities to improve health equity include: COVID-19 vaccination uptake rates; maternal outcomes for pregnant people and babies; behavioral health; and prevention.

- **Continued Focus on Condition Management**. The Department will set formal performance measures and hold RAEs accountable for identifying members with complex conditions and supporting PCMP-based condition management programs for maternity, diabetes, and members with complex care needs.
- **Home and Community-Based Services American Rescue Plan Act (ARPA).** The Centers for Medicare and Medicaid Services (CMS) has approved the Department's spending plan for American Rescue Plan Act (ARPA) Medicaid Home and Community-Based Services (HCBS). The spending plan includes $512.3 million to provide immediate relief for the provider network, direct support to members and their families during the recovery phase following the pandemic, and foster longer-term innovation and transformation to create an HCBS system of the future.
- **Core Measures**. The Department will begin integrating the Adult and Child Core Measure Sets set forth by CMS into all incentive programs to align efforts, benchmark against national performance, and maintain accountability while reducing measurement fatigue.

I. Accountable Care Collaborative: Overview, Budget, and Performance

This FY 2020–21 report for the Accountable Care Collaborative (ACC) covers the period from July 2020 to June 2021, a year shaped overwhelmingly by the COVID-19 pandemic.

It was a year of unpredictability and uncertainty in all areas of life, especially health care and economics, both of which affect Medicaid programs in countless large and small ways. Colorado's Medicaid program is no exception. While this report includes data that the Department of Health Care Policy and Financing (the Department) shares every year, the interpretation of the data is more challenging. Everything from enrollment to utilization to costs were affected by the pandemic, so these data are not comparable to past years or always helpful as signposts for future decisions.

Despite these limitations, there is much to learn from this report. As the core of the Colorado Medicaid program, the ACC is designed to bring coherence and leadership to a system that, before the program's inception in 2011, was characterized by fragmentation and inadequate support for both providers and members. This year, with its constant change and need for rapid response, was an important test for the ACC model.

This report includes both data and stories that demonstrate the importance of the kind of infrastructure the ACC provides. Interventions like outreach to members with chronic conditions, rapid deployment and support of telehealth services, financial support of primary care practices, and flexible approaches to closing the vaccination equity gap would have been difficult, if not impossible, in the previous fragmented system.

The program is still evolving as the Department continuously evaluates how to meet the health care needs of a changing Colorado while controlling costs. But the work of the program this year demonstrates why coordination and innovative payment models paired with regional flexibility constitute an approach worth fostering in Colorado.

A. About the Accountable Care Collaborative

The ACC is at the core of the state's Medicaid program. Launched in 2011, its fundamental premise is that regional communities are in the best position to deliver the programs that will improve member health and reduce costs. For this reason, the ACC does not use one central administrative organization, but instead has a Regional Accountable Entity (RAE) that manages care for each of the seven regions of the state. The program is authorized by Section 25.5-5 Part 4, C.R.S.

Figure 1. Regions and RAEs of the Accountable Care Collaborative

The ACC has four core components:

- Regional organizations called Regional Accountable Entities or RAEs; one for each of the seven regions in the state.
- Primary Care Medical Providers (PCMPs), which serve as medical homes for members. PCMPs serve as a member's central point of care and promote comprehensive, coordinated care for a positive member experience and better health outcomes. All members are attributed to a PCMP upon their enrollment into the program; members can select a different PCMP at any time. Providers are paid fee-for-service for the health care they provide and also receive a per-member-per-month (PMPM) payment from the RAEs for their medical home services.
- Comprehensive community-based system of mental health and substance use disorder (SUD) services. RAEs serve as the managed care entity for these services. They receive a PMPM payment to provide all covered behavioral health care and services to their members.

- Data and analytics. The Department, RAEs, PCMPs, and partners have access to actionable information about individual members, the program population, and system and practice performance.

The RAE model includes several key elements to help control costs and ensure members have access to quality care:

- **Regional focus**. Colorado's regional model recognizes that health care is local and gives each region the flexibility to develop tailored approaches that meet community needs, respond to community input, and fit community cultures.
- **Care coordination**. The program is designed so that a RAE can get to know its community and help doctors, hospitals, pharmacies, ancillary providers, and community organizations work together for seamless care. The RAE can help members understand and manage their benefits, find providers, and connect to social service resources such as transportation, housing, and food assistance.
- **Behavioral and physical health care integration**. RAEs support networks of both primary care and behavioral health providers, which increases points of connection in both systems and supports the state's vision of whole-person care.
- **Member participation**. This model creates opportunities for members to partner with their PCMP and RAE in their care. In addition, member advisory groups give members a voice and an opportunity to share important insights that give RAEs new ways to think about how they do their work.
- **Focus on social determinants of health**. With a focus on health neighborhoods that include community-based organizations, this model allows RAEs and their partners to address a variety of health and social needs.
- **Population health management.** This model allows RAEs to identify populations with specific health care needs and design targeted interventions.
- **Performance management.** The program measures progress on key performance indicators, including access-to-care and outcome goals, and creates incentives to hold RAEs and providers accountable.

B. The Role of Regional Accountable Entities and Managed Care Organizations

Regional Accountable Entities

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

The functions of the RAE are summarized below:

- **Contract with PCMPs**. RAEs contract with PCMPs to serve as medical homes for members.[1] RAEs provide training and support and distribute PCMP administrative payments to incentivize the delivery of comprehensive, cost-effective, team-based, quality care that leads to improvements in member health, as measured by state-defined performance indicators. RAEs use quality-based, tiered payment structures to help providers improve their practices and prepare them to participate in other state and federal value-based payment arrangements.

- **Manage the behavioral health capitation**. Most behavioral health services provided to Health First Colorado members are provided under a capitated managed care plan in order to provide a comprehensive array of mental health and substance use disorder services while controlling costs. RAEs receive a PMPM payment to administer this benefit and contract with providers in their region to maintain a network. The RAE has primary accountability for promoting optimized behavioral health and wellness for all members and providing or arranging for the delivery of medically necessary mental health and SUD services.

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

- **Manage overall administration, data and information, and member access to care**. The RAE is responsible for ensuring timely and appropriate access to

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

medically necessary services for all members. It establishes the infrastructure, tools, and resources that enable providers to serve members with complex conditions, obtain specialty consults, and make appropriate, timely, and coordinated specialty care referrals.

Managed Care Organizations

Unlike behavioral health care, most medical care is delivered and billed as fee-for-service rather than as a capitated managed care benefit. However, the Department operates two physical health limited managed care capitation initiatives as part of the ACC: Denver Health Medicaid Choice and Rocky Mountain Health Plans Prime. These initiatives are authorized by C.R.S. 25.5-5-415. Rocky Mountain Health Plans Prime is operated as part of the Region 1 RAE contract, while contracting for Denver Health Medicaid Choice changed in accordance with House Bill 19-1285 on January 1, 2020. This legislation resulted in a Department contract directly with Denver Health, which partners with the RAE in Region 5 to administer the capitated behavioral health benefit for its members. Both initiatives are to be administered in a manner that maximizes the integration of behavioral health and physical health services for enrolled members.

C. Accountable Care Collaborative Enrollment FY 2020-21

With few exceptions, Medicaid members participate in the ACC. In FY 2020–21, average enrollment increased by 15.67% from FY 2019–20. Before the pandemic began in March 2020, average enrollment hovered around one million, and increased as unemployment and economic instability increased. In addition, due to the COVID public health emergency, the federal government temporarily required Medicaid programs to continue health care coverage for all medical assistance programs, even if someone's eligibility changes. This continuous enrollment requirement expires at the end of the declared public health emergency. (The end date for this public health emergency has not yet been set, the operational requirements have not been finalized, and the federal funding available to states to support the transition out of the public health emergency has not yet been communicated to states.)

Table 1. Accountable Care Collaborative average enrollment by population, FY 2020-21

Population	Average Enrollment FY 2020-21	Percent of Total Enrollment
Children without disabilities	534,009	39.74%

Adults without disabilities, **eligible due to** the Affordable Care Act expansion	483,688	36.00%
Adults without disabilities, **eligible before** the Affordable Care Act expansion	233,038	17.34%
Children and adults with a disability, including Medicare-Medicaid members	92,862	6.91%
TOTAL	**1,343,597**	

D. Accountable Care Collaborative Budget

The budget for the ACC falls into three major categories:

- **Payments for medical and behavioral health care**. These are payments that cover the cost of care. Most medical services are paid fee-for-service directly to the provider that delivered the service. For medical care, the exceptions are the two managed care organizations (MCOs), Denver Health and Rocky Mountain Healthcare Prime. These MCOs receive a capitated monthly PMPM payment for medical services provided to members. Behavioral health care services are a capitated benefit; RAEs receive a PMPM payment to provide most behavioral health care services for members.
- **Administrative payments**. These are PMPM payments that go to the RAEs for doing the administration, care coordination, and population health work of the program. The RAEs distribute a portion of these payments to their networks of PCMPs to function as medical homes and perform some of the care coordination and population health work.
- **Incentive payments**. These are payments to incentivize and reward the RAEs for meeting or exceeding performance targets. Below is a description of the types of incentive payments. See the next section for a description of the measures used for incentive payments this fiscal year and performance on those measures.
    - **Key Performance Indicator (KPI)** incentive payments come from a portion of the RAE administrative PMPM payment that is set aside to incentivize RAEs to meet or exceed KPIs. The KPIs are designed to assess the functioning of the overall system and the individual RAEs.
    - **Behavioral Health Incentive Program** payments are used to incentivize performance on indicators specific to behavioral health.
    - The **Performance Pool** is a more flexible pool of funds that the Department can use to incentivize performance or support the improvement of RAEs or PCMPs. In FY 2020–21, RAEs used most of these funds to support practices that suffered financially during the pandemic.

Table 2. Budget Information for the Accountable Care Collaborative for FY 2020-21

Accountable Care Collaborative Budget Category	Expenditures FY 2020-21
Payments for Services	
Fee-for-service payments	$7,468,984,402
Denver Health MCO capitation payments	$261,476,971
RMHP Prime MCO capitation payments	$239,758,923
Behavioral health capitation payments	$776,859,700
Administrative and Incentive Payments	
Administrative per-member-per-month (PMPM) payments	$165,032,344
Key performance indicator (KPI) payments	$38,134,063
Behavioral health incentive payments	$14,893,929
Performance pool payments	$8,077,874
TOTAL ACC EXPENDITURES	**$8,973,218,206**

For this report, the Department performed a straight comparison of FY 2020–21 expenditures to FY 2019–20 expenditures for all full-benefit Medicaid members, excluding those enrolled in PACE.

The total amount paid for the ACC in FY 2020-21 was $8.9 billion, a 10.1% increase from the previous fiscal year. The primary driver for the increase in total costs was the 15.7% growth in member enrollment in the ACC resulting from the COVID public health emergency. Total costs are divided by total member months to yield an average program cost PMPM for the fiscal year. In FY 2020-21, the average PMPM was $557, a 1.4% decrease from FY 2019–20, when the average paid PMPM was $564.

E. Program Performance

This section describes the RAEs' performance on Key Performance Indicators, Behavioral Health Incentive Program Indicators, and Performance Pool incentive measures.

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Key Performance Indicators (KPIs)

Below is a description of the key performance indicators used to measure and incentivize RAE performance in FY 2020–21:

1. **Behavioral Health Engagement**: Percentage of members who receive at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit.
2. **Dental Visits**: Percentage of members who receive at least one dental service (medical or dental claim).
3. **Well Visits**: Percentage of members who have at least one well visit.
4. **Prenatal Engagement**: Percentage of members who have at least one prenatal visit within 40 weeks prior to the delivery and are Medicaid enrolled at least 30 days prior to the delivery.
5. **Emergency Department Visits**: Number of emergency department visits per 1,000 members per year, risk-adjusted to take into consideration the relative health of a RAE's population compared to that of other RAEs.
6. **Potentially Avoidable Costs**: The Department uses the PROMETHEUS tool to compare the standard cost of an episode of care to actual costs. Performance payments were based on process measures regarding the RAE's implementation of this tool into their cost control operations and management.
7. **Health Neighborhood**: This KPI comprises two components: one monitors how many PCMPs established or renewed care compacts with specialty care providers to facilitate referrals and the coordination of care for members, and the other is a claims-based measure looking at indications that a specialist visit resulted from a referral from a PCMP.

Table 3: FY 2020-21 KPI Performance by RAE[2]

RAE	ED (per 1000 members per year)	BH Engagement	Well Visits	Prenatal Engagement	Dental Visits
1	443	15.23%	28.88%	55.55%	38.24%
2	442	15.20%	23.16%	62.27%	35.04%

[2] The data included in this table reflects the RAE performance for the 12-month period ending March 31, 2021. The full year's performance could not be reported due to claims run-out and data validation.

