

Colorado's All Payer Claims Database

Medicaid Commission Data Request, August 27, 2026

Key Points:

- The Colorado All Payer Claims Database (CO APCD) is a resource the Commission can draw on immediately. Its public dashboards, reports, and publications are freely available to anyone.
- For analyses beyond what is published, the database's administrator can produce custom reports and de-identified datasets through an established request process.
- HCPF is responsible for administering a contract with the Center for Improving Value in Health Care (CIVHC), the organization that administers the CO APCD, and claims a federal match on much of the funding.

How the All Payer Claims Database (APCD) is Administered

Founding History

According to the [APCD Council](#), 24 states have an APCD. States use a variety of governance models for their APCDs, including administration by health or Medicaid agencies, insurance departments, independent state health-data agencies, universities, and nonprofits. In Colorado, the APCD is established in statute within the HCPF, which holds the contract with the database administrator and the mechanism through which state money is appropriated. HCPF develops the regulatory structure for the CO APCD through the rulemaking process.

The CO APCD was recommended by the Governor-appointed Blue Ribbon Commission on Health Reform (also known as the “208 Commission”), created by House Bill 10-1330, and now codified at C.R.S. § 25.5-1-204, with implementing rules at 10 CCR 2505-5, § 1.200. The Center for Improving Value in Health Care (CIVHC), a public-private nonprofit established in 2008, was named administrator by HCPF's Executive Director that same year, and the database launched in 2012. The enacting legislation was explicit that the data be accessible both to the public and to entities working to improve health care for Coloradans.

The database now holds more than 1.1 billion claims representing over 5 million Coloradans – commercial, Medicaid, Medicare Advantage, and Medicare fee-for-service – which CIVHC estimates at roughly 70 percent of the state's insured population. It does not include the

uninsured, most self-funded ERISA employer plans, or federal programs such as TriCare, the VA, or Indian Health Services.

Financial Infrastructure

HB 10-1330 passed without a state appropriation attached; CIVHC funded early planning and implementation through private grants from The Colorado Trust and the Colorado Health Foundation. CIVHC has received ongoing state funding to sustain the database beginning in FY 2019-20. This funding flows through HCPF and includes federal matching funds.

SFY	Total Funds	General Funds	Cash Funds	Federal Funds
2024-25	\$9,228,873	\$4,471,011	\$0	\$4,757,862
2025-26	\$9,619,029	\$3,541,068	\$685,936	\$5,392,025
2026-27	\$9,293,485	\$3,331,354	\$690,278	\$5,271,853

How the Commission Could Use APCD Resources

Public Dashboards

CIVHC releases many interactive dashboards and reports each year that include cost and utilization trend data, alternative payment models, Medicare Reference-Based prices, and other focus areas. The majority of these reports also include free access to the source data.

Public dashboards are available at <https://civhc.org/get-data/public-data>. The underlying data sets are available at no cost on each dashboard or report page by using the download button in the upper right-hand corner of the dashboard or by clicking on the “Download the Free Data” button.

Data Release Application

For custom requests, CIVHC uses a standard application template to document the request purpose and parameters so CIVHC can create accurate and actionable reports. The application collects specifications such as requested years of data, payer types, provider types, and service types, and is used by CIVHC’s Data Compliance team to ensure adherence to state and federal regulatory requirements. Ad Hoc contract hours included in CIVHC’s HCPF contract may be available to support custom requests.

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COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

Regional Accountable Entities: Primary Care Support and Care Coordination

Colorado's Regional Accountable Entities (RAEs) support members whose physical health services are paid fee-for-service. RAEs build and support primary care networks, coordinate care, and connect members to medical and social services. **They do not administer the underlying physical health benefit: HCPF retains benefit policy, coverage rules, fee-for-service payment, and program oversight.** A companion fact sheet explains the two local managed care organizations (MCOs) that pay physical health claims for members enrolled in those plans.

1. COLORADO'S DELIVERY MODEL IN THE NATIONAL CONTEXT

National baseline

CMS's 2024 managed care enrollment report shows **seven states with Primary Care Case Management (PCCM) Entity enrollment**, including Colorado. PCCM Entities perform defined care-management and primary-care-support functions and receive a monthly case-management fee, while covered health services may remain paid fee-for-service.

Colorado's blended operating model

Colorado administers the physical health fee-for-service benefit separately from the RAE program. HCPF program areas manage benefit policy, coverage requirements, and payment; RAEs provide primary care network support, care coordination, case management, and related member services. **The RAE role managing the behavioral health capitation is addressed in a separate fact sheet.**

2. RAES BY THE NUMBERS

All full-benefit Health First Colorado members, except members enrolled in the Program of All-Inclusive Care for the Elderly (PACE), are assigned to one of four RAEs.

4

RAE partners serving four regions

992,177

members assigned to a RAE

838

Primary Care Medical Provider (PCMP) sites contracted with a RAE

RAE Assignment and Primary Care Medical Home Snapshot			AUGUST 2026
RAE	Members Assigned to a RAE	PCMP Sites	Members Attributed to a PCMP
Region 1 - RMHP Rocky Mountain Health Plans	162,530	210	112,730
Region 2 - NHP Northeast Health Partners	159,946	131	102,894
Region 3 - CCHA Colorado Community Health Alliance	284,761	225	191,448
Region 4 - COA Colorado Access	384,940	272	286,059
RAE Total	992,177	838	693,131

Measure note: PCMP counts are site-level.



COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

RAE Care Management PMPM Payments and Spending

SECTION 2 CONTINUED

The financial information below covers **FY 2024-25** and does not include incentive payments. It reflects the seven-region Accountable Care Collaborative (ACC) Phase II structure in place during that fiscal year. The current four-region RAE contracts began July 1, 2025. The care-management per-member-per-month (PMPM) payment supports care coordination, the health neighborhood, practice support, and provider transformation work.

Physical health services

HCPF pays enrolled providers fee-for-service for covered physical health care. The RAE care management PMPM is not used to pay those service claims.

Care management support

HCPF pays each RAE a separate monthly care management PMPM. The payment supports care coordination, network development, practice support, and the regional health neighborhood.

PCMP Medical Home Payment

RAEs must pass through at least 33% of the care management PMPM to contracted PCMPs to support their role as a medical home.

FY 2024-25 Financial Information						EXCLUDES INCENTIVE PAYMENTS		
Category	R1 RMHP	R2 NHP	R3 COA	R4 HCI	R5 COA	R6 CCHA	R7 CCHA	RAE Total
HCPF Care Management PMPM Payments	\$19,415,672	\$11,654,470	\$40,492,939	\$16,865,796	\$18,046,545	\$19,693,026	\$22,921,046	\$149,089,494
CARE MANAGEMENT PMPM EXPENSES								
Indirect / Overhead	\$1,188,767	\$1,719,818	\$1,050,967	\$1,381,567	\$716,533	\$1,178,963	\$1,620,436	\$8,857,051
Care Coordination	\$7,173,528	\$8,624,274	\$20,054,197	\$11,101,550	\$12,888,719	\$7,414,144	\$8,712,605	\$75,969,015
Practice Support	\$8,981,035	\$1,097,104	\$13,335,404	\$2,444,615	\$4,981,289	\$9,715,780	\$10,732,221	\$51,287,448
Network Development	\$23,520	\$997,547	\$5,037,072	\$455,810	\$2,657,165	\$449,094	\$502,915	\$10,123,124
Community Infrastructure / Health Neighborhood	\$2,428,897	\$897,991	\$3,619,071	\$429,569	\$2,051,379	\$679,462	\$953,896	\$11,060,266
Other	\$73,874	\$1,274,800	-	\$6,514,619	-	\$5,017,536	\$4,454,898	\$17,335,727
Total Care Management PMPM Expense	\$19,869,621	\$14,611,534	\$43,096,711	\$22,327,730	\$23,295,085	\$24,454,978	\$26,976,971	\$174,632,631

Payments: FY 2024-25 care management PMPM payments made by HCPF to the seven RAE regions in the ACC Phase II structure.

Reported spending: FY 2024-25 care management PMPM expenses by category. Incentive payments are not included.

Financial reporting note: The relationship between care management PMPM payments and reported spending varies by RAE. Differences may reflect retained margin or profit and the timing of expenditures, including delayed expenditures.

Table note: Data in tables are rounded to the nearest dollar; totals may not sum exactly due to rounding.



How RAEs support physical health

3. HOW COLORADO ORGANIZES AND PAYS FOR SUPPORT SERVICES

RAEs support access, primary care, and coordination; they do not administer the underlying fee-for-service benefit.

Physical health providers bill HCPF for covered services, while the RAE organizes regional supports around the member and the member's medical home.

Primary care medical homes

Connect members to Primary Care Medical Providers that deliver preventive care, manage chronic conditions, and link members to specialty, behavioral health, and social supports.

Network adequacy and access

Maintain an adequate network of high-quality PCMPs so members can reach primary care when they need it.

Practice support and transformation

Provide technical assistance, care coordination support, and value-based payment opportunities that strengthen PCMP capacity.

Health neighborhood

Build condition-focused programs and regional connections to additional medical, behavioral health, and social services.

Tiered care coordination

Operate a standard three-tier framework through RAE staff or delegated providers, with flexibility to define populations within each tier.

Transitions and cross-system coordination

Alert providers when members are hospitalized, engage members after acute care, and retain ultimate coordination responsibility when members are involved in multiple systems.

HCPF AUTHORITY

These responsibilities remain with HCPF and the applicable physical health benefit programs.

- Set physical health benefit policy, coverage requirements, and medical-necessity rules
- Define provider enrollment, billing, and program requirements
- Pay covered physical health claims through the fee-for-service system
- Establish and implement provider reimbursement policy and rates
- Pay the separate RAE care management PMPM and quality incentive payments
- Oversee RAE contracts, performance, data, quality, and compliance

HOW A MEMBER INTERFACES WITH THE RAE

Members are assigned to a RAE based on the location of their primary care provider or home address. A member does not have to contact the RAE before using a covered physical health service, but the RAE is available when support is needed.

1

Find a primary care provider

The RAE helps identify a PCMP that can serve as the member's medical home.

2

Navigate and coordinate care

Support ranges from basic navigation to complex care management for members involved in multiple systems.

3

Address health-related social needs

The RAE can connect members with housing, food, and other regional medical or social supports.

4

Ask general questions

Members may contact the RAE when they are unsure where to go or what type of support is available.