3	454	15.99%	30.73%	60.88%	39.11%
4	403	17.96%	20.70%	69.57%	34.79%
5	466	19.70%	31.61%	72.23%	40.17%
6	427	18.74%	25.65%	56.99%	35.37%
7	504	17.97%	25.66%	66.62%	34.56%

Key:
Green = Met Tier 1 target
Yellow = Met Tier 2 target

All RAEs were able to meet the Tier 1 target to lower the number of emergency department visits per member per year, indicated by the green shading in the table. It is important to note, however, that emergency department visits dropped nationwide during the pandemic.[3]

Nationwide, utilization of primary care and preventive health services has dropped since the beginning of the pandemic. Preventive services like childhood immunizations and screenings all but stopped in March 2020 and have been slow to recover. Table 4 shows that prior to the pandemic, the program's performance data was trending in the right direction, with more preventive services being delivered to more members, but the pandemic has slowed or reversed some of these trends.

However, utilization rates for both behavioral health engagement and prenatal engagement showed lesser decreases and remained higher than performance during FY 2018–19 (pre-pandemic), which may be due in part to the ACC's efforts to connect members to these services.

Table 4: Average KPI Performance Measures FY 2018-19 to FY 2020-21 as of March 31 of Each Fiscal Year

KPI Measure	FY 2018-19	FY 2019-20	FY 2020-21
ED (per 1,000 members per year)	619	627	448.43
BH Engagement	16.71%	18.78%	17.26%
Well Visits	29.07%	30.00%	26.63%

[3] Yu, J., Hammond, G. Walken, R.J., Fox, D. and Joynt Maddox, K.E. "Changes In Non-COVID-19 Emergency Department Visits By Acuity And Insurance Status During The COVID-19 Pandemic." *Health Affairs,* Vol. 40, No. 6, June 2021. https://doi.org/10.1377/hlthaff.2020.02464.

Prenatal Engagement	55.61%	64.33%	63.44%
Dental Visits	35.89%	41.73%	36.75%
HN: Specialist Claims from Referrals	2.15%	2.12%	1.78%

Note: *This table shows KPI performance across three fiscal years as of March 31 of each fiscal year: FY 2018–19 was not affected by the COVID-19 pandemic, FY 2019–20 was affected for one month (March) of the reported period, and all of FY 2020–21 took place during the pandemic.*

Behavioral Health Incentive Program Indicators

Each year, the RAEs are eligible to earn up to 5% of their annual behavioral health capitation payment for reaching performance metrics. These are additional funds authorized by the General Assembly and the Centers for Medicare and Medicaid Services (CMS). Below is a description of the behavioral health incentive program indicators used to measure and incentivize RAE performance in behavioral health in FY 2020–21.

1. **Engagement in Outpatient SUD Treatment:** Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.

2. **Follow-up within 7 Days after an Inpatient Hospital Discharge for a Mental Health Condition:** Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.

3. **Follow-up within 7 Days after an Emergency Department Visit for a SUD:** Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.

4. **Follow-up after a Positive Depression Screen**: Percent of members engaged in mental health service within 30 days of screening positive for depression.

5. **Behavioral Health Screening or Assessment for Foster Care Children:** Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment.

Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, funds distributed to the RAEs in FY 2020–21 were for the RAEs' performance during FY 2019–20.

Table 5 reports on data from FY 2019–20, a time period that was affected by the pandemic for only the final three months (March –June 2020).

Table 5: FY 2019-20 Behavioral Health Incentive Program Performance by RAE

The table below shows the percentage of members in each RAE who received the service described in each performance indicator.

RAE	Outpatient SUD	Follow-up within 7 Days of Discharge	Follow-up within 7 Days of ED Visit	Follow-up within 30 Days of Positive Depression Screen	BH Assessment for Children in Foster Care
1	41.72%	47.66%	30.85%	51.47%	13.57%
2	42.34%	74.23%	39.25%	53.25%	23.00%
3	38.84%	64.71%	31.97%	41.50%	12.17%
4	38.98%	79.61%	43.83%	42.87%	27.78%
5	31.19%	71.20%	37.85%	34.64%	23.70%
6	35.29%	73.69%	37.42%	45.87%	20.79%
7	46.37%	77.93%	35.41%	61.75%	21.51%

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

Some of the largest gains were in the depression screen follow-up measure, as shown in Table 6.

Table 6. Follow-up within 30 Days of Positive Depression Screen, FY 2018-19 vs. FY 2019-20

RAE	Follow-up within 30 Days of Positive Depression Screen FY 2018-19	Follow-up within 30 Days of Positive Depression Screen FY 2019-20
1	25.05%	51.47%
2	36.64%	53.25%
3	33.28%	41.50%

4	37.74%	42.87%
5	30.00%	34.64%
6	26.56%	45.87%
7	49.94%	61.75%

Performance Pool

The Performance Pool is funded with money not earned by the RAEs for KPI performance and is often used to respond flexibly to timely needs and priorities. In FY 2020–21, the funds paid in the first two quarters were used to support COVID-19 response and the funds paid in the last two quarters were used to reward performance on indicators that measure health outcomes and total cost of care. (See the COVID-19 section of this report for more information about COVID-19 response activities.)

The Performance Pool payment that supported PCMPs in COVID-19 response activities was the second payment for this purpose; the first one was disbursed in FY 2019–20. Funds were used to alleviate the financial impact of the pandemic on practices and ensure that Medicaid members at the highest risk of contracting the virus could receive the necessary outreach and engagement to obtain care. By having access to these funds early in the fiscal year, RAEs and PCMPs were able to meet immediate and pressing needs related to the pandemic in their regions.

Table 7. FY 2020-21 Performance Pool Payments for COVID-19 Support by RAE

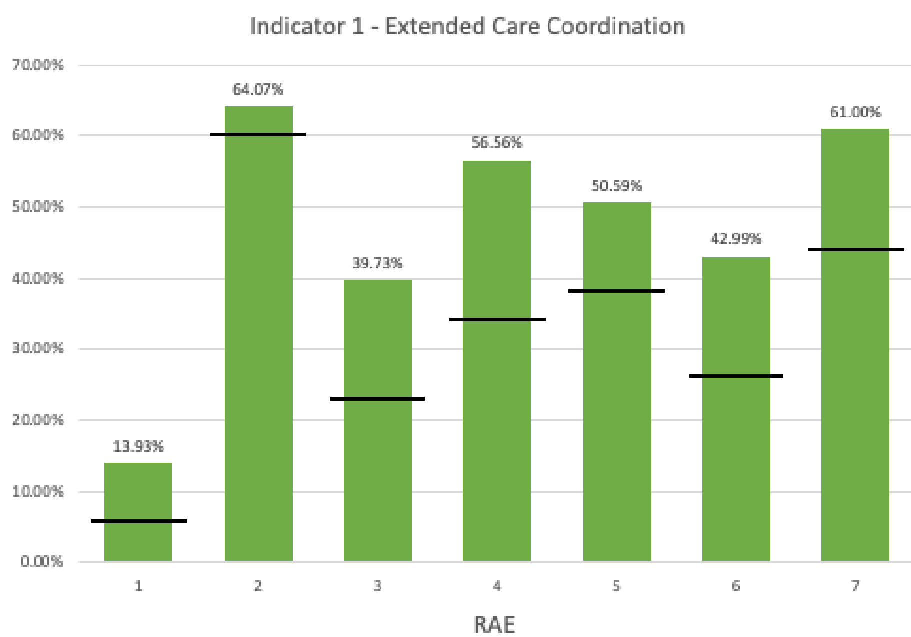
RAE	Payment 1 (Paid in FY 2019-20)	# PCMPs Paid with Payment 1	Payment 2 (Paid in FY 2020-21)	# PCMPs Paid with Payment 2	Total
1	$777,985.10	51	$718,056.10	51	$1,496,041.20
2	$132,322.00	23	$207,590.62	24	$339,912.62
3	$1,242,754.58	91	$1,162,827.95	65	$2,405,582.53
4	$307,981.68	34	$268,607.63	82	$576,589.31
5	$492,794.88	43	$446,169.55	22	$938,964.43
6	$356,475.00	49	$491,797.74	49	$848,272.74
7	$464,993.74	40	$527,045.87	40	$992,039.61

Total	$3,775,306.98	$3,822,095.46	$7,597,402.44

The remainder of the FY 2020–21 Performance Pool funds were used to incentivize the RAEs' 2019–20 performance on the following indicators: extended care coordination, premature birth rate, and behavioral health engagement for members releasing from state prisons.

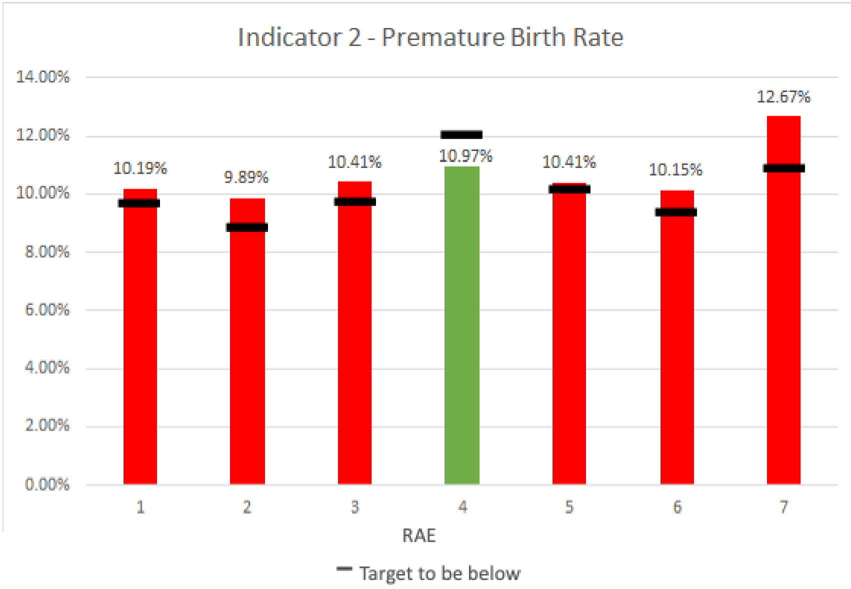
Extended Care Coordination is the percentage of members with complex needs who received extended care coordination as an intervention, which includes a care plan and bi-directional communication with the member through face-to-face conversations, phone or text. Figure 2 shows the percentage of members with complex needs who are receiving extended care coordination. All RAEs exceeded the improvement target for this measure.

Figure 2. Members with Complex Needs Receiving Extended Care Coordination by RAE, FY 2019-20



Premature Birth Rate is the percentage of premature births (< 37 weeks) per total live births during the measurement period. This measure is part of the Department's focus on improving maternity outcomes; the goal is to be below the target number of premature births.

Figure 3. Premature Birth Rate by RAE, FY 2019-20



Behavioral Health Engagement for Members Releasing from State Prisons is the 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 measure was especially salient during the pandemic because many low-risk individuals were released during COVID. Collectively, RAEs connected 10.56% of these members with at least one behavioral health service within 14 days of release, just exceeding their target of 10.23%. For more detail about the work RAEs are doing to meet the needs of this population, see the Services for Populations with Unique Health Challenges section of this report.

F. Provider and Member Experience

One of the aims of the ACC is to create infrastructure and supports that make the experience of care better for both providers and members.

Provider Experience

For providers, this support takes different forms, such as incentive payments to PCMPs, practice transformation support, help with care coordination for the

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members with many complex health care needs, and training on new benefits or other topics that affect Medicaid providers.

During this pandemic year, the program provided this support with a focus on COVID-19. For example, the Department and RAEs identified members who were at high risk for COVID-19 so providers could meet their care needs. RAEs supported providers with technology and training to get telemedicine services up and running.

The program also supported providers with additional funding during a time when many practices were seeing a dramatic decrease in visits and were even at risk of laying off staff or closing altogether. RAEs disbursed the Performance Pool funds to providers in their region so they could continue doing the important work of keeping their patients connected to care, providing education about COVID-19, and eventually getting members vaccinated.

Funds Prevent Practice Closure

RAE 6 (Colorado Community Health Alliance) provided funding to Arvada Pediatrics to identify patients who were overdue for well visits and reach out to reassure caregivers of COVID concerns and schedule children for a well visit. RAE 2 (Northeast Health Partners) and its board committed resources to support its providers during the pandemic: "Without NHP, our practice would have closed last year and that is a matter of fact. Your agency has helped us more than any agency ever has, and we know you are our biggest advocate," said Abe Herrera, President of A Children's Health Place, an independent pediatric practice that has been trusted in the community since 1983.

In partnership with five philanthropic foundations, the Department also created the Provider Interim Payment Program to help stabilize Colorado's health safety net system and preserve access to care during the pandemic. PCMPs that provide integrated health services received loan and grant funding through the program. The Department has released three rounds of payments to 54 clinics (totaling over $2 million) to ensure they would be able to continue to serve Medicaid members.