Program objectives and results

WHAT THE PRIMARY CARE AND CARE COORDINATION MODEL IS DESIGNED TO ACCOMPLISH

As we've continued to evolve the Accountable Care Collaborative (ACC), we've designed the program to accomplish the following objectives for primary care/care coordination:

1. Members have better connection to PCMPs that provide high quality preventive services and manage chronic conditions.
2. PCMPs are better able to deliver high quality care to Medicaid members due to the availability of RAE support and investment.
3. Members who use a PCMP have improved connections to specialists, behavioral health care, and social supports.
4. Members who see their PCMP have earlier identification of health needs and reduced use of acute care.
5. All members have access to high quality care coordination when they need it that meets their holistic needs.
6. RAEs improve transitions of care from acute settings for members at the most risk of adverse health outcomes.
7. As regional experts on medical and social supports, the RAEs extend the capacity of Medicaid providers, especially PCMPs, to serve complex members.
8. RAEs improve coordination of care by reducing gaps in care and duplicative care coordination across Medicaid programs.
9. RAEs appropriately identify high risk, high needs members and engage them with care coordination to improve health outcomes and manage cost trends.

4. WHAT COLORADO GETS FROM THIS STRUCTURE

Over the course of ACC Phase II, from FY 2018-19 through FY 2024-25, HCPF saw improvement in six of nine quality measures across all RAEs. Highlights include:

+13% Child and adolescent well-care visits Average improvement across all RAEs.	+17% Well-child visits, ages 15-30 months Average improvement across all RAEs.	+21% Timeliness of prenatal care Average improvement across all RAEs.	+31% Postpartum care Average improvement across all RAEs.	+74% Depression screening and follow-up Average improvement across all RAEs.
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Early ACC Phase III Indicators

Initial data from ACC Phase III, which began in July 2025, show that RAEs have helped connect members to a primary source of care. HCPF is also collecting more information about care coordination engagement from each RAE to better evaluate program effectiveness. Initial data are shown below.

+14%	PCMP Attribution - July 2025 to August 2026. Members attributed to a PCMP increased from 608,100 to 693,131. RAEs help connect members to a primary source of care; HCPF refers to this as being attributed to a PCMP.
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Care Coordination Engagement Data			FY 2025-26
RAE	Unique Members Engaged	Average Engagements per Member	
Region 1 - RMHP	15,571	1.9	
Region 2 - NHP	8,712	1.5	
Region 3 - CCHA	12,476	2.6	
Region 4 - COA	63,234	2.8	
RAE Total	99,993	2.5	

Links to additional information:

[CMS - 2024 Medicaid Managed Care Enrollment Report](#)

[HCPF - FY 2024-25 Annual ACC Legislative Report](#)

[HCPF - ACC Frequently Asked Questions](#)

[HCPF - Accountable Care Collaborative Phase III](#)

[HCPF - RAE Contracts](#)

[HCPF - ACC Provider and Stakeholder Resource Center](#)



COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

Regional Accountable Entities: Behavioral Health Capitation

Colorado uses four Regional Accountable Entities (RAEs) as behavioral health plans to arrange the continuum of covered behavioral health services, build and support provider networks, coordinate care, manage utilization, and pay providers through a capitated model. **HCPF retains benefit policy, capitation-rate development, financing, federal authorities, provider-enrollment rules, and contract oversight.**

1. COLORADO'S BEHAVIORAL HEALTH DELIVERY SYSTEM IN NATIONAL CONTEXT

National baseline

Nationally, **11 states, including Colorado, use limited-benefit managed care arrangements for behavioral health.** Colorado's arrangement is structured as a Prepaid Inpatient Health Plan (PIHP), under which the State contracts with regional plans to manage a limited benefit package that includes inpatient or institutional services.

National comparison: A KFF scan identifies limited-benefit behavioral health managed care in 10 other states. HCPF includes Colorado as the eleventh because Colorado's behavioral health PIHP is not separately classified in the KFF table.

Colorado's blended model

Colorado combines **fee-for-service (FFS) payment for most physical health services** with **capitated behavioral health services**. Companion fact sheets explain physical health FFS benefit administration, the RAE role supporting primary care and care coordination, and Colorado's two local physical health managed care organizations.

2. BEHAVIORAL HEALTH BENEFIT DELIVERY SYSTEM BY THE NUMBERS

Everyone enrolled in Health First Colorado has access to covered behavioral health services.

4

RAEs

279,356

unique members accessing
capitated behavioral health
services, FY 2024-25

4,506,450

capitated behavioral health claims,
FY 2024-25

14,800+

contracted behavioral health
practitioners, 2025

Data note: FY 2024-25 is the most recent complete and reliable full-year period for the member and claim measures. More recent capitated encounter data remain subject to change as encounters are priced and as reversals and voids are processed.



COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

Behavioral Health Capitation Payments and Spending

SECTION 2 CONTINUED

The financial information below covers **FY 2024-25** and does not include incentive payments. It reflects the seven-region Accountable Care Collaborative (ACC) Phase II structure in place during that fiscal year. The current four-region RAE contracts began July 1, 2025.

FY 2024-25 Financial Information					EXCLUDES INCENTIVE PAYMENTS			
Category	R1 RMHP	R2 NHP	R3 COA	R4 HCI	R5 COA	R6 CCHA	R7 CCHA	RAE Total
Capitated Behavioral Health Payments	\$206,509,012	\$67,893,328	\$308,686,344	\$114,736,582	\$177,716,870	\$162,635,253	\$133,453,881	\$1,171,631,270
BEHAVIORAL HEALTH EXPENSES								
Indirect / Overhead	\$4,658,712	\$3,326,168	\$629,889	\$111,868	\$317,051	\$1,588,516	\$1,822,304	\$12,454,508
Care Coordination	\$1,647,563	-	\$8,015,154	\$4,418,305	\$3,286,185	\$2,797,605	\$2,022,229	\$22,187,041
Practice Support	\$239,638	\$875,636	\$7,837,574	\$2,777,220	\$5,607,903	\$151,624	\$178,862	\$17,668,457
Network Development	\$151,412	\$875,636	\$2,890,957	\$2,272,271	\$1,528,371	\$15,369	\$17,887	\$7,751,903
Utilization Management	\$2,018,397	\$1,167,516	\$6,510,714	\$1,009,899	\$3,887,231	\$1,448,112	\$1,205,970	\$17,247,840
Paid behavioral health claims	\$210,120,978	\$66,447,452	\$304,864,683	\$113,221,265	\$174,758,282	\$137,667,995	\$146,617,565	\$1,153,698,220
Other	\$7,019,330	-	-	\$3,444,971	-	-	-	\$10,464,301
Total Behavioral Health Expense (Services plus Admin)	\$225,856,030	\$72,692,409	\$330,748,971	\$127,255,799	\$189,385,023	\$143,669,221	\$151,864,817	\$1,241,472,271

Payments: FY 2024-25 capitated behavioral health payments made by HCPF to the seven RAE regions in the ACC Phase II structure.

Reported spending: FY 2024-25 behavioral health expenses by category. Incentive payments are not included.

Financial reporting note: The relationship between capitation revenue and reported spending varies by RAE. Differences may reflect retained margin or profit and the timing of expenditures, including delayed expenditures.

Table note: Data in tables are rounded to the nearest dollar; totals may not sum exactly due to rounding.



How Colorado Organizes Behavioral Health Services

3. HOW COLORADO ORGANIZES AND PAYS FOR SERVICES

Arrange the service continuum

Organize access to community-based, substance use disorder, crisis, inpatient, institutional, and other covered behavioral health services.

Build and support the network

Contract with, credential, reimburse, train, and support behavioral health providers across the statewide network.

Manage utilization and financial risk

Design regional processes to manage service use and cost without compromising member access, within state and federal requirements.

Coordinate whole-person care

Support navigation, complex care management, provider-level integration, and transitions from inpatient or residential treatment.

Advance system initiatives

Partner in Section 1115 waiver substance use disorder (SUD) expansion, the Colorado System of Care, and other behavioral health transformation work.

Support members and providers

Answer benefit, network, authorization, and claims questions and help resolve grievances, appeals, and operational issues.

Member and provider call centers

Maintain regional service channels that answer benefit, network, authorization, claims, and operational questions from members and providers.

Regional stakeholder engagement

Operate general and member-focused advisory committees and maintain relationships with providers, members, and community partners.

Regional issue response

Coordinate regional responses to wildfires, natural disasters, public health emergencies, and other emerging local issues.

HCPF AUTHORITY These responsibilities remain with HCPF.

- Determine covered benefits and associated services
- Value the scope of services and develop RAE capitation payments with HCPF's actuary
- Set HCPF system rules that track provider enrollment
- Manage demonstrations, grants, and authorities, including Certified Community Behavioral Health Clinics (CCBHCs), Section 1115, Section 1915(b)(3), and reentry work
- Serve as Medicaid liaison with the Colorado Department of Human Services (CDHS), Colorado Department of Corrections (DOC), Colorado Department of Local Affairs (DOLA), and other state agencies
- Resolve differences between RAEs and providers
- Provide regulatory interpretation, clarification, and operational guidance
- Oversee RAE contracts and performance

HOW A MEMBER INTERFACES WITH THE RAE AND HCPF

Members are assigned to a RAE based on the location of their primary care provider or their home address. Members do not need to interact with the RAE before every health service. Because behavioral health care generally must be obtained through the RAE's network, the RAE is more likely to become a direct touchpoint when a member needs behavioral health services or assistance.

1

Find an in-network provider

The RAE helps the member identify a behavioral health provider in its statewide network.

2

Navigate and coordinate care

Support may range from basic care navigation to complex care management for members involved in multiple systems.

3

Address social needs

The RAE may help connect members with housing, food, or other health-related social-needs resources.

4

Ask general benefit questions

Members may contact the RAE when they are unsure where to go or need information about covered services.

5

Resolve authorization questions

The RAE answers questions about prior authorization requests for behavioral health services.

6

File an appeal or grievance

The RAE supports the applicable process when a member wants to appeal a decision or raise a concern.



Payment, Program Design, and Results

CONTINUED

HOW CLAIMS ARE PAID IN THIS MODEL

CAPITATION RATE	HCPF and its contracted actuary develop monthly per-member-per-month (PMPM) behavioral health capitation rates through an annual negotiation process with the RAEs.
PROVIDER PAYMENT	Providers submit claims to the member's RAE, and the RAE pays the provider. Each RAE establishes contracted provider payment arrangements for behavioral health services in its region, subject to applicable law and contract requirements.
RATE AUTHORITY	The General Assembly approves the fiscal-year budget that includes the budgeted amount for behavioral health capitation. HCPF and the Medicaid Provider Rate Review Advisory Committee (MPRRAC) do not set the individual reimbursement rates RAEs pay behavioral health providers. HCPF oversees the capitation arrangement, covered-benefit policy, contract requirements, and program performance.

4. WHY COLORADO USES A BEHAVIORAL HEALTH CAPITATION STRUCTURE

Managed care authority

HCPF has used managed care for behavioral health services since the 1990s. Moving to managed care provided federal authority to offer alternative behavioral health services that were not otherwise authorized under the Medicaid State Plan.

Integrated regional model

Before 2018, Behavioral Health Organizations (BHOs) managed behavioral health capitation while Regional Care Coordination Organizations (RCCOs) separately supported physical health medical homes. In 2018, HCPF combined those contracted scopes under the RAE model to promote integrated, whole-person care through organizations positioned to respond to regional resources, needs, and differences.

WHAT THE BEHAVIORAL HEALTH CAPITATION MODEL IS DESIGNED TO ACCOMPLISH

Members have improved outcomes because of timely access to the full continuum of behavioral health services (community-based services, SUD, crisis, inpatient) in the settings that are most integrated to the way they receive care.

RAEs collaborate with behavioral health providers, especially safety net providers and specialists, to ensure members do not cycle in acute behavioral health settings of care.

RAEs design operationally efficient processes that effectively develop, maintain and support a high quality, statewide behavioral health provider network.

RAEs adequately manage utilization and reduce cost burden to HCPF without compromising member access to care.

5. WHAT COLORADO GETS FROM THIS STRUCTURE

16% → 24%

Behavioral health penetration rate

The share of members accessing behavioral health services increased from 16% in FY 2018-19 to 24% in FY 2023-24 during Accountable Care Collaborative (ACC) Phase II.

+30%

Contracted behavioral health practitioners

The number of practitioners contracted with the RAEs increased from 2023 to 2025, reaching more than 14,800. While previous policy direction focused on network growth, to support sustainability RAEs are focusing their provider network development on quality of care and cost control.

BEHAVIORAL HEALTH PROGRESS IN QUALITY AND ACCESS

Measures that improved

- Behavioral health engagement for members released from state prisons increased from **10.6% in FY 2019-20 to 46.8% in FY 2024-25**.
- Extended care coordination improved from **47% in FY 2019-20 to 68.5% in FY 2024-25**.
- Follow-up after positive depression screen increased from an average of **46.9% in FY 2018-19 to 61.4% in FY 2024-25**.
- Behavioral health screening or assessment for children in the foster care system increased from an average of **16.7% in FY 2018-19 to 26% in FY 2024-25**.



COLORADO MEDICAID — PROGRAMMATIC PARTNER FACT SHEET

Fee-for-Service Benefits

Colorado Medicaid uses a fee-for-service (FFS) model for benefits and services that remain outside managed care arrangements. HCPF retains direct responsibility for benefit policy, coverage requirements, reimbursement methodologies, and program oversight, while a network of specialized programmatic partners supports claims processing, utilization management, pharmacy operations, care management, eligibility, data, and other administrative functions.

1 COLORADO'S FEE-FOR-SERVICE DELIVERY SYSTEM IN THE NATIONAL CONTEXT

National context

Medicaid delivery systems vary across states. States may administer benefits through fee-for-service, managed care, or a combination of both delivery approaches. CMS also recognizes that states may operate managed care and FFS concurrently within the same Medicaid program.

Colorado's blended model

Colorado uses a combination of **FFS, managed care, and primary care case management (PCCM)**. Most physical health benefits are administered through FFS, including Home and Community-Based Services (HCBS). Exceptions include physical health benefits managed through the two local MCO programs, RMHP PRIME and Denver Health Medicaid Choice, and PACE. A small number of behavioral health services are also delivered through FFS; most behavioral health and primary-care care-management services are delivered through managed care arrangements.

2 FEE-FOR-SERVICE BY THE NUMBERS

FFS claims are paid for each covered service provided to an eligible Medicaid member. The FY 2024-25 claims and spending figures below reflect paid claims at the adjudication level.

32.7M

claims paid in FY 2024-25

\$11.323B

dollars paid through claims in FY 2024-25

3 HOW HCPF ORGANIZES AND PAYS FOR FFS BENEFITS

HCPF contracts with several programmatic partners to support different parts of Medicaid benefit delivery. These partners perform specialized operational functions; HCPF retains responsibility for the underlying Medicaid benefit and its policy framework.

SELECTED PROGRAMMATIC PARTNERS

Enterprise operations and claims

Gainwell Technologies – MMIS/interChange; claims processing, adjudication, and payment

Edifecs – electronic data interface

Conduent – Enterprise Data Warehouse

Ernst & Young – system integrator

Deloitte – eligibility and enrollment systems, including CBMS and PEAK

Specialized benefit and program operations

Accentra – utilization management and prior authorization support

MedImpact – pharmacy claims, prior authorization, rebates, and Preferred Drug List support

OpiSafe – opioid-risk information for prescribers

Alivia – recovery tracking and program integrity support

Sandata – electronic visit and verification

Selected examples: HCPF works with additional programmatic partners across Medicaid benefit delivery. A complete vendor and entity list can be provided upon request.

HCPF AUTHORITY

HCPF retains responsibility for establishing and directing Medicaid benefit policy and for oversight of the programmatic partners supporting FFS delivery.

- Define covered services, eligibility and coverage requirements, limitations, medical necessity, prior authorization, provider, and billing requirements.
- Implement federal and state benefit changes and work with stakeholders and other Department offices.
- Analyze rates and support the comprehensive rate review process.
- Manage contracts and oversee vendors that provide specialized services to Health First Colorado members.



Member experience, FFS framework, and payment flow

SECTION 3 CONTINUED

HOW A MEMBER INTERFACES WITH FFS PARTNERS AND HCPF

Members receiving FFS physical health benefits can interact directly with HCPF for information, assistance, and questions about Health First Colorado coverage. Members access FFS services through enrolled providers, who submit claims to the Department for payment. Member engagement with RAEs is described in the companion RAE fact sheets.

HCPF direct touchpoints

- Health First Colorado Member Contact Center for benefit and service questions
- PEAK and the Health First Colorado website and mobile app
- Find a Doctor provider search
- Benefit-specific questions about coverage, medical necessity, prior authorization, and benefit requirements
- Appeal rights for decisions affecting coverage or services

Programmatic partner touchpoints

- Prior authorization and utilization management support through specialized vendors
- Pharmacy claims and prior authorization support through MedImpact
- Provider call-center support and claims questions through contracted partners
- Care coordination and case management through RAEs and LTSS/HCBS partners
- Specialized supports for consumer-directed services, disability determinations, and pre-admission screening

FFS PROGRAM FRAMEWORK

Benefit authority

FFS benefits are generally documented across the Colorado Medicaid State Plan, Code of Colorado Regulations, and HCPF policy and billing manuals. The State Plan describes the nature and scope of benefits and provides the basis for federal financial participation.

Operational requirements

HCPF policy and billing manuals provide detailed requirements for procedure codes, modifiers, coverage limitations, prior authorization, medical necessity, provider qualifications, billing, and reimbursement methodologies.

HOW CLAIMS ARE PAID IN THIS MODEL

1

Provider submits claim

Enrolled providers submit FFS claims through Medicaid MMIS (interChange).

2

Fiscal agent processes

The fiscal agent applies HCPF payment methodologies and claims edits.

3

Claim decision

The claim is paid, denied, adjusted, or routed for additional processing under program rules.

4

Payment and notice

The fiscal agent issues payment to the provider and provides a Remittance Advice showing the payment or denial.

Rate setting

FFS rates are established through the Colorado legislative budget process and applicable Department policies.

MPRRAC

The statutory advisory committee reviews rate and access analyses and makes recommendations to HCPF on provider reimbursement and rate-review strategies.

Budget authority

HCPF prepares the annual rate review analysis and recommendations report; the Joint Budget Committee considers the recommendations during the state budget process.

Rate authority: MPRRAC does not have authority to change rates on its own. HCPF is responsible for establishing reimbursement rates and implementing rate changes through the Medicaid program.



Why Colorado uses FFS and results

4 WHY COLORADO USES FEE-FOR-SERVICE

Direct administration

FFS provides a mechanism for HCPF to directly administer and pay for covered Medicaid services for members and services that are not included in a managed care arrangement. This allows HCPF to maintain direct responsibility for benefit policy, reimbursement methodologies, claims administration, and program oversight.

Concurrent delivery models

Colorado uses FFS alongside managed care and PCCM. Programmatic partners support specialized administration while HCPF retains direct administration and oversight of Medicaid benefits across delivery models.

5 WHAT COLORADO GETS FROM THIS STRUCTURE

Direct policy control

Benefit management

HCPF directly establishes coverage, medical necessity, utilization, reimbursement, and provider-participation requirements for benefits retained in FFS.

Detailed program data

Visibility and oversight

Claims and administrative data support monitoring of access, quality, utilization, expenditures, provider participation, and program integrity.

Implementation flexibility

Policy and payment changes

The FFS structure allows HCPF to identify trends, evaluate benefit and payment changes, and adjust benefits and payment methodologies within federal and state requirements.

SOURCES AND AUTHORITIES

Federal: Centers for Medicare & Medicaid Services, Medicaid and CHIP Scorecard: Medicaid Enrollment by Delivery System – Managed Care vs. Fee-for-Service, CY 2024; CMS, Managed Care Entities; CMS, T-MSIS Coding Blog: Fee-for-Service Claims and Managed Care Encounter Claims; CMS, Medicaid NCCI Technical Guidance Manual, Section 5.4.1, Primary Care Case Management.

Colorado: Colorado Medicaid State Plan; Code of Colorado Regulations; HCPF policy and billing manuals; HCPF Medicaid Provider Rate Review materials; MPRRAC annual Medicaid Provider Rate Review Analysis and Recommendation Report.

Authority note: This fact sheet cites 42 CFR § 430.10 for the Medicaid State Plan framework. Additional state-specific authorities are contained in the Colorado Medicaid State Plan, applicable regulations, and HCPF policy and billing materials.



COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

Physical Health MCOs: Denver Health and RMHP PRIME

Colorado operates two full-risk physical health managed care organizations (MCOs) for subsets of Health First Colorado members: **Denver Health Medicaid Choice** and **Rocky Mountain Health Plans (RMHP) PRIME**. The MCOs receive monthly capitation payments, maintain provider networks, pay covered physical health claims, and coordinate care under HCPF policy. **HCPF retains benefit definition, rate development, financing, and contract oversight.** A companion fact sheet explains how Regional Accountable Entities support primary care and care coordination for members whose physical health services remain fee-for-service.

1. COLORADO'S MCO DELIVERY SYSTEM IN NATIONAL CONTEXT

National baseline

KFF's national data show that, as of July 1, 2024, **42 states, including the District of Columbia, contracted with at least one comprehensive Medicaid MCO**. Comprehensive MCOs receive a fixed per-member payment to cover a defined package of acute, primary, and specialty services.

Colorado's MCO model

All full-benefit Health First Colorado members have access to physical health care services. Most physical health services are paid fee-for-service, but some members in defined service areas are enrolled in one of two MCOs that act as the payer for covered physical health services.

COLORADO STATUTORY AUTHORITY

RMHP PRIME

RMHP PRIME developed from Colorado's Medicaid payment reform and innovation initiative authorized through **C.R.S. 25.5-5-415**, which permits innovative payment methodologies designed to improve value, outcomes, and member satisfaction.