Member Experience

The Department contracts with the Health Services Advisory Group, Inc. (HSAG) to annually administer a standardized survey to members receiving services through Health First Colorado and to report the results. This year, HSAG administered the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Patient-Centered Medical Home (PCMH) Survey to 36 program practices (16 pediatric and 20 adult). The goal of the PCMH Survey is to give practices and RAEs feedback that will help them improve member services. A total of 2,161 parents/caretakers (15.41% response rate) returned a completed survey on behalf of their child, and 3,751 adult members (17.36% response rate) returned a completed survey.

Results varied widely across practices surveyed, but overall, the majority of parents/caretakers and adult members were satisfied with their providers and their overall care. About 79% of parents/caretakers rated all of their child's health care as a 9 or 10 and 83.5% rated their child's provider as a 9 or 10 for how well they communicate with parents/caretakers. Among adults, 68% of adults rated their provider as a 9 or 10 and 64% rated all of their health care as a 9 or 10. While 68% of parents/caretakers and 49% of adult members are able to access care after hours (evenings and weekends) and get timely appointments, there are improvements to be made in this area. The full results of the surveys are available at www.colorado.gov/hcpf/client-satisfaction-surveys-cahps.

II. Response to COVID-19

The power of the ACC's regional model was particularly evident this fiscal year as the state navigated the COVID-19 pandemic. RAEs were able to adapt to the rapidly emerging threats caused by the pandemic both to members and to the health care system itself. They were able to be flexible and nimble in how they directed funding and supported provider sustainability and the community response in their region and shifted resources to meet the evolving needs during the pandemic. They were also able to leverage their care coordination systems and long-standing relationships with providers and community-based organizations to disseminate information and give providers and members support.

A. Increasing COVID-19 Vaccination Rates

Once vaccinations became widely available for Medicaid members, the RAEs played a critical role in identifying and reaching out to unvaccinated members and collaborating with providers and community-based organizations to increase vaccination rates. The Department obtained weekly vaccination data from the Colorado Department of Public Health and Environment, which allowed the program to track vaccination progress and share information with the RAEs for member outreach.

The Department partnered with RAEs, MCOs, and LTSS case management agencies to focus additional resources on increasing vaccination rates for two priority populations: members of color and members who are potentially homebound. To increase vaccination rates, the Department secured $13.3 million in Federal Emergency Management Agency funds for RAEs and MCOs to use to support vaccination clinics, reach out to members disproportionately impacted by COVID-19, and draw on existing community partnerships and built new ones to remove barriers to vaccination.

Examples of Diverse COVID-19 Vaccination Strategies Among Regions

RAEs and MCOs used a range of approaches to help members get vaccinated. Approaches depended on the unique needs and geographical barriers in the region.

RAE 1 offered financial incentives to practices that see many Medicaid members, particularly members of color, to begin providing vaccinations. They also funded transportation to address access barriers in rural southwest Colorado.

The RAE 2 equity taskforce partnered with agencies in the region to diminish and eliminate vaccination barriers by addressing accessibility (language and physical) and transportation challenges. For example, they collaborated with Spanish-speaking churches for outreach about the importance of getting vaccinated and to set up vaccination events after church services.

RAE 3 sought to provide vaccines in non-traditional settings, including at two bus stops and partnered with RAE 5 on back-to-school events to promote the vaccine.

RAEs 3 and 5 did a texting campaign to reach members of color in the region with information about COVID-19, vaccine sites, vaccine efficacy, vaccine cost (none), safety, return to normalcy, side effects, and stories from others who were vaccinated. The program reached 293,000 unique members with roughly 2.5 million individual messages.

RAE 4 and its partners set up mobile vaccination clinics (vans) to reach and vaccinate migrant farmworkers and pop-up clinics throughout the region.

RAEs 6 and 7 had their care coordination team outreach through multiple modalities including text, phone calls, and mail, to reach potentially homebound members to get them a vaccine.

Denver Health (MCO) partnered with Denver Public Health and Denver Health and Hospital Authority to deploy mobile units to reach members where they live, including home health settings.

RAEs and MCOs were eligible to receive these funds contingent upon the successful completion of a COVID-19 vaccination response plan and achievement of three additional performance measures:

- 100% completion of outreach to the list of potentially homebound members to support connections to vaccinators and to share accurate vaccine information
- Disparity between members of color and white members must be three percentage points or less for Phase 1 of the vaccine rollout.
- Disparity between members of color and white members must be three percentage points or less for Phase 2 of the vaccine rollout.

RAEs and MCOs were required to direct at least 75% of all incentive dollars to providers and community partners, such as faith-based organizations, community-based organizations, advocacy groups, and food banks. This effort concluded in September 2021.

COVID-19 Vaccination Among Members of Color

By the beginning of February 2021, just 5 percent of Colorado's COVID-19 vaccines had gone to Hispanic Coloradans even though they constitute 22 percent of Colorado's population. This disparity was especially concerning because Hispanic Coloradans and other members of color were experiencing higher case rates and death rates.[4]

This reinforced the need for a health equity strategy with regard to vaccinations. Not only have systemic factors historically reduced access to care and levels of trust in the medical system for people of color, but vaccine supply was also initially low, creating competition for limited appointments. Misinformation about the vaccine and barriers to care, particularly transportation and translation services, exacerbated this challenge.

RAEs and MCOs implemented the following activities and initiatives to reduce vaccination disparities:

- Identify and distribute lists of unvaccinated members to PCMPs with messaging and, often, financial support to encourage an increase in vaccinating providers.
- Train care coordinators and trusted community messengers to promote accurate vaccine information and dispel myths.
- Fund *promotoras* to outreach to members in their communities about why and how to get vaccinated.
- Support PCMPs (especially Federally Qualified Health Centers) in diverse communities, including administrative support, supplies, and in some cases, incentive payments.
- Set up pop-up clinics in communities, often staffed with bilingual workers and paired with COVID-safe events.
- Fund alternative transportation options for members.
- Form partnerships with housing partners, advocacy groups, schools, community-based organizations, local public health agencies, vaccination

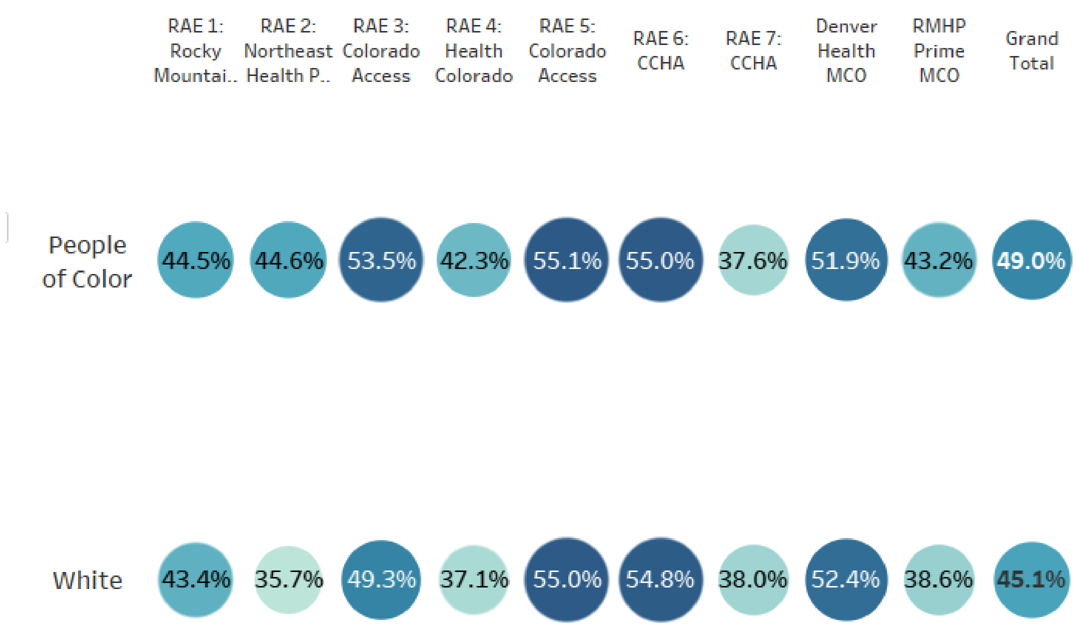
[4] Kaiser Family Foundation State COVID-19 Data and Policy Actions, Dashboard, August 2, 2021.

task forces, childcare providers, radio and media groups, and faith-based organizations.

The RAEs have met their disparity reduction goals, ensuring that vaccination rates between white members and members of color were within three percentage points. By the end of August, the percentage of Hispanic/Latinx members who had at least one vaccine dose surpassed the percentage of white members with at least one dose.

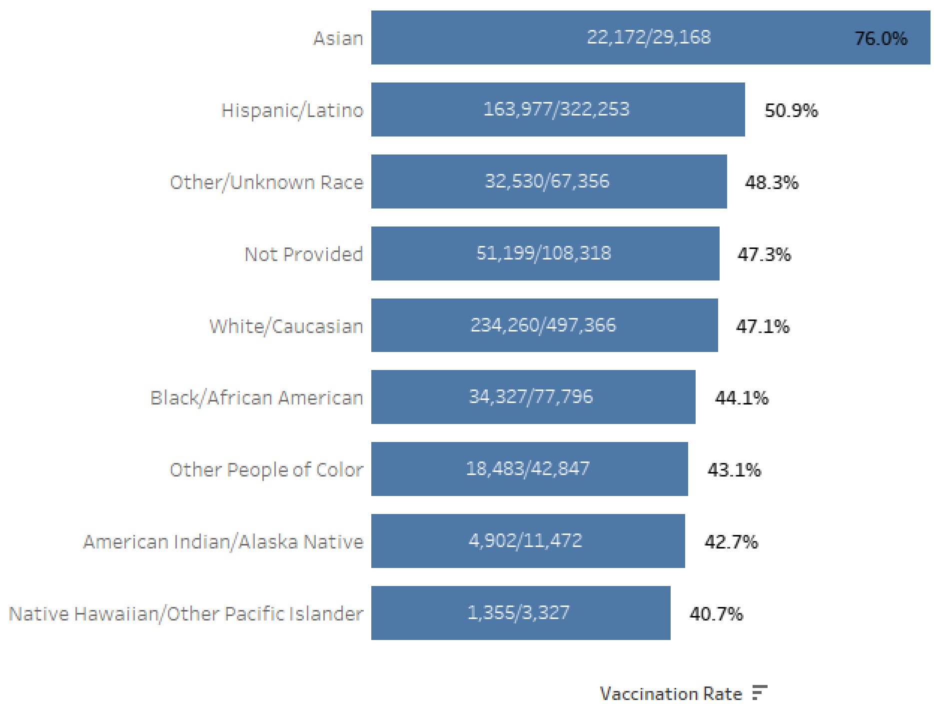
Figures 4 and 5 show vaccine rates by race/ethnicity as of October 2021. Asian members had the highest rates of vaccination – a vaccine outreach success reflected in the overall Colorado population and nationally.

Figure 4. Medicaid COVID-19 Vaccination Rates for Members of Color vs. White Members, from December 2020 to October 7, 2021[5]



[5] Bubbles represent the vaccination rate within each race/ethnicity grouping (e.g., 49.0% of eligible people of color have received at least 1 dose of COVID-19 vaccine). Data includes Medicaid members 12 and above. Data includes vaccine service dates through 10/7/21. Vaccination rates reported here include both fully and partially vaccinated members. Only members that have been continuously eligible for Medicaid and continuously assigned to the same RAE/MCO since January 2021 were included here. Members were excluded here if they did not select a race/ethnicity option, if they selected the "Other/Unknown" race/ethnicity option and nothing else, or if they selected the "Other/Unknown" option in combination with the "White/Caucasian" option and nothing else. Members in facilities were excluded.

Figure 5. Medicaid COVID-19 Vaccination Rates by Race/Ethnicity as of October 7, 2021



Note: Vaccination rates reported here include both fully and partially vaccinated members. The bars represent the vaccination rate within each race/ethnicity group (e.g., 76.0% of eligible Asian members have received at least one dose of the vaccine). Data only includes Medicaid members ages 12 and over. Data includes vaccine service dates through 10/07/21.

RAEs plan to continue to work on vaccination outreach, particularly in areas with low vaccination rates, as overall vaccination rates for Medicaid members are lower than that of the Colorado population (about 50% compared to over 75% as of October 7, 2021). This mirrors trends in the nation, in which lower-income individuals are less likely to be vaccinated than those with higher incomes, which may be due to concerns with taking time off work and other access barriers.[6]

COVID-19 Vaccinations for Homebound Members

Another group at risk for low COVID-19 vaccination rates were homebound members. This group was identified as having a high need for support in receiving the vaccination due to their inability to leave the home to get a vaccine. In addition, they have an increased risk of contracting COVID because many have care staff coming into their homes to deliver services.

[6] Census Bureau's weekly household pulse survey, June 9-21, 2021.