Denver Health

C.R.S. 25.5-5-402 requires HCPF to offer a direct physical health MCO contract with the Denver Health plan from July 1, 2025 through June 30, 2032, if the plan continues to meet HCPF's MCO criteria.

2. PHYSICAL HEALTH MANAGED CARE BY THE NUMBERS

As of August 2026, 134,481 members were enrolled in one of Colorado's two physical health MCOs.

2 physical health MCO partners	134,481 members enrolled across both MCOs	96,231 members enrolled in Denver Health	38,250 members enrolled in RMHP PRIME	Through 2032 current contract period
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Physical Health MCO Enrollment			AUGUST 2026
Managed Care Organization	Members Enrolled	Share of Two-MCO Enrollment	
Denver Health Elevate Medicaid Choice	96,231	71.6%	
RMHP PRIME Rocky Mountain Health Plans	38,250	28.4%	
Total	134,481	100.0%	

Measure note: Enrollment is as of August 2026. Percentages are calculated from the two enrollment counts shown above.



COLORADO MEDICAID - PROGRAMMATIC PARTNER FACT SHEET

Physical Health Capitation Revenue and Spending

SECTION 2 CONTINUED

The financial information below covers **FY 2024-25** and does not include incentive payments. HCPF pays each MCO a prospective per-member-per-month (PMPM) capitation payment to manage a defined package of physical health services. The MCO assumes financial risk and pays contracted providers for covered care.

HCPF capitation

HCPF pays each MCO a monthly PMPM amount. HCPF and its actuary develop actuarially certified rates through the annual rate-setting process.

MCO financial responsibility

The MCO manages service costs and utilization within the capitation. It is accountable for covered physical health services and associated administrative functions.

Provider payment

Providers bill the member's MCO. The MCO establishes contracted payment arrangements and adjudicates provider claims under applicable law and contract requirements.

The two plans serve different populations. Although RMHP PRIME and Denver Health Medicaid Choice (DHMC) are both MCOs, they are structured differently and their costs of care should not be directly compared. RMHP PRIME only covers children with a disability and adults. Because its population tends to have higher acuity, the services it pays for tend to be more expensive. In contrast, DHMC covers all children and adults, which spreads the cost of services for higher-acuity members over a larger population.

FY 2024-25 Financial Information		EXCLUDES INCENTIVE PAYMENTS	
Category	RMHP PRIME RAE Region 1	Denver Health Medicaid Choice Region 5	MCO Total
Capitated MCO Payments	\$241,982,570	\$267,122,953	\$509,105,523
MCO EXPENSES			
Indirect / Overhead	\$14,233,493	\$16,448,805	\$30,682,298
Care Coordination	\$884,519	\$2,208,327	\$3,092,846
Practice Support	\$345,492	-	\$345,492
Network Development	\$228,528	\$223,275	\$451,803
Utilization Management	\$1,432,665	\$2,140,094	\$3,572,759
Claims Processing	\$222,892,293	\$249,958,469	\$472,850,762
Other	\$335,514	-	\$335,514
Total MCO Expense	\$240,352,503	\$270,978,970	\$511,331,473

Capitation paid: FY 2024-25 capitated MCO payments made by HCPF to RMHP PRIME (RAE Region 1) and Denver Health Medicaid Choice (Region 5).

Reported spending: FY 2024-25 MCO expenses by category. Incentive payments are not included.

Financial reporting note: Data in tables are rounded to the nearest dollar; totals may not sum exactly due to rounding. The relationship between capitation revenue and reported spending varies by MCO. Differences may reflect retained margin or profit and the timing of expenditures, including delayed expenditures.



How MCOs support physical health

3. HOW COLORADO ORGANIZES AND PAYS FOR SERVICES

The MCO is the physical health plan and payer for enrolled members. Within federal and state requirements, the plan has flexibility to manage service delivery, cost, and utilization because it assumes financial risk for the covered physical health benefit. HCPF intentionally aligns MCO and Regional Accountable Entity contract requirements where possible to support a consistent member experience.

Full-risk physical health plan

Manage the cost and utilization of covered physical health services and assume financial responsibility as the payer for enrolled members.

Network adequacy and access

Maintain sufficient provider access, support providers, and help members find appropriate primary and specialty care.

Member and provider services

Maintain call centers, communicate benefit and authorization information, support grievances and appeals, and engage regional and member advisory groups.

Provider network management

Contract with, credential, reimburse, and support networks of primary care, specialty care, hospital, ancillary, and pharmacy providers.

Utilization and transitions of care

Set clinical and utilization-management processes and coordinate care when members transition from inpatient or other acute settings.

Regional programs and health neighborhood

Respond to local emergencies, offer value-based payment and care-coordination support, and connect members to additional medical and social services.

HCPF AUTHORITY

These responsibilities remain with HCPF.

- Define the Health First Colorado physical health benefit the MCOs must manage
- Work with a contracted actuary to develop annual actuarially certified physical health capitation rates
- Pay monthly capitation to the MCOs
- Oversee MCO contracts and monitor compliance, network adequacy, quality, data, and performance
- Ensure the MCOs follow applicable state and federal Medicaid requirements

HOW A MEMBER INTERFACES WITH THE MCO

Members enrolled in an MCO contact the plan for plan-specific questions and support related to covered physical health services. The MCO can help members understand benefits, locate care, resolve authorization issues, and coordinate services.

1

Find a provider

Get help locating a primary care or specialty provider in the MCO network.

2

Prescriptions and medications

Ask questions about pharmacies, covered drugs, and medication-related services.

3

Hospital and surgery support

Receive help navigating hospitalizations, surgeries, and related services.

4

Care coordination

Use care navigation or complex care management, including across multiple systems.

5

Health-related social needs

Connect to housing, food, and other medical or community supports.

6

Authorization and appeals

Ask about or appeal a prior authorization decision for physical health care.

7

Benefits and coverage

Get information about covered physical health services and plan requirements.

8

General questions

Contact the plan when unsure where to go or how to obtain a covered service.



Claims payment, quality, and care coordination

HOW CLAIMS ARE PAID IN THIS MODEL

RATE SETTING	HCPF and its contracted actuary use historical utilization and cost data to develop prospective per-member-per-month (PMPM) capitation rates through an annual process with the MCOs. The rates are actuarially certified for the defined physical health service package and enrolled populations.
PROVIDER CLAIMS	Providers submit claims to the member's MCO, and the MCO pays the provider. Each MCO establishes contracted provider payment arrangements for physical health services in its service area, subject to applicable law and contract requirements.
PUBLIC BUDGET	The General Assembly approves the fiscal-year budget that includes physical health capitation. HCPF and the Medicaid Provider Rate Review Advisory Committee (MPRRAC) do not set the individual reimbursement rates that MCOs pay contracted providers.

Responsibility follows the payment: because the MCO receives capitation and pays covered physical health claims, it is accountable for network access, utilization management, provider payment, care coordination, and member service within the contracted benefit.

4. WHAT COLORADO GETS FROM THIS STRUCTURE

MCO performance is assessed through a managed care quality structure that differs from the Regional Accountable Entity quality measures. The most recent performance data for the MCOs, from FY 2024-25, are highlighted below.

3 of 4

Denver Health quality goals met

Denver Health met goals for:

- Timeliness of prenatal and postpartum care
- Initiation and engagement in substance use disorder treatment
- Screening for depression and follow-up

4 of 4

RMHP PRIME quality goals met

RMHP PRIME met goals for:

- Initiation and engagement in substance use disorder treatment
- Timeliness of prenatal and postpartum care
- Screening for depression and follow-up
- Diabetes HbA1c control

HCPF is now collecting more information about care-coordination engagement from each MCO to better evaluate program effectiveness. Initial data from the first year of Accountable Care Collaborative (ACC) Phase III are included below.

Care Coordination Engagement			FY 2025-26
MCO	Unique Members Engaged	Average Engagements per Member	
Denver Health	27,053	2.85	
RMHP PRIME	9,409	3.55	

Links to additional information:

[KFF - Total Medicaid MCOs](#)

[HCPF - ACC Provider and Stakeholder Resource Center](#)

[HCPF - Managed Care Programs Billing Manual](#)

[HCPF - ACC Frequently Asked Questions](#)

[HCPF - Accountable Care Collaborative Phase III](#)

[HCPF - Health First Colorado Managed Care Contracts](#)

[HCPF - FY 2024-25 Annual ACC Legislative Report](#)

[Colorado Revised Statutes - Title 25.5, sections 25.5-5-402, 25.5-5-408, and 25.5-5-415](#)

Child Health Plan Plus Health Plans

CHP+ is Colorado's public, low-cost health insurance for eligible children and pregnant and postpartum members. For medical coverage, every member is connected to a managed care organization that maintains the provider network, supports members, manages covered care, and pays providers. HCPF retains eligibility, benefit and cost-sharing policy, rate development, financing, provider enrollment, and oversight.

① COLORADO'S CHP+ DELIVERY SYSTEM IN NATIONAL CONTEXT

National program choices

All states and the District of Columbia operate CHIP. States may use a **Medicaid expansion, a separate CHIP program, or a combination**. A 2023 national scan identified 34 states with a separate CHIP component for children; 27 of those states used managed care organizations.

Colorado's operating model

Colorado created CHP+ in 1998 and operates a combination Medicaid-CHIP and separate-CHIP program. The separate program is organized through **fully managed medical care** for children and pregnant members, with dental administered separately.

② COLORADO CHP+ BY THE NUMBERS

5

plan partners: 4 medical health plans and 1 dental plan

71,128

children enrolled, annualized

3,014

pregnant members enrolled, annualized

\$245M

annual capitation payments to medical health plans

Medical plans: Colorado Access, Denver Health, Kaiser Permanente, and Rocky Mountain Health Plans. **Dental:** DentaQuest.

\$28M

other program impacts, including fee-for-service and reconciliation payments outside medical capitation

4 FTE

HCPF staffing

③ HOW WE ORGANIZE AND PAY FOR SERVICES

CHP+ is fully managed care for medical services and is organized around a defined population. HCPF pays monthly per-member capitation. Plans organize access, administer covered services, support members and providers, pay claims, and report performance. DentaQuest administers dental separately.

CHP+ health plans perform the contracted managed care functions below.

Member enrollment and continuity

Send welcome materials and ID cards, conduct renewal outreach, and support continuity during eligibility or plan changes.

Member engagement and appeals

Operate call centers, websites, and handbooks; provide language access and communications; manage grievances and appeals.

Provider network and support

Build networks, meet time-and-distance standards, credential providers, maintain directories, and provide training and technical assistance.

Clinical and utilization management

Set clinical guidelines, manage referrals and authorizations, conduct site reviews, and address screening, licensure, and terminations.