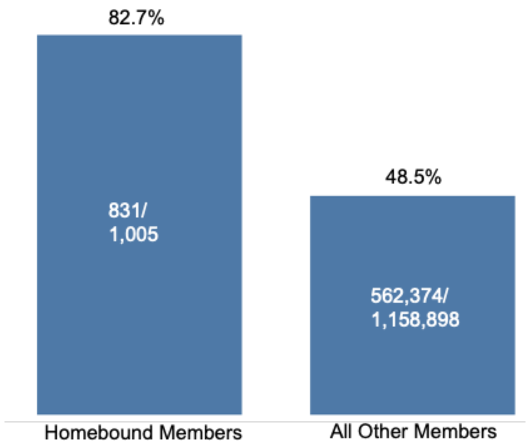
To address this need, the Department worked with RAEs, MCOs, and LTSS case management agencies to identify members who were potentially homebound and those with a disability. RAEs established regular information and data exchanges with case management agencies to identify unvaccinated members with support needs, particularly transportation and information about the vaccine, and fill gaps as needed.

RAEs and MCOs received funding to reach out to these members; over the course of two months, trained customer support staff and care coordinators reached out to members on the list multiple times to identify who was interested in the vaccine but needed support obtaining it, such as assistance with scheduling an appointment or with transportation options.

RAEs and MCOs successfully reached out to all members on their lists who were not already vaccinated (approximately 32,000 individuals total). Of those contacted, approximately four percent self-reported as homebound and an additional 11 percent requested assistance through resources or scheduling of an appointment in the community.

Where possible, RAEs connected homebound members with in-home vaccination. In areas with limited in-home vaccination options, RAEs worked with local partners to help homebound members get the support they needed to receive the vaccine outside of their home. Once accessibility issues were successfully addressed, members who are homebound proved highly motivated to become vaccinated. Figure 6 shows that at the close of the fiscal year, members who are homebound had much higher vaccination rates than the rest of the Medicaid population.

Figure 6. Medicaid COVID-19 Vaccination Rates in Members Who Are Confirmed Homebound vs. All Other Members as of October 7, 2021[7]



B. Meeting the Needs of High-Risk Members During COVID

The pandemic posed a particular risk to older members and those with chronic conditions. Before the vaccine became available, these members were at higher risk for contracting the virus and dying from it. Moreover, due to the threat posed by the virus, these members were at risk for not receiving the routine care they needed for their chronic conditions. The ACC already had the structure and focus on high-risk populations to allow the program to quickly respond to these risks.

The program was able to use its existing analytics capabilities to identify members at a high risk for contracting COVID-19 based on age and medical conditions. This is something that would not have been possible just ten years ago. With this information, RAEs identified and reached out to members with the highest risk of contracting COVID-19. Their care coordinators and other trained staff offered these members information about COVID-19 prevention, symptoms, and vaccinations when they became available. The RAEs shared the lists of high-risk members with the PCMPs who serve these members. In addition, the RAEs supported access to care through telehealth by creating telehealth toolkits for the PCMPs who serve these members. The use of data and the ability to deploy solutions rapidly were both possible because of the existing program infrastructure.

[7] Bars represent the vaccination rate within each group. Data includes only Medicaid members aged 12 years and older. Data includes vaccine service dates through 10/7/21. Vaccination rates reported here include both fully and partially vaccinated members. Members in the Confirmed Homebound group were confirmed homebound via an outreach form completed by a CMA or RAE/MCO.

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Table 8. Number of Members at High Risk for COVID-19 Outreached and Engaged, by RAE

RAE	Number of Members at High Risk for COVID Outreached	Number of Members at High Risk for COVID Engaged
1	53,465	2,341
2	31,807	2,857
3	196,923	16,370
4	56,418	8,133
5	98,823	9,165
6	61,106	5,269
7	74,293	5,171

Note: A member was engaged if a care coordinator was able to talk with the member and provide information about the COVID-19 vaccine and how to access the vaccine.

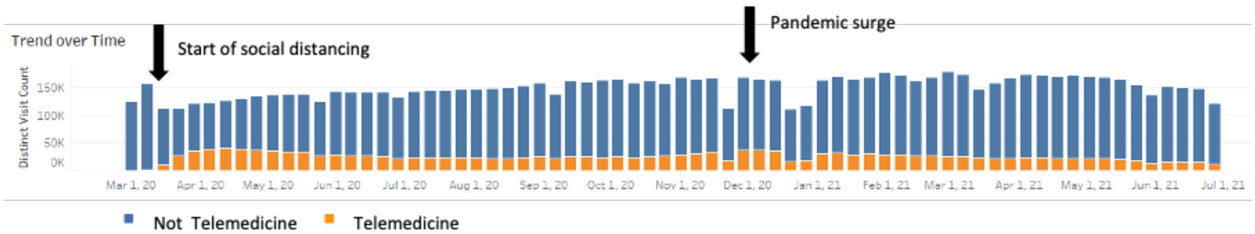
C. Expanding Access to Telemedicine

One impact of the COVID-19 pandemic was a rapid expansion of telemedicine services to maintain safe access to services. Through rulemaking during March and April 2020, the Department expanded the allowable provider types and opened the ability to bill for audio-only services and have them reimbursed at the same rate as in-person services. These rules were codified with the passage of Senate Bill 20-212, signed into law by Governor Polis in July 2020.

After the new telemedicine rules were approved, RAEs expanded the utilization of these services in their regions by surveying providers to find out what support they needed to offer telemedicine. RAEs trained providers via webinars, offered software platforms and other resources to providers, and made phones, tablets, and internet access more readily available to members. This not only made care more available to members, it also stabilized providers struggling with reduced demand for services.

Fee-for-service telemedicine increased from less than one percent of all visits prior to the pandemic to a high of 32.2% of visits during the first week of April 2020. Fee-for-service visits are those that are not provided under a capitated managed care program, so most behavioral health services are not captured here. Figure 7 displays the percentage of telemedicine eligible fee-for-service visits delivered by telemedicine during FY 2020–21. Throughout this year, the percentage of visits delivered by telemedicine hovered around 15%. Telemedicine visits saw an uptick during the winter of 2020, when Colorado experienced a wave of COVID-19 cases.

Figure 7. Percentage of Eligible Fee-for-Service Visits Conducted by Telemedicine, March 11, 2020 to July 1, 2021



The use of telemedicine for care varied by region, as shown in Table 9. Regions covering more rural areas of the state (RAEs 1, 2, 4 and 7) had lower rates of telemedicine visits while the three urban regions (RAEs 3, 5 and 6) had higher telemedicine uptake. This may be due to the challenges with accessing broadband to conduct visits in more rural regions: according to the Colorado Rural Health Center's 2018 *Snapshot of Rural Health in Colorado*, about one in four rural households in Colorado does not have access to broadband.[8]

Children were high utilizers of telemedicine for ongoing therapies such as speech, physical, and occupational therapies, partially because early intervention services were only delivered remotely in the beginning of the pandemic. Adults used telemedicine for more varied services, including services related to chronic disease management and treatment of behavioral health issues such as anxiety.

Making Telemedicine Possible

Telemedicine was not commonly used before the pandemic, so RAEs had to scale this infrastructure up quickly when the pandemic began.

RAE 1 collaborated with the Colorado Health Foundation to support approximately 20 community agencies with the purchase of tablets, laptops, phones, and data plans for members to access telemedicine services.

In RAE 4, safety-net providers used funds from the RAE to assist members with broadband, phones, tablets, and other resources to increase access to telemedicine services.

RAEs 6 and 7 used their practice transformation coaches to help PCMPs set up telemedicine.

[8] Colorado Rural Health Center (2018). *Snapshot of Rural Health in Colorado*. http://coruralhealth.org/wp-content/uploads/2013/10/2018-Snapshot-FINAL-VALIDATED.pdf

Table 9. Average Percentage of Fee-for-Service Telemedicine Visits by Region, March 8, 2020 to June 27, 2021

RAE	Average % of Eligible Fee-for-Service Telemedicine Visits
1	14.5%
2	14.8%
3	21.5%
4	12.5%
5	22.1%
6	21.5%
7	12.6%

Note: This table shows only the percentage of eligible visits, not all visits. Not all visits are eligible for telemedicine.

Behavioral health providers have been high adopters of telemedicine throughout the pandemic. In the first two months of 2020, prior to the pandemic, the average telemedicine utilization rate for capitated behavioral health was 0.9%. By April 2020, the average across the seven regions had grown to 50.4%. From March 2020 through March 2021, the statewide average telemedicine rate for behavioral health visits was 40.3%. See Table 10 for the rate by region.

Figure 8. Capitated Behavioral Health Telemedicine Visits, March 2020 to March 2021

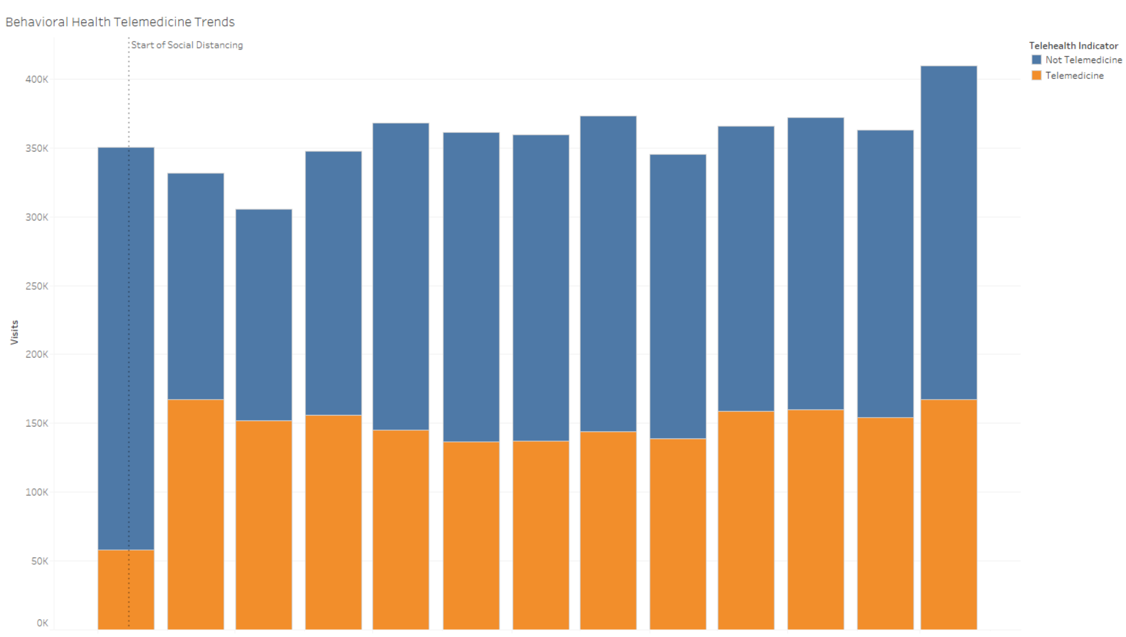


Table 10. Percentage of Capitated Behavioral Health Telemedicine Visits by Region, March 2, 2020 to March 31, 2021

RAE	Average Percentage of Capitated Behavioral Health Visits Conducted by Telemedicine
1	34.75%
2	47.44%
3	41.24%
4	38.07%
5	30.58%
6	48.57%
7	50.22%

As with physical health services, children were the highest utilizers of behavioral health telemedicine. The most common diagnoses associated with telemedicine visits for behavioral health were similar across RAEs and included post-traumatic stress disorder, anxiety disorders, major depressive disorders, opioid dependence, and alcohol dependence. There was no apparent geographic pattern to the uptake of behavioral health telemedicine.

> ***Telemedicine Helps Young Members***
>
> RAEs could continue to meet the unique needs of children and teens during the pandemic with telemedicine.
>
> One RAE needed providers to help with a teen member who was struggling with an eating disorder. The RAE was able to connect the member with the array of services needed, including nutrition consults, through telemedicine.
>
> In another RAE, a teen member was able to quickly schedule an appointment through telemedicine to have psychiatric medication adjusted, relieving the member's symptoms and preventing the need for more intensive services later.

A telemedicine report released by the Department in February 2021 offers more insight into the expansion of telemedicine during the pandemic and how its impact on access to care. One encouraging finding is a decrease in no-show rates for telemedicine visits, especially among members of color. The Department partnered with the Farley Center for Health Policy at the University of Colorado to analyze no-show rates for in-person versus telemedicine visits for members at Denver Health. Findings indicate that no-show rates for telemedicine visits were about half the rate for in-person visits both before and during the pandemic. Black members, who had the highest no-show rates for in-person visits, saw the largest reduction in no-show rates with telemedicine visits. Results were also promising for members with complex health care needs. Medically complex members had higher no-show rates than other groups for in-person visits, but similar rates for telemedicine visits. These results indicate telemedicine's potential to increase access to care and reduce disparities.