Claims and financial operations

Pay claims timely, administer FQHC/RHC reimbursement requirements, and recover overpayments.

Population health and quality

Assess health needs, reach high-risk members, coordinate early intervention, build community partnerships, and operate quality-improvement programs.

HCPF AUTHORITY

These responsibilities remain with the Department.

- Determine eligibility (through county and MA sites) and enroll members in plans
- Set CHP+ benefit and member cost-sharing policy
- Develop capitation rates and pay the health plans
- Monitor contracts, plan performance, and network adequacy
- Measure quality, validate data, enroll providers, manage risk, and enforce state and federal requirements



③ HOW WE ORGANIZE AND PAY FOR SERVICES - CONTINUED

How a member interfaces with a CHP+ health plan

The State determines eligibility and enrolls the member in a plan available in the member's county. The medical health plan then becomes the primary point of contact for most covered care and plan-level questions.

1 Enroll and receive materials The plan sends a welcome packet, ID card, handbook, and coverage information.	2 Choose a PCP or find care The member uses the directory or Member Services to select a PCP and locate network providers.	3 Get routine or specialty care The provider schedules care and follows plan referral or authorization rules when applicable.
4 Use plan support Call centers, language services, and care coordinators help resolve access or benefit questions.	5 Plan pays and reports The provider bills the plan; the plan pays the claim and provides EOB or claims information.	6 Change or appeal The plan helps with PCP changes, provider departures, continuity of care, grievances, and appeals.

How capitation rates and provider claims work

RATE SETTING	Plan data → HCPF + actuary → Prospective monthly rates. Plans submit financial, claims, and encounter data. HCPF and its contracted actuary review eligible base data and apply trend, policy, benefit, and administrative assumptions to develop PMPM rates for the upcoming year.
STATE TO PLAN	HCPF → CHP+ MCO → Monthly capitation. HCPF pays the plan for each enrolled member and covered month. The plan assumes contractual responsibility for covered services and required administrative functions.
PLAN TO CARE	CHP+ MCO → Network providers → Provider payment. Each MCO contracts with its own network, establishes provider payment arrangements, adjudicates claims, pays providers, and reports encounter data to HCPF. Members generally contact the plan - not HCPF - about plan claims or care concerns.

What the 85% standard means. Federal CHIP managed care rules require rates to be designed to reasonably achieve a medical loss ratio of at least 85%. The numerator includes incurred claims and qualifying quality-improvement activities; rates may also provide for reasonable administrative costs. This is a rate-design and reporting standard, not a guarantee that every plan's actual annual spending is an exact 85/15 split. Dental, brief pre-MCO fee-for-service coverage, and specified reconciliation or outside-capitation payments use separate payment lanes.

④ WHY CHP+'S DELIVERY SYSTEM IS ORGANIZED THIS WAY

Federal design choice

When Congress created CHIP in 1997, states could expand Medicaid, establish a separate CHIP program, or combine both. Separate CHIP programs may use benefit and delivery approaches that resemble commercial insurance, including managed care.

Colorado's choice

Colorado authorized CHP+ in 1998 as a combination Medicaid-CHIP and separate-CHIP program and organized the separate component through managed care. A health plan is responsible not only for paying claims, but also for access, care coordination, quality, cost management, and helping members navigate the system.

⑤ WHAT COLORADO GETS FROM THIS STRUCTURE

Preventive and coordinated care Plans organize primary, specialty, behavioral health, pharmacy, and care-coordination functions around the member and promote preventive services and early intervention.	A health home and navigation A PCP, network, and care-coordination structure gives members a defined point of contact and is intended to reduce avoidable emergency use.	Network and quality accountability Plans are contractually accountable for network adequacy, timely access, member experience, quality improvement, grievances, and appeals.	Comparable public measures Required Child Core Set reporting and annual external quality review allow HCPF, CMS, and the public to compare access and quality across plans and over time.
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Published quality review. Colorado's FY 2023-24 external quality review found moderate to strong compliance and performance in performance-improvement projects, managed care compliance, network adequacy, and quality-of-care grievance processes. Some plan-level scores were above 2023 NCQA national averages, although differences were not always statistically significant; the review also identified opportunities to improve performance-measure and CAHPS results.

LINKS TO ADDITIONAL INFORMATION / DEEPER DIVES

[HCPF - Child Health Plan Plus](#)

[HCPF - CHP+ Managed Care Contracts](#)

[HCPF - Provider Contracting and Enrollment](#)

[Georgetown CCF - 2023 Managed Care in CHIP Scan](#)

42 C.F.R. § 457.1203

[HCPF - Annual Technical Reports](#)

[HCPF - CHP+ CAHPS Reports](#)

[CMS - Child Core Set](#)

[CMS - CHIP Program Information](#)

Authority: Social Security Act Title XXI; 42 C.F.R. Parts 438 and 457; C.R.S. Title 25.5, Article 8.

Pharmacy Benefit Management System

Colorado Medicaid uses administrative partners to perform required functions that otherwise would be carried out by the State or another vendor. The PBMS is organized by **benefit expertise** and operates key parts of the fee-for-service pharmacy benefit - real-time claims processing, prior authorization support, pharmacy and prescriber assistance, rebate administration, and program reporting. **HCPF retains coverage, formulary, clinical, reimbursement, financing, and oversight decisions.**

PBMS: Pharmacy Benefit Management System.

① COLORADO'S PHARMACY BENEFIT DELIVERY SYSTEM IN NATIONAL CONTEXT

National baseline

Pharmacy coverage is optional under federal Medicaid law, but **all 50 states and the District of Columbia** currently cover outpatient prescription drugs and participate in the Medicaid Drug Rebate Program. States use different operating structures to administer those benefits.

Colorado's operating model

States use different combinations of state systems, fiscal agents, health plans, and PBM contractors. Colorado uses a contracted PBMS module to turn HCPF policy into point-of-sale claim decisions and related pharmacy operations. **MedImpact became the fee-for-service claim processor effective April 1, 2026.**

② COLORADO PHARMACY BENEFIT BY THE NUMBERS - FY 2024-25

685,939

unique members accessing pharmacy benefits

8,123,662

pharmacy claims paid

\$1,636,328,924

direct pharmacy benefit spending, before rebates

Through FY 2027-28

current PBMS base contract term

Source note: SFY 2024-25 pharmacy program figures supplied for the Commission materials. The spending figure is shown before rebates.

③ HOW WE ORGANIZE AND PAY FOR SERVICES

Purpose of the PBMS. MedImpact operates the pharmacy claim processing system that applies HCPF's pharmacy benefit policies. The contractor does not make final formulary, coverage, clinical criteria, rebate acceptance, or pharmacy reimbursement decisions.

MedImpact - Contracted PBMS Functions Performs the operational functions below under HCPF policy.

Claims administration

Processes electronic and paper pharmacy claims; returns paid or rejected responses; interfaces with eligibility, provider, prior authorization, and payment systems.

Prior authorization operations

Receives and processes pharmacy authorization requests using HCPF's published criteria and supports electronic, phone, and fax workflows.

Pharmacy and prescriber support

Operates a call center that provides clinical and technical help for claim submission, basic coverage questions, and issue resolution.

Rebate administration support

Supports supplemental rebate solicitation, contracting, invoicing, collection, reconciliation, and manufacturer communications.

Utilization and cost reporting

Produces operational, utilization, and financial information to support HCPF pharmacy benefit management and oversight.

PDL and benefit technology

Supports the Preferred Drug List, real-time benefit information, and data exchange across Colorado's modular Medicaid enterprise.

HCPF AUTHORITY

These responsibilities remain with the Department.

- Coverage and prior authorization criteria
- Final drug formulary and Preferred Drug List decisions
- Pharmacy reimbursement methodology and rates
- Program financing, federal compliance, audits, and contract oversight
- Supplemental rebate acceptance decisions

③ HOW WE ORGANIZE AND PAY FOR SERVICES - CONTINUED

How a member interfaces with the PBMS

Most PBMS activity is invisible to the member and occurs in real time between the pharmacy, the PBMS, and HCPF systems. Direct touchpoints arise when a claim rejects, prior authorization is required, or a member needs help understanding coverage.

1 Prescription written A prescriber sends the prescription to the member's pharmacy.	2 Claim submitted The pharmacy sends a standard electronic claim to the PBMS.	3 Rules checked The PBMS checks eligibility, coverage, prior authorization, refill, other insurance, and payment edits.	4 Dispense or resolve An approved claim allows dispensing; a rejected claim identifies the issue to resolve.	5 Support if needed The pharmacy or prescriber can use PBMS support and submit a prior authorization.
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How claims, administration, and rebates are paid

CLAIM DOLLARS	Enrolled pharmacy → PBMS adjudicates → Approved claims are reimbursed under HCPF policy. HCPF determines covered drugs and the pharmacy reimbursement methodology, including ingredient-cost and professional-dispensing-fee rules; the PBMS applies those rules to each claim.
ADMIN DOLLARS	HCPF → MedImpact. PBMS compensation is governed by a separate administrative contract. It is accounted for separately from the pharmacy claim dollars paid for medications and dispensing services.
REBATE DOLLARS	Drug manufacturers → State + federal share. Manufacturer rebates offset gross Medicaid drug costs. The PBMS supports invoicing and collection, while HCPF makes policy and supplemental-rebate acceptance decisions. All rebate dollars pass through to HCPF. The FY 2024-25 spending figure on page 1 is shown before rebates.

Colorado Medicaid PBM pricing safeguard. For applicable contracts issued or renewed on or after January 1, 2025, state law requires the amount charged to HCPF or an affiliated Medicaid managed care organization for a dispensed drug to be no more than the amount paid to the pharmacy.

④ WHY COLORADO USES A PBMS

Federal and operational requirements

Colorado must administer outpatient drug coverage, Drug Utilization Review, rebate reporting, coordination of benefits, and other federal Medicaid pharmacy requirements. The program also needs a secure, continuously available system capable of processing high-volume point-of-sale claims in real time.

Colorado's delivery-system choice

Federal law does not require Colorado to use a particular PBM vendor. Colorado contracts for a specialized pharmacy claim system and operations while keeping policy authority inside HCPF. The current modular approach also separates functions so modules can be integrated, updated, or recompeted without replacing the entire Medicaid enterprise.