III. Behavioral Health Care

One of the primary objectives of this phase of the ACC is to combine accountability for physical health and behavioral health under each of the RAEs. RAEs administer the capitated behavioral health managed care benefit for their region, a model that has several advantages for members. Behavioral health is complex and often requires several services from different providers. A managed care model helps to ensure that these services are connected and coordinated. The managed care model also allows the state to offer specialized benefits that would not be available under a fee-for-service model. These services, referred to as "B3 services," include respite care, community-based support services, supported employment, clubhouse and drop-in center services, and case management. B3 services offer members a way to connect with peers, develop life skills, and prevent isolation. These services can be especially important for members with severe and persistent mental illness.

In addition, the accountability structures that are built in to managed care give the state the ability to track progress on metrics and adjust policies or practices. Finally, a region-based managed care model provides structure that allows the Department to connect physical and behavioral health, and respond quickly and flexibly to emerging needs, such as the need for behavioral health telemedicine during the pandemic.

A. Access to Behavioral Health Care

This fiscal year, the Department continued to work with the RAEs to ensure that members can access the full range of behavioral health services they need. One measure often used to assess adequate access to care is the penetration rate, which is the percentage of all members who used behavioral health services. In FY 2020–21, 18.2% of members accessed capitated behavioral health services, including substance use disorder services. As a point of comparison, the behavioral health penetration rate for Medicaid nationally was approximately 14% at the end of December 2020 (not including SUD services) according to the National Committee for Quality Assurance. Although these figures are not directly comparable, they provide a rough indicator that member access to behavioral health is near the national average and may be above it, given that penetration rate only captures capitated services.

This year, the Department expanded behavioral health services to include residential and inpatient substance use disorder treatment services. The benefit rolled out in January 2021 and from January to June 2021, 664 members accessed residential treatment and 4,225 members accessed withdrawal management services.

The Department will continue to connect members with the behavioral health services they need, especially given the risks posed by the pandemic. According to a February 2021 Kaiser Family Foundation report, populations at risk for increased anxiety, depression, and substance use due to the pandemic include those who have experienced job and income loss, parents of children (especially mothers), young adults, and people of color.[9] Communities of color have often had difficulty accessing adequate behavioral health care even before the pandemic, so it is particularly pressing to improve their access to care now. In addition, the behavioral health needs of Colorado's children are growing, and children require specialized care. Like much of the nation, the Department is working with other state agencies to overcome the challenges of a limited workforce, particularly among practitioners serving children, to ensure that members can get the care they need.

B. Behavioral Health Provider Network

The RAEs have worked to expand their networks of behavioral health providers, contracting with many more independent providers. This has been more important over the past fiscal year to meet both the needs of increased membership and the behavioral health challenges resulting from the pandemic. Despite workforce challenges, the RAEs have continued to increase the total number of contracted behavioral health providers over the last fiscal year.

Table 12. Number of RAE-Contracted Behavioral Health Providers (by Unique National Provider Identifier), by Quarter

Fiscal Year and Quarter	Number of Enrolled Behavioral Health Providers

[9] Panchal, N., Kamal, R., Cox, C., and Garfield, R. (February 2021). *The Implications of COVID-19 for Mental Health and Substance Use*. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

FY 2019-20 Q4	6,391
FY 2020-21 Q1	7,451
FY 2020-21 Q2	7,984
FY 2020-21 Q3	8,307
FY 2020-21 Q4	8,627

Note: Enrolled providers were counted by unique NPI. Missing, duplicated or invalid NPIs were excluded.

The Department and RAEs are also working to build the provider network for the new residential and inpatient benefit for SUD treatment. This year, the Department met individually with providers upon request to explain the enrollment process and answer questions. The Department also expedited the review of SUD provider enrollment applications. As of June 2021, 28 unique provider agencies across 58 locations have enrolled to provide inpatient and residential SUD services.

C. New Benefit: Residential and Inpatient Treatment for Substance Use Disorder

The ACC is designed to grow, evolve, and flexibly respond to the needs of the state. On January 1, 2021, the program made a big change by expanding its SUD benefit in accordance with House Bill 18-1136. This expansion completes the full continuum of services as defined by the American Society of Addiction Medicine (ASAM), including residential and inpatient services, ensuring that members can access the level of care most appropriate for them.

This addition of this benefit required extensive stakeholder work, legal/regulatory approvals from both the state and federal government, changes to operational infrastructure (e.g., billing and enrollment), and RAE contracts. This process is always challenging, and even more so during a pandemic. The Department, the Office of Behavioral Health, RAEs, and behavioral health managed services organizations (MSOs) worked together in the SUD Capacity Work Group and SUD Implementation Work Group to prepare for the benefit expansion and roll out of the benefit.

To prepare providers to deliver this benefit, the Department and its partners, including the Office of Behavioral Health, hosted provider trainings that were attended by approximately 340 individuals and gave providers access to online ASAM training and free copies of *The ASAM Criteria™: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2013). Two hundred books were distributed to 43 unique provider agencies. In addition, the Department created and published a SUD Provider Manual covering benefit policies and procedures. RAEs continue to support providers, improve benefit administration and utilization management processes, track availability of beds, and connect members to services.

Care Coordination for Relapse Prevention

A member was introduced to a RAE Substance Use Disorder Care Coordinator after an admission to a psychiatric hospital. The member was ready to be discharged but expressed concern about becoming homeless and at risk for relapse. The care coordinator worked with the member to find a sober living placement and secure funding for the placement from community organizations.

Challenges are part of any new benefit implementation of this scale. Below are some of the challenges the Department has addressed or is currently addressing:

- **Utilization management:** Utilization management is required by federal regulation for this benefit. Currently, to receive approval for this benefit, providers use the ASAM criteria to do a manual assessment that is subsequently reviewed by the RAEs. The Office of Behavioral Health is in the process of procuring a vendor that will use the ASAM criteria to develop an electronic, standardized statewide patient placement tool to streamline the utilization management process. This will reduce the administrative burden on providers and standardize the approval process. In the meantime, the Department has worked with RAEs to standardize authorization timeframes for special populations such as pregnant and parenting individuals.
- **Access to services and service capacity:** The Department has received comments regarding waitlists and difficulty accessing services due to insufficient provider capacity. The Department is currently working on a behavioral health provider capacity assessment to analyze the access gaps for members for SUD services.
- **Billing for withdrawal management:** Provider billing for withdrawal management changed when the expanded SUD benefit was implemented. In response to challenges with billing, the Department adjusted its billing strategies for this benefit to better serve the RAEs and providers.

Better Outcomes though a Managed Substance Use Disorder Benefit

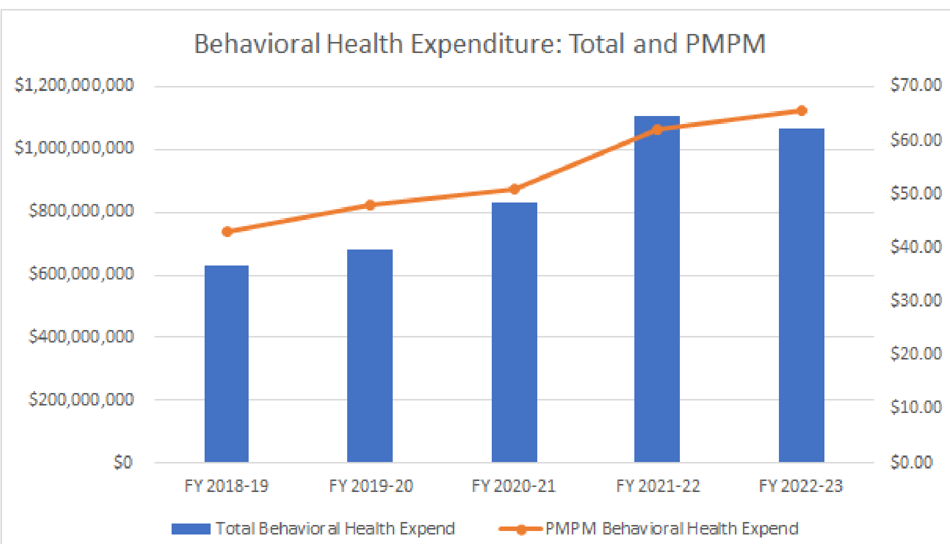
A member was being treated in a residential program that the member did not believe was a good fit. The member knew people in the program and was unable to be as open and honest as was needed to progress in the program, so the member dropped out. The RAE's SUD case manager helped the member find another residential program and assisted with completing the intake paperwork. The RAE's blended utilization management and case management staff followed up with the member to ensure the member was receiving needed care and responded to additional requests for support.

The member completed the full course of treatment at the new residential facility in 25 days.

The team met with the member prior to discharge to set up appointments for outpatient therapy, groups, psychiatry, and a primary care provider. The RAE remains in contact with the member, who is employed and has remained sober.

D. Investing in Behavioral Health

With strategic investment in behavioral services, the Department can make needed services available to members while preventing more serious and costly problems. The signs are evident both nationwide and in Colorado: an investment in behavioral health must be made at this critical time to address the challenges our population is facing. Even prior to the expansion of the SUD benefit this fiscal year, the Department had been consistently increasing the dedication of resources to behavioral health.



In addition to the specific Medicaid ACC increased investment in behavioral health, the state is establishing a Behavioral Health Administration (BHA). The Department

COLORADO Department of Health Care Policy & Financing will support the formation of the BHA to strengthen the behavioral health safety net, reduce barriers for providers, and focus on outcomes-based payments while supporting appropriate projects associated with the 19 priorities identified through the Behavioral Health Task Force. As well, the Department and the RAEs are engaged in the Behavioral Health Transformational Task Force, which will decide on how to invest $450 million in ARPA dollars to transform the behavioral health industry across Colorado.

IV. Condition Management and Complex Care Coordination

From the beginning of the ACC, one of its important functions has been to help Health First Colorado members manage chronic and complex conditions. Unmanaged conditions can be costly and lead to lower quality of life and preventable loss of life. By managing the care of members with certain conditions or complex health needs, the Department can improve member health while controlling costs.

Diabetes Management: The Key to Care

A member needed surgery, but the surgeon would not schedule it until the member's HbA1c was lower. It had been unmonitored at 12.9 – much higher than normal. The care coordinator worked with the member weekly, asking the member to check blood sugar at different times during the day. The care coordinator also encouraged the member to make gradual dietary changes. Eventually, the member's HbA1c went down to 9.7, 8.8, and finally to 7.3.

The member now watches diet carefully, checks blood sugar daily, and was able to schedule the needed surgery.

The Department identified 10 conditions that could benefit from condition management and cost control and chose three for the RAEs to focus on: maternity, diabetes, and complex care coordination. Maternal health was selected because Medicaid covers more births than any other payer in the state. The Department selected diabetes because of its prevalence and potential for serious health problems that are preventable. Complex conditions, by definition, require ongoing care from multiple providers and are major cost drivers.

A. Condition Management Approach and Participation

The Department created a standardized approach for condition management that uses a population management framework to understand and address the health care needs of the RAE's different populations. It gives the RAE a framework for assessing and understanding which groups require high-cost, complex care, and how to manage their care to prevent disease progression.

The Department identified five universal components of condition management programs for RAEs to include:

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- Member identification and risk stratification
- Culturally competent specialized care teams
- Facilitation of access to appropriate medical services, resources, and community programs
- Delivery of evidence-based/informed interventions
- Program measurement and reporting on target outcomes

Prior to implementation of the condition management programs, the Department helped the RAEs use an inventory to assess their current capacity in both maternity and diabetes care. This gave the RAEs an opportunity to align their current program elements with the five components. After extensive collaboration between the Department and RAEs, all three condition management programs were implemented by all RAEs by December 2020. The Department will continue to work with the RAEs to expand and refine their programming, with an emphasis on PCMP-based programming.

Table 13. Participation in Diabetes Condition Management by RAE, January - -June 2021

RAE	# of members with diabetes	# of members participating in a RAE condition management program	# of members participating in a PCMP condition management program
1	8,858	6,881	179
2	6,214	N/A*	2,305
3	20,770	8,485	2,185
4	19,338	44	9,601
5	12,488	4,483	2,592
6	7,411	673	1,032
7	8,085	455	2,357

**August 2021 launch*

Note: Depending on the RAE, members can participate in the RAE program, the PCMP program, or both.

Table 14. Participation in Maternal Health Condition Management by RAE, January - June 2021

RAE	# of pregnant or postpartum members	# of members participating in a RAE condition management program	# of members participating in a PCMP condition management program

1	10,631	8,452	4,717
2	10,690	N/A	4,893
3	12,828	4,854	969
4	6,943	0**	2,766
5	5,530	2,333	1,269
6	3,082	214	230
7	4,233	114	290

***July 2021 launch.*

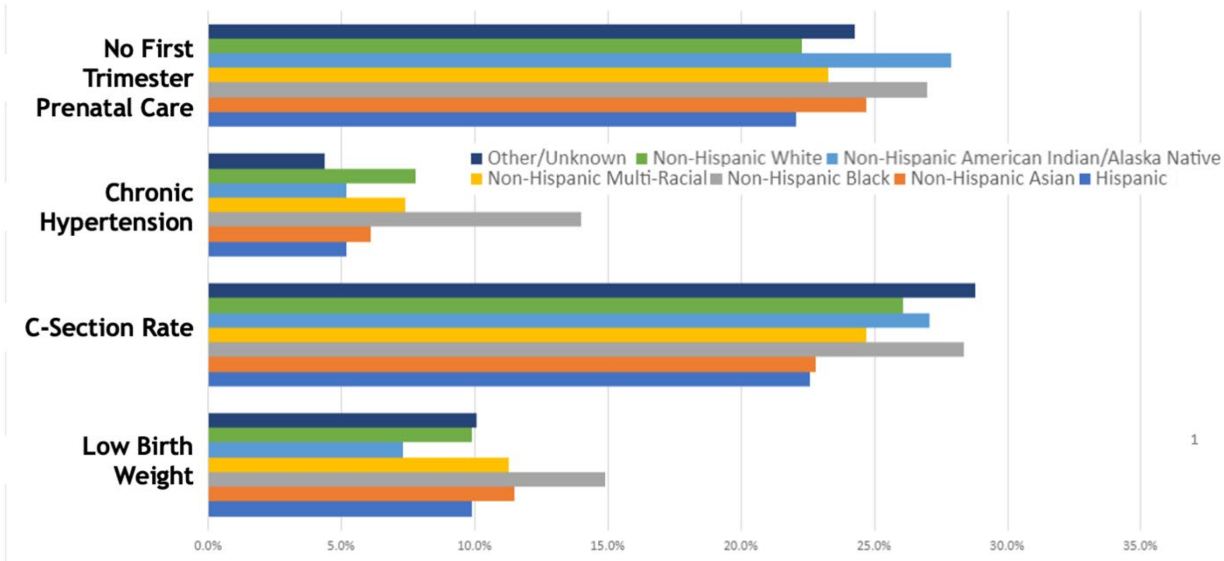
B. Maternal Health Condition Management for Better and More Equitable Outcomes

Maternal and infant health outcomes are among the most important indicators of the health of the state and nation. Providing prenatal care for more than 40% of births in the state each year, the Department is focused on improving health outcomes for parents and newborns. Given that preterm birth rates continue to rise and racial and ethnic disparities in outcomes persist, a broad selection of initiatives will be required to improve health outcomes and change the current state and national trajectory.

In addition, long-standing systemic racism, including economic and environmental injustice, has created conditions that negatively affect marginalized communities, particularly people of color. These conditions, which limit opportunities for optimal health and influence individual behaviors, are critical predictors of health and birth outcomes and have contributed to inequities in pregnancy outcomes (see Figure 10). To realize a future where all Coloradans can thrive, the Department and RAEs must be part of undoing policies and practices that have contributed to these inequities.

Equity issues persist in many conditions that make pregnancy dangerous for both parent and child, like chronic high blood pressure. Condition management improves the likelihood that these conditions are treated earlier in pregnancy to reduce the risk of poor outcomes and close the equity gap. See the Department's [Fall 2021 report on maternal health] for more data and information.

Figure 10. Medicaid Maternity Outcomes by Race/Ethnicity



The Department has a long history of special programming for pregnant and newly parenting people. This includes: 1) Prenatal Plus, which provides team-based care for birthing people at risk of adverse birth outcomes that includes a mental health professional, a dietitian and a specialized perinatal care coordinator; 2) Nurse Family Partnership, which offers nurse home visiting services to first-time birthing parents, prenatally through the child's second birthday; and 3) Special Connections, a gender-responsive, trauma-informed continuum of SUD services for pregnant and parenting individuals up to one year postpartum. The RAEs leverage these and other programs to improve the outcomes and experiences of pregnant and newly parenting people.

The Department's newest initiative is the creation of a Maternity Advisory Committee composed primarily of Black, Indigenous, and People of Color (BIPOC) with lived experience in Medicaid maternity care. Through stakeholder engagement on the application and an extensive outreach process, the Department received more than 100 applications from eligible Medicaid members and interviewed 35 candidates. Sixteen committee members, of which 80% identify as BIPOC, began meeting in August 2021.

C. Evaluating Condition Management Program Performance

As this condition management effort evolves, performance will be assessed using outcome measures that align with other existing performance measures, such as the KPIs, behavioral health incentive measures, and Core Measures from CMS. Because the new condition management programs began in the middle of this fiscal year, the

Department completed a more informal assessment to evaluate performance and identify areas for growth. Summary of findings:

- The RAEs demonstrated flexibility and creativity in connecting members to physical and behavioral health services through both traditional visits and telemedicine, ensuring that these members received needed care. RAEs also funded community-based services and trained their care coordination staff to support members directly, provide information about their conditions, and refer them to resources to address non-medical needs, such as food insecurity.
- All RAEs have room for growth in delivering culturally competent services. This includes hiring bilingual staff, partnering with community-based organizations that serve subpopulations specific to the region, offering member resources in multiple languages, and offering staff training relevant to facilitating the delivery of services to members including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- There is room for growth across all RAEs in program measurement and reporting towards target outcomes, specifically in tracking outcomes for complex care coordination. The definition of *complex*—which conditions it includes and how many of them—is evolving. This makes measurement from year to year a challenge.
- RAEs differed in how they measured outcomes for their programs, and not all RAEs reported on the optional outcome metrics. The Department will continue working with the RAEs to drive performance and move towards outcome-based measures.

One example of a promising Condition Management program is in RAE 1. The RAE has redesigned its care coordination process to use a tool that assesses a member's relative risk of accruing high health care costs, with a higher number indicating higher risk. The RAE offers extended care coordination to members that have a certain level of risk. This is an intense form of care coordination for higher acuity members who require more intense and extended assistance. It typically includes a care plan, a monitoring plan, and bi-directional communications (face-to-face, telephone, or text). Both emergency department utilization and inpatient admissions are decreasing for members who participate in the program.

V. Services for Populations with Unique Health Challenges

The RAEs have a particularly important role to play in meeting the needs of members who face unique health challenges or belong to a population that has historically fallen through the cracks of the health care system. This section is an update on how the ACC is serving four of these populations: justice-involved members, members in the child welfare system, children requiring Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program services, and members experiencing homelessness.

A. Services for Justice-Involved Members

Justice-involved individuals experience significant health needs, particularly behavioral health. Within Colorado prisons, 35% have a significant mental health need and 72% have a pressing need for substance use treatment.[10] Some individuals receive treatment through the Colorado Department of Corrections' Approved Treatment Provider (ATP) network, which provides limited sexual offense and SUD treatment modalities, but individuals have historically encountered significant obstacles in accessing care upon re-entry.

> ***Getting Care for a Justice-Involved Member with a Health Condition***
>
> A member who was transitioning out of the Department of Corrections needed a new doctor and treatment for an ongoing illness. The care coordinator identified the appropriate PCMP, one that could quickly provide the needed treatment. When the member shared that he had no way to get to treatment, the care coordinator connected him with non-emergent medical transportation.
>
> These logistical challenges and decision points can pose an intimidating barrier to care, but they are surmountable with the help of a knowledgeable care coordinator.

The Affordable Care Act extended Medicaid eligibility to this population in 2014, offering a critical tool for a state's overall criminal justice reform strategy. However, a 2018 analysis by the Department indicated that health care access and utilization is fragmented and ineffective. Utilization of Medicaid-reimbursable behavioral health services within the critical 14-day post-release period was minimal during the initial years of expansion, rising to a peak of 7% in 2016. This indicates that most individuals either relied on the limited ATP program or went without treatment altogether. More importantly, mortality rates for the population remained consistent with or higher than pre-expansion rates.

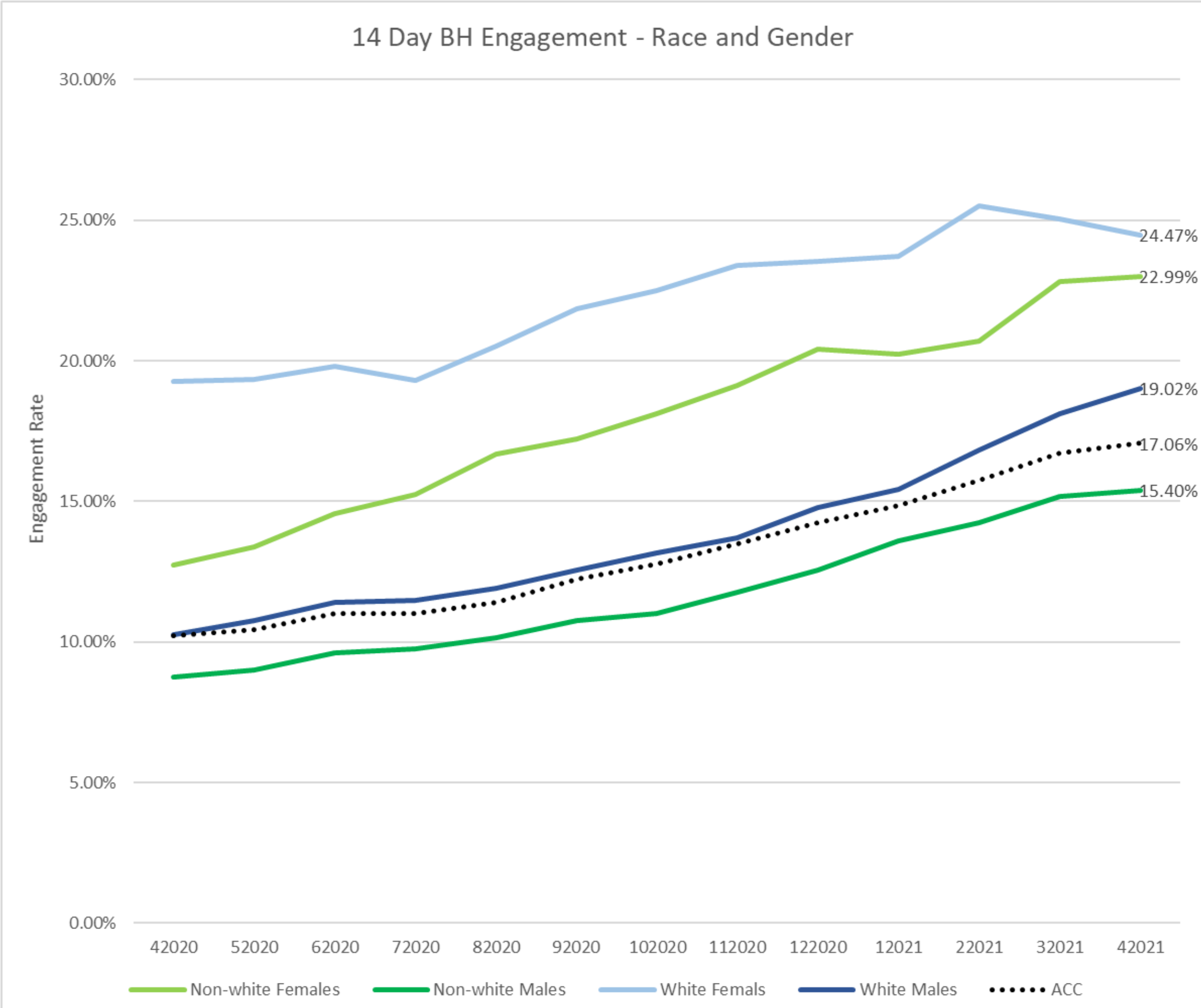
To improve access to care for the 70–80% of individuals who are Medicaid-eligible upon re-entry, the Department established a data-sharing agreement with the Department of Corrections to identify and transmit a roster of Medicaid-eligible individuals to RAEs for support and care coordination. In summer of 2021, the process was automated which allowed for a daily transfer of the roster to RAEs. In August

[10] *Inmate Population Profile*, Colorado Department of Corrections Departmental Reports and Statistics. Accessed 11 November 2020.

2021, the Department completed a similar data-sharing agreement with the Colorado Judicial Branch to better support members involved with the justice system (e.g., probation).

The Department is working with RAEs and other stakeholders to bridge the services gap for justice-involved individuals. In compliance with 25.5-1-130, C.R.S. (Senate Bill 19-222), the Department worked with stakeholders to develop a financially incentivized performance metric for RAEs: coordinate behavioral health services for members within 14 days of release from a Department of Corrections facility. From April 2020 to April 2021 (the most recent available claims data), the statewide rate of engagement within 14 days has increased from just over 10% to 17.06%. Based on the data, women are accessing services more than men, and white individuals are accessing services at a higher rate than other groups (see Figure 11). In the upcoming fiscal year, the Department will continue to work with stakeholders to improve overall engagement rates, minimize disparities, and implement the judicial data-sharing agreement.

Figure 11. Behavioral Health Engagement Among Justice-Involved Individuals within 14 Days of Re-Entry by Race and Gender, April 2020-April 2021



B. Services for Members in the Child Welfare System

Children in the child welfare system often require multiple services from multiple agencies. Child welfare funding is complex and heavily regulated, as is Medicaid funding, so it is difficult to braid funding in a member-centered way. The systems and regulations do not always lend themselves to collaboration to meet the needs of the child and family.