⑤ WHAT COLORADO GETS FROM THIS STRUCTURE

Real-time decisions Point-of-sale claim responses allow pharmacies to identify coverage, eligibility, authorization, refill, and payment issues before dispensing.	Member and provider support The pharmacy call center is available during normal business hours, 7 days a week. Pharmacy prior authorization requests are processed within 24 hours, with many phone and electronic submissions decided within minutes.	Policy consistency The same HCPF coverage criteria, Preferred Drug List rules, and reimbursement methodology are applied across fee-for-service pharmacy claims.	Data and cost controls Claims, utilization, prior authorization, and rebate information support public committees, program oversight, audits, and cost-management decisions.
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LINKS TO ADDITIONAL INFORMATION / DEEPER DIVES

[HCPF - PBMS Procurement and Transition](#)

[HCPF - CMES Executed Contracts](#)

[HCPF - MedImpact PBMS Contract](#)

[HCPF - Pharmacy Resources](#)

[CMS - Prescription Drugs](#)

[HCPF - Pharmacy Billing Manual](#)

[HCPF - Pharmacy Benefits](#)

[HCPF - Pharmacy and Therapeutics Committee](#)

[HCPF - Drug Utilization Review Board](#)

[CMS - Medicaid Drug Rebate Program](#)

Authority: Social Security Act section 1927; 10 C.C.R. 2505-10; C.R.S. 25.5-1-134.

Program data: SFY 2024-25 member, claim, and spending figures supplied for the Commission materials.

Dental Administrative Services Organization

Colorado uses a contracted Dental ASO to put HCPF dental policy into day-to-day operations: recruiting and maintaining the participating dentist network, reviewing authorizations, processing claims and making payments to dental providers, and supporting members and providers. **HCPF retains benefit design, coverage, payment policy, provider enrollment, program financing, and oversight.**

① COLORADO'S DENTAL BENEFIT DELIVERY SYSTEM

What the Dental ASO does

An Administrative Services Organization puts Department policy into practice through day-to-day operations. DentaQuest performs member and provider support, prior authorization and clinical review, network and directory administration, education, claims processing, provider payment, reporting, program integrity support, and quality monitoring.

Colorado's current model

Colorado has used a Dental ASO since 2014, when the model was implemented alongside the adult dental expansion authorized by **SB 13-242**. **DentaQuest is the current Dental ASO.** The arrangement uses annual option letters; HCPF plans a new procurement in **SFY 2028-29**.

② COLORADO DENTAL ASO BY THE NUMBERS

554,052 unique people receiving dental services in SFY 2024-25	1,890 unique dental providers paid in SFY 2024-25	1,667,481 dental claims processed in SFY 2024-25	\$590.84M dental claims paid to providers in SFY 2024-25
\$8.29M FY 2025-26 Dental ASO administrative payments; paid through a PMPM methodology	13,000 system edits configured through Dental ASO systems; HCPF systems do not currently have this capacity	2 FTE HCPF staff overseeing dental program operations, policy implementation, stakeholders, and issue resolution	Through 2029 current contract horizon, using annual option letters; RFP planned for SFY 2028-29

SFY 2024-25 service figures come from the Health First Colorado Dental Annual Report.

③ HOW WE ORGANIZE AND PAY FOR DENTAL SERVICES

Purpose of the Dental ASO. The Dental ASO administers the benefit under HCPF policy. It does not establish benefits, set coverage policy or provider reimbursement, enroll providers with the State, or make final program decisions.

DentaQuest performs the contracted Dental ASO functions below.

Network and directory management

Recruits and maintains participating dentists, monitors access, and keeps provider-directory information current.

Prior authorization and clinical review

Reviews requests and documentation using HCPF coverage and clinical criteria.

Claims processing and payment

Receives, edits, adjudicates, and pays fee-for-service dental claims on the Department's behalf.

Member and provider support

Operates member and provider call centers; answers benefit, claim, authorization, grievance, appeal, and operational questions.

Member and provider education

Explains covered dental services, billing rules, documentation requirements, and program processes.

Reporting, integrity, and quality

Produces operational data, supports fraud-waste-and-abuse work, monitors performance, and identifies outliers for follow-up.

HCPF AUTHORITY

These responsibilities remain with the Department.

- Benefit design and coverage policy
- Dental fee schedule and reimbursement methodology
- Provider enrollment
- Program financing and federal compliance
- Contract and performance oversight
- Policy development, stakeholder liaison, and issue resolution

2 HCPF FTE oversee dental program operations.

③ HOW WE ORGANIZE AND PAY FOR DENTAL SERVICES - CONTINUED

How members interact with the Dental ASO

Members are assigned to a dental home when they enroll and may change their dental home at any time. DentaQuest supports the member and provider throughout the process; participating dentists provide the care.

1 Dental home assigned A dental provider is assigned at enrollment; the member may change it.	2 Schedule care The member contacts the dental office and schedules a visit.	3 Authorization The provider requests authorization when a service requires it.	4 Receive care The participating dentist provides the covered service.
5 Submit claim The provider submits the claim and documentation.	6 Adjudicate and pay DentaQuest applies HCPF rules and pays the provider.	7 Ongoing support Members and providers receive assistance as needed.	

How claims and administration are paid

CLAIM DOLLARS	Provider submits claim → DentaQuest adjudicates → HCPF funds approved claims through weekly payments to DentaQuest, and DentaQuest pays dental providers. HCPF establishes the covered benefits, reimbursement policy, and allowable fee-schedule amounts.
ADMIN DOLLARS	HCPF → DentaQuest. Administrative services are paid separately through a PMPM methodology. FY 2025-26 administrative payments were \$8,286,868. The Dental ASO does not receive a percentage of provider claim payments.

Dental payment policy. Dental services are paid fee-for-service using Colorado's Medicaid dental fee schedule. Like other fee-for-service rates, dental rate changes proceed through the State budget process when the General Assembly appropriates funding. Dental rates are reviewed by the Medicaid Payment Rate Review Advisory Committee on a three-year cycle, which informs recommendations about rate adequacy.

④ WHAT COLORADO GETS FROM THIS STRUCTURE

96% monthly claims-accuracy standard The contract requires at least 96% of claims to be processed accurately each month.	51,165+ member and provider calls answered Contact-center volume reported for SFY 2024-25.	1.3 days adult prior-authorization turnaround Average business-day turnaround reported for adults.	2.3 days child prior-authorization turnaround Average business-day turnaround reported for children.
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LINKS TO ADDITIONAL INFORMATION / DEEPER DIVES

[HCPF - Health First Colorado Dental Annual Report, SFY 2024-25](#)

[HCPF - Dental Benefits](#)

[HCPF - Provider Rates and Fee Schedule](#)

[HCPF - Medicaid Provider Rate Review Reports](#)

Current Dental ASO contract and annual option letters

Program history and authority: SB 13-242; C.R.S. section 25.5-5-207; Social Security Act sections 1902(a)(43) and 1905(r).

Data periods: Service and quality measures are SFY 2024-25 unless otherwise labeled. Administrative payment is FY 2025-26.

Prepared for: Colorado Commission on Medicaid.



HCPF's Assessment of the Accountable Care Collaborative

Medicaid Commission Data Request, August 27, 2026

The Department of Health Care Policy and Financing (HCPF) has used some form of managed care since the 1990s, though the structure of the delivery system has continued to evolve. This brief focuses on the Accountable Care Collaborative (ACC), which launched in 2011. The information provided focuses primarily on ACC Phase II, the second iteration of the delivery system, which operated from July 1, 2018 to June 30, 2025 because this is the most recent and complete data.

During ACC Phase II, HCPF contracted with five Regional Accountable Entities (RAEs) who managed care in seven regions across the state. RAEs were, and continue to be, responsible for administering the capitated behavioral health benefit, building and supporting a network of primary care medical providers (PCMPs) that serve as medical homes for members in their regions, coordinating health care services for members, supporting cost control and quality improvement efforts across Colorado Medicaid, and responding to the unique community needs in their regions. In addition to the RAEs, two physical health managed care capitation plans, referred to as Managed Care Organizations (MCOs) participate in the ACC. More information about the MCOs can be found in the corresponding Physical Health MCO fact sheet.

HCPF measures performance by analyzing clinical quality metrics, RAE operational metrics, and financial performance. This brief is organized around the Commission's three-part question: What improved over the course of ACC Phase II?, What did not improve?, and What HCPF cannot measure and why? It also outlines changes made for ACC Phase III in response to these findings.

Quality Metrics

HCPF sets quality goals every year for the RAEs, in both behavioral health and overall health care. The RAEs report annually on nationally accepted quality indicators, like follow up after discharge from an emergency department or hospital visit, primary care and well child visits, and timeliness to prenatal care. HCPF is able to pay these incentives by withholding a portion of the RAE care management PMPM payments plus some administrative budget for behavioral health. Over time, HCPF has worked to move away from homegrown metrics toward nationally recognized, standardized measures developed by national measure stewards such as the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS). This makes it easier to compare Colorado's performance against other states and reduce administrative burden on providers by better aligning across payers. Performance measures are benchmarked to national rates; the list of measures, their measurement and target specifications, and performance are available on the [HCPF Accountable Care Collaborative website](#).

HCPF paid out \$411.8 million to the RAEs for quality performance during the seven years of ACC Phase II. The RAEs distributed earned incentive funding with their contracted providers directly. The following are specific metrics that were measured for all or most of ACC Phase II and, on average across all RAEs, improved:

- Child and adolescent well-care visits increased from 29.8% in FY 2018-19 to 46% in FY 2024-25.
- Timeliness of prenatal care improved from 56.3% in FY 2018-19 to 72.6% in FY 2024-25.
- Behavioral health engagement for members released from state prisons increased from 10.6% in FY 2019-20 to 46.8% in FY 2024-25.
- Extended care coordination improved from 47% in FY 2019-20 to 68.5% in FY 2024-25.
- Premature birth rate decreased from 10.7% in FY 2019-20 to 10.3% in FY 2024-25.
- Follow-up after positive depression screen increased from an average of 46.9% in FY 2018-19 to 61.4% in FY 2024-25.
- Behavioral health screening or assessment for children in the foster care system increased from an average of 16.7% in FY 2018-19 to 26% in FY 2024-25.

Operational Metrics

In addition to quality performance, HCPF monitors a number of operational metrics to understand how well the RAEs are ensuring access to care for members, meeting contract expectations and responding to member and provider concerns.

Access to Behavioral Health Services: From FY 2018-19 to FY 2023-24, the share of members accessing behavioral health services, referred to as the behavioral health penetration rate, increased from 16% to 24%. Additionally, the number of behavioral health providers contracted with the RAEs increased by 30% between 2023 and 2025, resulting in 14,800 enrolled providers. However, challenges with accessing certain behavioral health services have persisted for certain populations.

In February 2024, HCPF entered into a settlement agreement requiring that HCPF build a systematic approach to providing Health First Colorado members under the age of 21 with intensive behavioral health services in their homes and communities, referred to as the Colorado System of Care (CO-SOC). As of August 2026, CO-SOC is now serving 67 children. CO-SOC is also focused on ensuring appropriate workforce capacity to serve these children and youth and their families; a new Workforce Capacity Center (WCC), in partnership with Colorado State University, will support training providers in evidence-based models of care for children and youth.