In addition to its regular meetings and collaboration with the Colorado Department of Human Services (CDHS) and county staff, this year the Department created the HRCC forum, so named because it is co-chaired by **H**CPF (the Department), the **R**AEs, **C**DHS (Colorado Department of Human Services), and the **c**ounties. This group has been working over the last year to build relationships, establish common understanding and provide information, clarify roles and responsibilities, and address systemic issues that affect the care and support provided to this population. The HRCC collaboration has produced tip sheets and guidelines for processes used to meet children's needs, including RAE care coordination, protocols for out-of-state placements, and best practice guidelines for discharge planning (in partnership with hospitals).

The Department is also partnering closely with CDHS to implement the federal legislation Family First Preventions Services Act of 2018 (FFPSA). This legislation overhauled financing of child welfare services to prioritize families and family-like settings and minimize the use of group settings. The legislation has significant implications for the Department and its provider network; Medicaid is the primary health care payer for children in out-of-home placements, and the law created a new out-of-home provider type, Qualified Residential Treatment Programs. These programs have new assessment and treatment requirements. To adjust its policies and educate stakeholders, the Department has met with CDHS staff and leadership, providers, and county staff in groups and individually. Colorado's process has become a model for other states, informing their implementation of FFPSA.

Finally, the Department worked with counties and providers this year to expand the Psychiatric Residential Treatment Facility (PRTF) benefit to meet the needs of high-acuity children and avoid their being placed out of state. The Department interviewed county representatives, identified barriers to utilization, and met with current providers and interested providers to discuss programming, population needs, and rates. The Department nearly doubled the per diem rate for this service and developed fact sheets to clarify the benefit, resolve misunderstandings, and address concerns about access. This year, additional beds were allocated to meet the needs of high-acuity children; more than 100 beds will be available to them by December 2021.

C. Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, including adults who are pregnant, who are enrolled in Medicaid. Services include dental, mental health, developmental, and specialty services, including services that are medically necessary but are not covered in a state's Medicaid plan. EPSDT is designed to address problems early, correct or ameliorate illnesses and conditions, and intervene as early as possible.

EPSDT also requires case management services and outreach to eligible pregnant women and families or caregivers of EPSDT eligible members. By strengthening the linkages between primary health care providers and other child and family services, both case management and care coordination can better ensure that children receive needed services on a timely basis. Without these supports, children and families are more likely to delay or not receive services to address risks and prevent conditions from worsening.

On July 1, 2020, the Department transitioned the work of the Healthy Communities Program to the Department's RAEs. Historically, the Healthy Communities program provided outreach to newly enrolled families with children under the age of 21 and pregnant women enrolled in Colorado's Medicaid Program. A component of this outreach was informing eligible members about the EPSDT program. This outreach is now performed by the RAEs and MCOs as it aligns well with their existing work and provides cost savings opportunities.

The RAEs now use a combination of oral and written materials to outreach EPSDT-eligible members and inform them about the benefits of preventive health care, the services available under the EPSDT program, and how to obtain EPSDT services. Additionally, the RAEs are responsible for outreaching families or caregivers of EPSDT-eligible members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics “Bright Future Guidelines” and “Recommendations for Preventive Pediatric Health Care.

To assist EPSDT-eligible members and their families or caregivers who may be in crisis, the Department developed Creative Solutions calls/meetings to bring all funders and programs into a cohesive group. Creative Solutions can be requested by anyone - the family, provider, advocates or systems like child welfare agencies or the Community Centered Boards or Case Management agencies.

In 2018, the Department began transitioning the Creative Solutions process to the RAEs to facilitate these meetings as they are care coordination activities. This has assisted the RAEs in developing stronger relationships with the community programs like Momentum, Child Welfare prevention dollars and county child welfare staff, who need to access these additional resources for the children and youth in their care. The Department, as well as the Colorado Department of Human Services and the Office of Behavioral Health, have assigned specific staff to assist the RAE in these meetings. State staff attend an average of 40 Creative Solutions calls or meetings per month.

Many of these Creative Solutions meetings lead to the use of the Fee for Service benefits and the EPSDT services, often called wrap-around benefits. They also facilitate an understanding of when and how families or caregivers can access Children's Habilitation Residential Program and Children's Extensive Support, which are two of four Home and Community Based Services waivers available to children/youth offered in Colorado.

D. Services for Members Experiencing Homelessness

Homelessness is a pressing health and social issue in Colorado that affects some Health First Colorado members. To better understand homelessness among members, the Department created a working data definition for housing instability and homelessness using Health First Colorado application data. This definition uses the homeless indicator, living arrangement field, and address field from the application to create a flag. The indicator flag is then shared with the RAEs to improve care coordination.

The Department completed a data-sharing agreement with the Department of Local Affairs' Division of Housing. This agreement allows DOLA to share housing voucher data about Health First Colorado members with the Department to align and coordinate benefits between agencies.

In addition to these data initiatives, RAEs and MCOs are working on programs to address the needs of members experiencing homelessness. RAE care coordinators form relationships with homeless shelters and supportive housing service providers to share data, make and receive service referrals, and coordinate care. These relationships have been particularly important during the COVID-19 pandemic, as RAEs coordinate with homeless shelters to identify members at high risk of contracting COVID-19 to move them into more isolated settings such as hotels. The Department received a technical assistance award from the National Academy for State Health Policy to study opportunities to provide housing supports to members experiencing homelessness.

Community Partnerships to Meet the Needs of Members Experiencing Homelessness

During the pandemic, RAE 5 connected with Safe Outdoor Spaces (SOS), an initiative of the Interfaith Alliance of Colorado that provides temporary outdoor housing in heated tents to mitigate the spread of COVID-19 and connects unhoused individuals with health care and other services. Each site houses 30 to 40 individuals and is staffed 24 hours per day. Services include daily wellness screenings, COVID-19 testing, hotel referrals, de-escalation and conflict resolution, resident intake and referrals to housing, employment, and benefit navigation.

The RAE provides case management that includes a social determinants of health assessment and a care plan developed with the member. The RAE also financially supported reliable internet and access to telemedicine.

VI. Advancements in Data Collection and Use

With the ACC, the Department began to use data in new ways to inform clinical care decisions for members, guide regional and statewide policy decisions, and track the program's progress. The Department continues to build the ACC's data infrastructure and process so it can continue to understand member needs, make informed policy decisions, and respond to novel situations like the pandemic.

A. Data Sharing with RAEs

The ACC has continued to refine its data products that support decision making for the program and evaluate program outcomes. During FY 2020-21, the Department focused on sharing its internal data products with RAE partners to support condition management programming (see Condition Management and Complex Care Coordination in this report) and track progress on key performance indicators.

Bimonthly Program and Data meetings offer opportunities for the Department and RAEs to share data and discuss future opportunities for additional data collection. In FY 2020-21, the Department and RAEs began holding regular Program and Data meetings to share information about multiple topics including maternity outcomes, diabetes care, members experiencing homelessness, emergency department utilization, and behavioral health utilization.

B. Data Transparency with Partners and the Public

Data transparency and data sharing have been built into the ACC since its inception, and the Department continues to refine access to data and information. This fiscal year, maternity outcomes were a focus across several departments and a priority for the Governor's Office. The ACC used a linked dataset from the Department of Public Health and Environment to better understand maternity outcomes. By linking the Medicaid ID of the birthing parent with the birth certificate of the newborn, the analysis enables the Department to understand the relationships between prenatal care and behaviors and the outcomes for the newborn. The resulting report was made available to the public, and is helping the RAEs, state agencies, and other partners to make better programming decisions to improve maternity outcomes.

The Department also released a report this year about telemedicine utilization across the regions and is currently working on a public report regarding emergency department utilization. It explores pre-COVID and COVID-19 period trends to inform a larger emergency department strategy in each region and the whole state.

This continued movement towards more transparent, public reporting of data and outcomes is beneficial both to our partners and the Department, making the ACC's long-standing goal of data-informed programming a reality.

C. Better Race and Ethnicity Data to Ensure Equity

As part of its broader focus on equity, the Department is working to refine its data on race and ethnicity so the Department can more accurately identify and address health disparities between members of different racial and ethnic backgrounds. This work involves analyzing how data is collected on the Health First Colorado application to ensure that the race/ethnicity question meets best practice standards. The Department is also working to disaggregate the "multiple" race/ethnicity category to better understand the needs of these members.

The Department is also working to incorporate race and ethnicity data into its existing data dashboards and all forthcoming analyses. The Department is currently working with the Colorado Community Managed Care Network to obtain electronic health record (EHR) data, including demographic data, for members who receive care from federally qualified health centers (FQHCs). FQHCs serve more than a third of Health First Colorado members, so data from their EHRs can be used to fill in race and ethnicity gaps in the Department's data.

Better Data, Better Care

In addition to participating in statewide data initiatives, RAEs use and share data with the providers in their regions. RAEs 3 and 5 have developed platforms that gather data from multiple sources and display it on easily accessible dashboards. This gives program leaders and staff the ability to quickly assess and respond to emerging needs.

RAEs 6 and 7 launched a provider portal this year, allowing them to share patient and practice information securely. During the first year, 51 users across 34 PCMP practices used the portal, and they will continue to expand this in the next year.

RAE 2 established two health care data platforms for the RAE and its providers and to improve care management. One enables primary care providers to measure their performance against trends and benchmarks. Another is a Social Health Information Exchange and care coordination platform that can receive data from many data sources and is used by care coordinators.

The Department has been able to share race/ethnicity data that RAEs had not previously had access to. This is furthering the program's work to address health disparities by giving RAEs better information for decision-making. For example, data on tobacco smoking rates by region and race/ethnicity highlighted a specific area of concern among pregnant members who are white non-Hispanic, allowing RAEs to focus their efforts on this population.

VII. Priorities for FY 2021-22

The ACC Program has a central role to play in ensuring quality of care, access to care, and good health outcomes while controlling costs. Each of these is a priority for the Department. A significant focus is on ACC cost control impact because of the state's projected revenue challenges in the coming years. Ultimately, the ACC structure and value-based payment investments will better control costs, helping to protect member access to high quality Medicaid benefits and provider reimbursements in the years to come.

The COVID-19 pandemic has had both health and economic implications. During an economic downturn like this, unemployment rises and, as a result, so does membership. After an extended period of declining enrollment in Medicaid and CHP+, a dramatic increase began in April 2020. As of September 2021, the total number of Medicaid members increased from 1.25 million to 1.54 million, which is an increase of 23% in 18 months.

The influx of members resulted in increased costs to the state at a time when the state has lower revenues. Even after Colorado's economy recovers, program membership will likely remain above pre-pandemic levels for some time because people earning lower wages suffered more job losses and are gaining those jobs back more slowly than people earning medium or higher wages.

After engagement with stakeholders, the Department modernized its mission this year: Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado. The work of the ACC is aligned with this emphasis on health care equity, cost control, and health care affordability for all Coloradans. These values are reflected in our goals and work this past year and will inform our work in the coming year. Below are initiatives that will move the program and Department forward in its mission now and in the future.

A. Behavioral Health Administration

In April 2021, Governor Polis signed Colorado House Bill 21–1097, which directs the CDHS to establish a new Behavioral Health Administration (BHA) by July 2022.

The Behavioral Health Administration (BHA) is the next stage of a multi-year behavioral health system reform effort to provide cross-system, cross-sector oversight and support of the state's behavioral health. In addition to consumer navigation supports, cross-sector policy alignment, and analytics, the BHA brings improved system transparency and accountability through an innovative governance structure that brings consumers and local entities to the forefront of state policy making. The BHA will sit within CDHS, and the BHA Commissioner will report directly to the governor as a member of the Cabinet.

During the current phase of the ACC, the Department has placed a strong emphasis on physical and behavioral health integration by making RAEs the single entity that combines primary and behavioral health care administration. The RAEs are critical to improving the current, fragmented behavioral health landscape, and will play a vital role in realizing BHA-led reforms at the local and regional levels. These changes will be executed primarily through ACC 3.0.

B. Hospital Transformation Program

The goal of the Hospital Transformation Program (HTP) is to improve the quality of hospital care provided to members by tying provider fee-funded hospital payments to quality-based initiatives. With the implementation of this program in April 2021, RAEs will have an important role to play in ensuring that hospitals are able to continue to meet the needs of the community as hospitals implement the program. RAEs will do the following to assist with implementation of the HTP:

- Work with the Department and other stakeholders to understand how the HTP will work in Colorado and the hospitals' role and responsibilities
- Help hospitals determine priorities and select projects, interventions, and performance goals for the HTP
- Collaborate with hospitals to improve care transitions, implement person-centered planning at hospital discharge, and address the needs of members with complex health needs.

RAEs are in a position to bring partners together and coordinate collaboration of all stakeholders. RAEs will use the Program Improvement Advisory Committee infrastructure to engage stakeholders and serve as a venue for bringing partners together during the Community and Health Neighborhood Engagement process.