Substance Use Disorder (SUD) waiver demonstration: In January 2021, HCPF implemented the 1115 SUD waiver to increase access to SUD services for members. As part of the waiver demonstration process, HCPF completed an interim evaluation showing how the implementation of this waiver addressed our focus areas. In our most recent evaluation of the program in 2026 for 2020-2024, we found the following:

- Focus Area 1, increase rates of identification, initiation and engagement in treatment: Overall the rate of initiation and engagement in treatment has not improved. Additionally, some SUD provider capacity issues persist especially in rural areas and for children, pregnant people, and individuals with criminal justice involvement.
- Focus Area 2, improve access to care for physical health conditions among members with opioid use disorder or other SUDs: Access to physical health care services and follow-up after emergency department visits has improved. However, there is overutilization of withdrawal manager services relative to treatment retention and increased emergency department and hospital utilization. Care coordination remains an area of potential growth.
- Focus area 3, reduce high-dose opioid use and high readmission rates: Opioid use in high dosages has not decreased and readmission rates remain high and are increasing.
- Focus area 4, reduce emergency department and inpatient hospital utilization: Both emergency department rate and inpatient utilization have increased.

HCPF is actively developing a work plan with steps to meet our commitments to the Centers for Medicare and Medicaid Services (CMS) to improve outcomes for the second period of our SUD waiver.

Member experience: HCPF measures member experience in a few different ways. The first is through standardized Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan surveys. Most recently available survey results for FY 2024-25 for the RAEs statewide show:

- 86% of adults and 80% of children reported satisfaction with care coordination
- 86% of adults and 86% of children report satisfaction with their RAEs' customer service

HCPF also assesses the responsiveness of each RAE call center by monitoring call volume, call response time and call abandonment rate. Below is most recently available call center data for FY 2024-25:

Member call center data by MCE, FY 2024-25

MCE	Average member monthly call volume	Member response times (avg. speed of answer)	Member call abandonment rate
1 (RMHP)	3,515	8 seconds	0.6%
2 (NHP)	362	2 seconds	0.1%
3 (COA)	1,561	41 seconds	1.2%
4 (HCI)	361	2 seconds	0%
5 (COA)	1,561	41 seconds	1.2%
6 (CCHA)	1,620	13 seconds	0.7%
7 (CCHA)	659	14 seconds	0.8%

Note: The following MCEs shared a member call center: RAEs 2 and 4, and RAEs 3 and 5.

Updated survey and call line data will be available in the FY 2025-26 ACC Legislative report, which will be submitted to the General Assembly on Dec. 1, 2026.

HCPF also monitors the member grievances that are submitted for each RAE to identify patterns and ensure members are able to access the services they need. Grievances are defined as an expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to, quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights as defined in federal regulations.

*Number of Grievances Submitted by RAE from FY 2021-22 through FY 2024-25**

RAE	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
RAE 1**	75	438	218	281
RAE 2	10	91	58	36
RAE 3	71	89	119	208
RAE 4	39	188	163	169
RAE 5	43	52	58	56
RAE 6	34	72	80	92
RAE 7	26	71	96	144

*Grievance counts are not adjusted for regional membership size; higher counts in large regions do not necessarily indicate worse performance.

**RAE 1 grievance data also includes grievances submitted for the managed care organization PRIME.

Provider experience: HCPF also measures provider experience in multiple different ways, including smooth enrollment and contracting, timely processing of claims payments and timely responses to questions. As managed care entities for behavioral health, RAEs are responsible for contracting with providers and ensuring a good provider experience that will lead to better care and outcomes for members. As of June 2025, the most recently available data, all seven RAEs met or exceeded contract standards for clean claims payment within 30 days (standard:90%), response to provider inquiries within two days (standard: 100%), and credentialing and contracting within 90 days (standard: 90%). The following table shows RAE performance for different provider service requirements as of June 2025, the most recently available data:

Performance on provider service requirements by MCE, June 2025

MCE	% of clean claim payments within 30 days (standard: 90%)	Response to provider inquiries within two days (standard: 100%)	Credentialing and contracting within 90 days (standard: 90%)
1 (RMHP)	99.9%	100%	100%
2 (NHP)	97.8%	100%	100%
3 (COA)	92.3%	100%	100%
4 (HCI)	98.7%	100%	100%
5 (COA)	99.1%	100%	100%
6 (CCHA)	100%	100%	100%
7 (CCHA)	100%	100%	100%

The RAEs also staff provider call centers and by contract must meet certain call center service level agreements. Provider call center performance followed a similar pattern in FY 2024-25, with average answer speeds ranging from 4 to 44 seconds and abandonment rates of 1.3% or lower across all RAEs. The following table shows provider call center performance by each RAE in FY 2024-25, the most recently available data:

Provider call center data by MCE, FY 2024-25

MCE	Average provider monthly call volume	Provider response times (avg. speed of answer)	Provider call abandonment rate
1 (RMHP)	2,976	23 seconds	1.3%
2 (NHP)	407	4 seconds	0.1%
3 (COA)	1,956	44 seconds	0.8%
4 (HCI)	407	4 seconds	0%
5 (COA)	1,956	44 seconds	0.8%
6 (CCHA)	1,271	16 seconds	0.7%
7 (CCHA)	1,271	16 seconds	0.7%

Note: The following MCEs shared a provider call center: RAEs 2 and 4, RAEs 3 and 5, and RAEs 6 and 7.

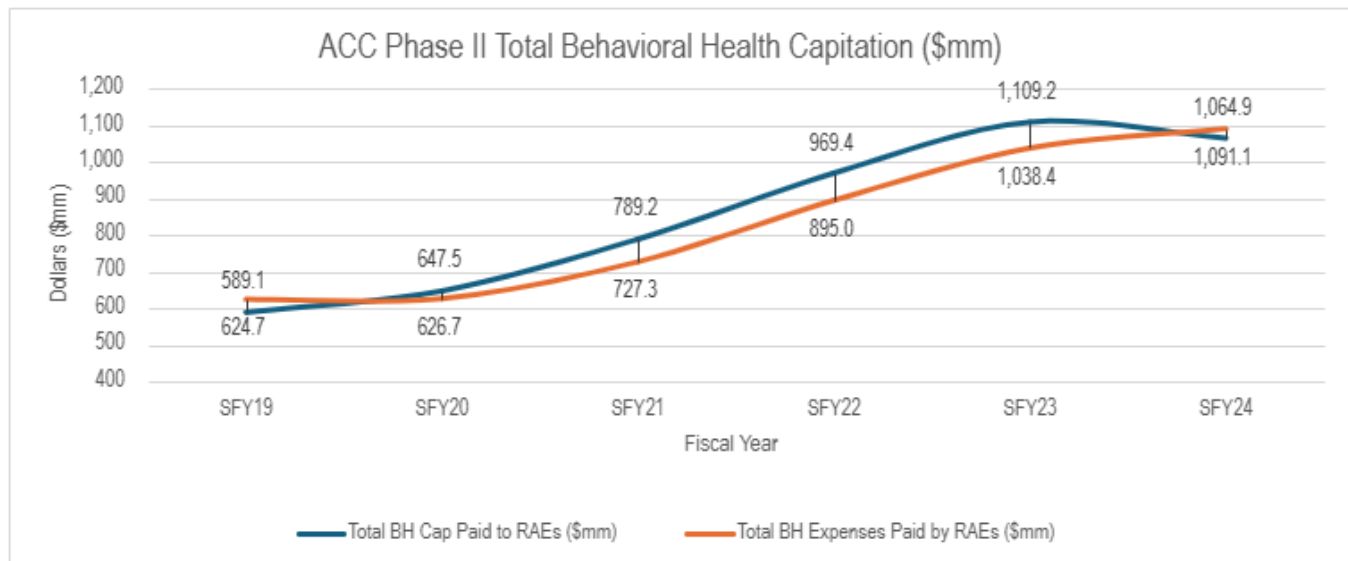
Updated provider experience metrics will be available in the FY 2025-26 ACC Legislative report.

Financial Performance Over Phase II

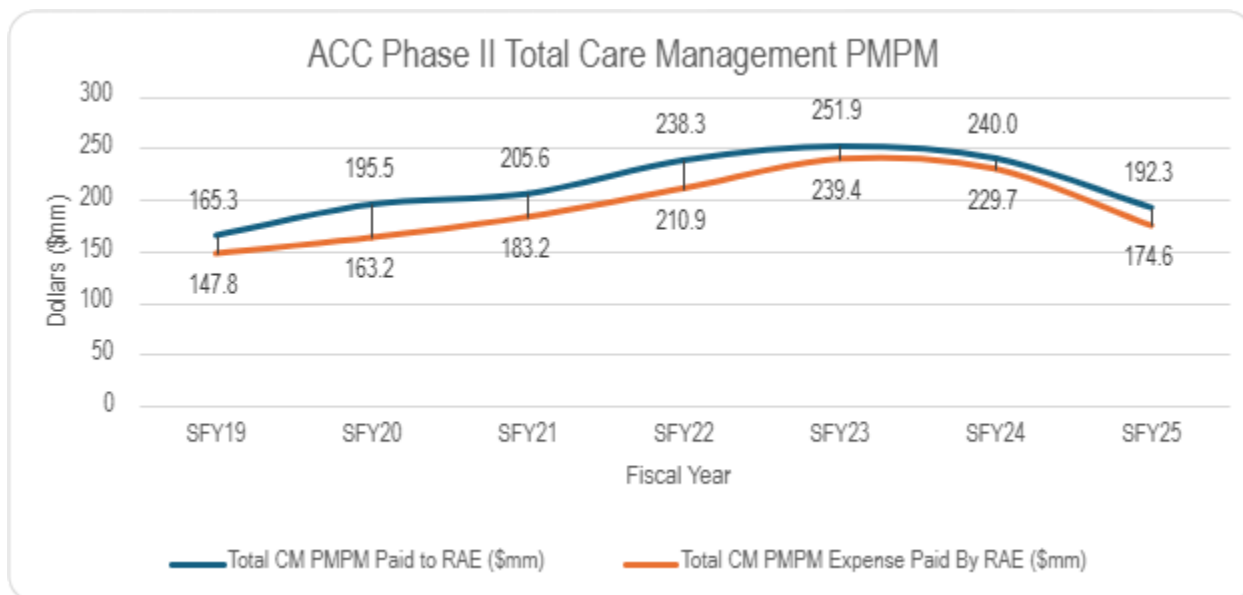
RAE Financial Summaries

HCPF looks at two separate financial summaries to reflect the different responsibilities RAEs have between physical and behavioral health, as described in the respective partner fact sheets. The following graph shows the total behavioral health capitation paid to the RAEs compared to the total amount RAEs spent managing the behavioral health capitation over the course of ACC Phase II. Since

the start of Phase II, the statewide behavioral health profit margin has been as low as -4% in FY 2018-19 and as high as 3.4% in FY 2019-20. In the most recent year of data, FY 2024-25, the profit margin was -0.4%.