RAEs will also continue to support both members and hospitals by implementing programs to support discharge planning, transitions of care to long-term services and supports, and prevent emergency department visits and hospital admissions when possible. Finally, RAEs can share data expertise and facilitate health data sharing among providers in the health neighborhood to inform this process.

C. Prescription Drug Costs

The high cost of prescription drugs, especially specialty drugs, continues to be a challenge for Medicaid and all health plans. One of the Department's Wildly Important Goals is to increase savings on pharmacy costs by 83% through pharmacy cost control initiatives, from $12 million in FY 2020-21 to $22 million by June 30, 2022.

The Department is focused on decreasing Medicaid pharmacy expense by implementing effective policy like the electronic prescribing tools that empower providers to choose the most cost-effective drugs for their patients, and provider reimbursement models like value-based payments. The RAEs will work with providers to support their participation in the Maximum Allowable Cost methodology, as well as a new alternative payment model designed to incentivize increased utilization of the prescriber tool and medications on the Preferred Drug List. The prescriber tool is a multifunctional platform accessible through electronic medical records. It includes an opioid module from OpiSafe that will provide prescribers with patient-specific opioid risk metrics and medication monitoring.

As the primary resource for provider education and support in their region, RAEs are essential for helping providers to adopt the measures, which are meant to control costs for Medicaid and improve health care affordability statewide.

D. Value-based Payment

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

Bundled Payments: The Department is developing bundled payment strategies that create specialist accountability for patient outcomes while rewarding innovations that improve quality and keep the total cost of care low for targeted episodes of care. The Department's voluntary maternity bundled payment episode went live on November 1, 2020 and gives obstetric care providers a single, comprehensive payment covering services within an episode of care such as a pregnancy and birth. As the second program year starts in November 2021, the Department is in the process of recruiting more providers to join the program, selecting and purchasing a data sharing solution, and finalizing program quality measures that will be used to evaluate providers' annual performance and determine incentive payments.

Alternative Payment Methodology 1 (APM 1): The Department continues to evolve this pay-for-performance model, which rewards PCMPs with financial incentives for meeting quality goals. High-quality primary care has been shown to improve health outcomes in a low-cost setting and reduce unnecessary acute care utilization, lowering overall spending for the Department. The Department is currently reviewing and updating the measure set for calendar year 2022. The updated measure set will align quality measures with those of other payers in Colorado and the CMS Core Measures to reduce provider burden. It will also ensure weighting is reflective of how difficult it is to implement and report on the selected measures.

Alternative Payment Methodology 2 (APM 2): APM 2 is designed to pay primary care providers part of their historical Medicaid revenue as a capitation payment, with the opportunity to earn extra reimbursement for meeting quality goals. This is modeled after Medicare's Comprehensive Primary Care (CPC) Track 2 program. Having stable revenue allows primary care providers to innovate their care delivery to improve member outcomes while decreasing unnecessary acute care utilization. The extra reimbursement will be tied to a primary care physician's ability to reduce unnecessary acute care utilization. APM 2 is expected to go live January 2022, pending CMS approval. Participating PCMPs will be paid a PMPM fee for attributed members and will receive upside only gainsharing payments for managing defined chronic condition episodes.

Providers of Distinction. The ACC will invest in the development and rollout of Providers of Distinction and the value-based payments that reward proper referrals from PCMPs to those providers who are proven to have superior outcomes and more affordable costs for specific procedures and chronic conditions.

E. Expanded Use of Telemedicine and eConsults

As this report demonstrates, the infrastructure for telemedicine and the use of telemedicine increased dramatically when the pandemic began, and the Department plans to continue to use remote treatment not only to meet needs during the pandemic, but to improve access to care throughout the state.

House Bill 21-1256, signed into law by Governor Polis on May 27, 2021, gives the Department the authority to set rules designed to guide provider entities that operate predominately or solely using telemedicine. To that end, this year the Department will assess and set policy for these Electronic Health Entities (eHealth Entities), engaging broadly with providers, members, and advocacy groups to ensure their voices, ideas, and concerns are heard and addressed. The ACC has been built around the medical home model of care and coordination of services, so it is important that the rules for eHealth Entities complement this model while also maximizing the potential benefits of telemedicine.

Concurrently, the Department will explore the development of policy to codify use of eConsults. eConsults, or electronic consultations, are communications between a primary care provider and a specialist physician in which the primary care provider transmits a clinical question and medical information to be reviewed by a specialist physician. The specialist physician then reviews the case without the member being present. The specialist physician provides medical consultative guidance that assists the primary care provider in the diagnosis and management of the member's health care needs, thereby reducing inappropriate specialist visits. If a referral for a face-to-face visit is appropriate after the consultation, the eConsult process further supports referrals to a Provider of Distinction to improve quality patient outcomes and to reduce costs. RAEs will continue be an important part of building infrastructure for remote care throughout the state and training and educating providers about new tools and resources.

F. American Rescue Plan Act (ARPA).

The Centers for Medicare and Medicaid Services (CMS) has approved the Department's spending plan for ARPA Medicaid Home and Community-Based Services (HCBS). The spending plan includes $512.3 million to support enhancing, expanding and strengthening the HCBS system. Through 2024, the Department will be implementing priority initiatives that reflect stakeholder feedback, requirements from CMS, and priorities articulated in the legislation from the Joint Budget Committee. These initiatives will provide immediate relief for the provider network, direct support to members and their families during the recovery phase following the pandemic, and foster longer-term innovation and transformation to create an HCBS system of the future.

G. Health Equity

The Department will continue to use a health equity framework as part of its policymaking. In FY 2020–21, the Department applied this framework across health programs, starting with maternity care and COVID-19 response. The Department's Chief Medical Officer and Medicaid Director will collaborate to apply a health equity lens to payment reform, maternal health, hospital transformation, and other major programs.

This year, the Department will use its improved race and ethnicity data to understand more about equity gaps and address them. Because disparities in maternal health outcomes persist in the state, RAEs will continue to focus on maternal health in their complex care management programs.

H. Continued Focus on Condition Management

The Department will continue to hold RAEs accountable for condition management programming with specific focus on maternity, diabetes, and members with complex care needs. The Department will work with RAEs to strengthen PCMP-based condition management programs, set performance measures and goals, and improve risk stratification among members to identify members to participate in the program.

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

I. Core Measures

The Department is shifting focus where applicable to the Adult and Child Core Measure Sets set forth by the CMS for use in incentive programs. The Department is working to align efforts across all programs statewide to maintain accountability while reducing measurement fatigue. Alignment efforts are happening in all Department programs, including the ACC.

Some of the data for these measures will be collected from claims, but other data sources are required as well. The Department is already reporting or building reporting capabilities on all measures regardless of the data source, while also working to access supplemental data, such as the immunization registry and lab data, to accurately capture services and values to supplement claims data. See the CMS Core Measures website for a list of the measures.

VIII. Appendices

A. Access in Rural and Frontier Counties

The rural and frontier regions of Colorado face unique challenges in ensuring access to health care. Colorado is a geographically diverse state with five of the seven RAE regions containing rural or frontier counties; only Region 3 (Adams, Arapahoe, Douglas, and Elbert) and Region 5 (Denver County) do not. Below are strategies the ACC used in FY 2020–21 to improve access to care in Colorado's rural and frontier counties.

Improved access to telehealth. RAEs continue to support their PCMPs and members with the knowledge and technology to conduct both medical and behavioral health visits via telehealth. For example:

- The behavioral health providers in RAE 2 have increased their adoption of telehealth platforms and services for behavioral health care. This year, 64 providers reported that they offered telehealth services, compared to just 20 at the end of last fiscal year. In addition, 52 PCMP locations continued to offer telehealth services in some capacity this fiscal year.
- RAE 4, Health Colorado Inc., is exploring and vetting telehealth vendors for the providers in their region to ensure that providers have a system that works for them and their members.
- RAEs 6 and 7, Colorado Community Health Alliance, educated PCMPs on changes to telehealth benefits, helped set up telehealth workflows, and shared best practices for telehealth. This RAE also collaborated with providers as they expanded their telehealth abilities to serve rural populations, especially places that lack broadband. For example, mental health provider Diversus CMHC expanded their Wi-Fi to their parking lots so members could access the internet to safely attend their behavioral health appointments without being in person.

Network adequacy monitoring. The RAEs regularly monitored their provider networks to ensure that each member has access to PCMPs and behavioral health providers within a reasonable distance from where they live. The RAEs also track calls to customer service centers and solicited feedback from advisory councils to identify trends in member concerns about access to providers.

Special support for rural members. RAEs that work in rural and frontier areas reach out to members to ensure that they are aware of transportation and mobile services that are available to them. For example:

- RAEs 6 and 7, Colorado Community Health Alliance, continues to contract with Rocky Mountain Rural Health (RMRH) in Park County and Aspen Mine Center (AMC) in Teller County to serve rural members with care coordination services. They provide Medicaid benefit education, assess needs, and connect members to needed health care providers and community resources. They also outreach to members who are diagnosed with diabetes. Both rural contractors are trusted within their communities and work closely with community providers.
- RAE 1, Rocky Mountain Health Plans, collaborated with the Colorado Health Foundation to support approximately 20 community agencies with the purchase of tablets, laptops, phones, and data plans for members to access telehealth services.
- In response to transportation barriers to accessing behavioral health services in largely rural and frontier counties, RAE 4 (Health Colorado, Inc.) purchased shuttle buses to assist clients with transportation services in Pueblo County and works with its care coordinator, case managers, and community to find innovative solutions to transportation problems.

B. Coordinating with LTSS

Colorado's system of LTSS provides comprehensive services to people with many types of long-term care needs, including those with physical disabilities, serious mental health needs, and developmental or intellectual disabilities.

Most members access the LTSS system through two types of entities: Single Entry Points (SEPs) and Community Centered Boards (CCBs). SEPs predominately serve as the entry point and case management agency for older individuals, adults with mental health needs, individuals with traumatic brain or spinal cord injuries, and children with life-limiting illnesses. CCBs predominately serve as the entry point and case management agency for individuals with intellectual or developmental disabilities and children with autism. There are 24 SEPs and 20 CCBs throughout the state.

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

RAEs have also pursued a variety of activities to improve the coordination of care for members shared with the SEPs and CCBs. Some have a dedicated staff member who works to coordinate with the SEPs and CCBs in the region. Others train their care coordinators, especially those who focus on members with complex conditions, to work collaboratively with SEPs and CCBs and review complex cases together. The RAEs partnered closely with the SEPs and CCBs to meet the COVID-19 vaccination needs of homebound individuals this year.

In the next fiscal year, the Department will use ARPA funds to enhance, expand, and strengthen Medicaid Home and Community-Based Services (HCBS). This will provide immediate relief for the provider network, direct support to members and their families during the recovery phase following the pandemic and foster longer-term innovation and transformation to create an HCBS system of the future.

C. Reducing Waste and Inefficiencies

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

Regional Model

The RAE model is designed to reduce inefficiencies. RAEs served as a single resource to help both providers and members navigate the Medicaid system of care. Based on practice needs, RAEs helped practices enroll as a Medicaid provider, establish relationships with hospitals and other providers in the region, create effective administrative systems, implement data and technology tools, improve billing and coding practices, and implement better patient communication strategies. For members, the RAEs helped explain Medicaid benefits, establish relationships with PCMPs, coordinate care with behavioral health providers and other Medicaid providers, address grievances, arrange non-emergency medical transportation, and connect members with community resources to address non-medical needs.

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

Utilization Management

The ACC has several utilization management programs to ensure that services are available to those who need them but are not used inappropriately, for services that do not meet medical necessity standards, or do not serve the best needs of the member. ColoradoPAR is the Health First Colorado utilization management program for fee-for-service medical care such as physical/occupational therapies, imaging, and medical equipment. The RAEs have their own utilization management programs for behavioral health services to reduce waste and promote more efficient and cost-effective care.

D. Advisory Committees and Stakeholder Engagement

In FY 2020-21, the ACC offered members and stakeholders several ways to participate in decision-making and offer feedback.

Program Improvement Advisory Committee (PIAC)

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

The PIAC leveraged the following subcommittees to provide more detailed guidance on future activities: behavioral health and integration strategies, provider and community experience, and performance measurement and member engagement. In FY 2020–21, the PIAC continued its work on creating alignment between the Colorado Crisis Service System and the ACC, examining member access to specialty care, and exploring care coordination models and chronic disease management strategies.

In addition, the PIAC worked on methods for addressing and evaluating racial equity, advised the Department on how to provide behavioral health services to justice-involved members who are leaving prison (in compliance with Senate Bill 19-222), recommended strategies for better care transitions and implementation of the Hospital Transformation Program, and advised on COVID-19 vaccine distribution and outreach.

Regional Program Improvement Advisory Committees and Member Advisory Councils

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

All the RAEs have also formed member advisory councils, which focus on understanding the member's perspective regarding how they access health care services to drive changes on policy, program decisions, and member communications.