The following graph shows the total care management per-member-per-month (PMPM) payment to all of the RAEs compared to the total amount RAEs spent managing those responsibilities over the course of ACC Phase II. Since the start of Phase II, the statewide care management PMPM profit margin has been as low as 4.3% in FY 2023-24 and as high as 16.5% in FY 2019-20. In the most recent year of data, FY 2024-25, the profit margin was 9.2%.



Value Based Payments in Colorado

Creating value-based payment opportunities is a core part of the RAE structure. As part of the care management PMPM that RAEs receive from HCPF, they pay their contracted primary care medical providers (PCMPs) a monthly medical home payment based on the number of members assigned to their practice. This payment supports the PCMP role as a medical home for members and focuses on building and maintaining advanced primary care activities, such as care coordination, integrated behavioral health services and population health management. In FY 2024-25, the RAEs paid \$63,895,024 in total to their PCMP network, which represents 43% of the total care management PMPM.

Additionally, HCPF has tested several approaches to value-based payment within Colorado Medicaid over the last decade and has continued to refine or replace models based on emerging results and stakeholder feedback. These models have shown to improve quality, change patterns of care, and in some cases generate savings. They also show that payment design and meaningful incentives are critical to success. Key highlights include:

1. *Quality incentives can affect care patterns.* An evaluation of Alternative Payment Model (APM) 1, an APM in which Colorado tied a portion of primary care reimbursement to performance on quality measures related to preventive care, chronic condition management, behavioral health, and practice capabilities, found increased primary care utilization and statistically significant lower emergency department utilization, without evidence of increased overall fee-for-service spending. Providers also reported that the model helped reinforce quality improvement priorities. Similar results can be seen in the ACC Quality Incentive Program.
2. *Shared Savings models can reduce cost.* Shared savings programs, such as the Maternity Bundle program, in which participating maternity providers have the opportunity to share in savings across prenatal, delivery, and postpartum care when meeting quality requirements, have saved \$6.7M over 5 years of program history and demonstrated movement away from avoidable emergency care toward prenatal and postpartum services. The Chronic Conditions Shared Savings program has demonstrated similar results of \$2.5M saved over 3 years. Both programs are in the process of expansion based on these results.

Stakeholder Feedback

HCPF regularly engages with a statewide ACC Program Improvement Advisory Committee and three subcommittees for feedback from a variety of stakeholders about the program. Additionally, HCPF held 135 stakeholder meetings with over 5,700 attendees across 18 months to gather feedback to inform the design of ACC Phase III. Full summaries of feedback HCPF received are available on the [ACC webpages](#), including a [fact sheet](#) on how feedback shaped ACC Phase III.

As part of the transition to ACC Phase III, HCPF made the following changes to address feedback:

- Where possible, simplifying systems for members and providers by reducing the number of RAE regions, improving communication accessibility requirements, emphasizing disability competent care, and improving the methodology to attribute members to PCMPs.
- Assuring quality care by requiring RAEs to collaborate with other entities serving members, like the Behavioral Health Administrative Service Organizations (BHASOs), creating an updated

policy to support the sustainability of integrated care, creating a standardized three-tier model for care coordination, and supporting the implementation of CO-SOC.

- Supporting providers by ensuring RAEs provide practice transformation and technical assistance to encourage providers to participate in VBPs and standardizing quality measures across programs and payers to reduce provider administrative burden.
- Fostering accountability by introducing the Commitment to Quality program and by ensuring RAEs remain accountable to their regional communities through formalized member and other stakeholder advisory council requirements.

What Is Not Measurable and Why

The Commission's question asks not only what improved and what did not, but what HCPF cannot measure. Three limitations are important for interpreting the evidence in this deliverable:

Cost savings attributable to managed care. Once ACC Phase II began, all full-benefit members except those in PACE were enrolled in the ACC. Without a comparison group of members outside managed care, HCPF can no longer calculate avoidable costs or cost savings attributable to the program. Available literature also shows little consistent connection between managed care strategies and cost savings.

The effect of the COVID-19 pandemic on quality performance. Quality performance during Phase II was significantly affected by the public health emergency. It is not possible to determine how much of the underperformance on certain metrics reflects program design versus pandemic disruption.

Whether rising escalation and grievance volumes reflect rising problems. Increases in provider escalations and member grievances may reflect greater awareness of these processes rather than more underlying issues. Raw counts are also not adjusted for regional membership size. HCPF monitors these metrics for patterns rather than treating them as direct performance indicators.

Changes for ACC Phase III

In response to the performance results and stakeholder feedback described above, HCPF made the following changes with the transition to ACC Phase III:

- **Attribution:** Attribution is the methodology that HCPF uses to connect a member to a PCMP based on their utilization history or their choice of provider. Attribution is also used to assign members to a RAE. Based on stakeholder feedback, HCPF removed the practice of geographically attributing members to a provider, meaning if we had no utilization history or preference from the member, we would attribute them to the nearest provider to their home address. This means that some members in Phase III are considered unattributed. We monitor this metric closely because an important part of the program is ensuring that members have a focal point of care. The RAEs actively work to help connect members to PCMPs. The number

of members attributed to a PCMP has increased by 14% from July 2025 to August 2026, from 608,100 to 693,131 members.

- **Commitment to Quality program:** To address stakeholder concerns around program accountability, HCPF implemented the Commitment to Quality program which ties financial accountability to performance on defined standards throughout the RAE contract. The first year of ACC Phase III has been focused on the implementation of this program so that HCPF can report on individual and statewide performance in subsequent years.
- **Quality program:** In response to stakeholder feedback, HCPF updated the quality program to measure and pay provider performance at the individual level instead of the regional level, align performance measures across programs, and move towards a calendar year measurement period to create a more standard experience for providers that participate in quality programs with other payers. As part of the change to measure and pay individual performance, HCPF formalized in the RAE contracts that 75% of possible quality incentive funding is designated for PCMPs and 25% is designated for the RAEs. To effectively transition the program, the first 18 months of ACC Phase III are a transition period where providers are able to complete quality improvement activities aimed at improving clinical workflows and quality measure performance to earn quality incentive payments. An example of a current quality improvement activity is that the provider office is implementing a follow-up process for patients who have an elevated blood pressure reading that cannot be improved before they leave the office and they are incorporating specific coding for hypertension management. Initial program performance includes:
 - 798 out of 846 participating providers earned quality payment for their engagement in quality improvement activities from July 1 to December 31, 2025, which equals \$15.9 million in quality incentive payments
 - Additionally, RAEs are eligible to receive quality incentive payments based on the percentage of providers they have engaged in the quality program. The following table shows the amount of quality incentive payments that RAEs earned in the same time period. Data for provider and RAE performance in the first half of calendar year 2026 will be available in fall 2026.

Percent of Providers Engaged in Quality Improvement Activities and Quality Incentive Payment Earned by RAE

RAE	Percentage of Providers Engaged	Amount of Payment Earned
RAE 1 - RMHP	92%	\$2 million
RAE 2 - NHP	99%	\$1.92 million
RAE 3 - CCHA	92%	\$3.53 million
RAE 4 - COA	96%	\$4.7 million

Discussion: What Managed Care Has or Has Not Delivered in Colorado

In ACC Phase II, the following were accomplished as part of the structure of the ACC:

- Increased access to behavioral health services, as seen by the increased behavioral health penetration rate over the course of ACC Phase II as well as the increase in the number of behavioral health providers contracted with RAEs and providing behavioral health services to members.
- The ability to test and expand value-based payment programs that continue to pay providers for delivering high quality care and improving members outcomes. While the scale is still small, shared savings programs have demonstrated savings across multiple years and are continuing to expand. The managed care organization on the Western Slope (RMHP PRIME), which began as a payment reform pilot, has given providers additional value-based payment opportunities.
- One of the key reasons we have the structure we do is that the federal PCCM entity authority allowed us the flexibility to pay for care coordination services at a time when care coordination was not a billable service. There are some instances now where providers can bill for care coordination services (e.g., formal transitions of care codes), but those are still limited and often don't pay for the full value of the services provided.
- RAEs are authorized through our federal 1915(b)(3) waiver which also gives us expanded access to provide community based mental health and substance use disorder services.
- As regional organizations, the RAEs have unique expertise to support the diverse communities in their regions. For example, RMHP works closely with the Western Slope Native American Resource Center to better support their tribal communities. RAEs also serve as a boots-on-the-ground extension of HCPF and are able to respond more nimbly to policy changes and emerging issues. For example RAEs have been able to provide support to members and providers impacted by wildfires, such as during the Marshall Fire or the recent fires on the Western Slopes.
- The RAEs also have more flexibility in how they structure their programs to respond to changing policy direction at the federal and state level. And, as many of the RAEs are backed by national organizations, they are often able to bring more sophisticated tools and expertise to support this work. For example, as HCPF continues to address the sustainability of the Medicaid program, RAEs have been key partners in work to identify fraud, waste and abuse and enact other cost control measures, such as limiting their provider contracting.

The following are areas where we have not seen improvements over the years:

- Once Phase II began, we lost the ability to calculate avoidable costs/cost savings for members enrolled in the program. This is because all full-benefit members, except for those in PACE, are enrolled in the ACC. Because of this, we no longer have the ability to create a comparison group of members that are not part of a managed care program for these calculations. Additionally, review of available literature shows little connection between the use of managed care strategies and cost savings.

- Throughout the course of ACC Phase II, we paid out approximately 50% of available quality incentive metrics. While many quality metrics showed improvement over all seven years of the contract, there were still many that did not. However, performance was significantly impacted by the COVID-19 pandemic, so it's possible that we would have seen larger-scale performance improvements if not for the public health emergency.
- Issues with access to services still persist for certain populations. As seen with the interim evaluation for the SUD 1115 waiver demonstration, there is still significant room for improvement in ensuring access to appropriate services while reducing unnecessary utilization of emergency department and inpatient hospital services. Additionally, while HCPF is implementing CO-SOC, there is still significant room for improvement in access to and delivery of services for children and youth.
- Although we have made significant efforts to improve the availability of information to members about the Medicaid program, it remains a complex and challenging system to navigate. In some cases, the RAEs are helpful partners in outreaching members to get routine preventive care, access healthy reward programs, get enrolled in condition management programs, or inform them of key changes, like the end of continuous coverage during the PHE or upcoming work requirement and renewal changes with HR 1. However, we also receive the feedback that members receive too much communication between HCPF, the RAEs and other partners in the healthcare system which makes it harder for them to understand how to navigate the system.
- With the transition to ACC Phase III, we received a lot of feedback about administrative burden for providers. To address this, we reduced the number of regions across the state and therefore the number of RAEs a provider may need to work with and we standardized certain quality measures across programs and payers. However, we have received initial feedback from providers that some of the other changes made for Phase III to collect more accurate and actionable data about the program have led to further administrative burden for practices.

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