COLORADO
Department of Health Care Policy & Financing

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

September 1, 2020

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

Dear Representative Esgar:

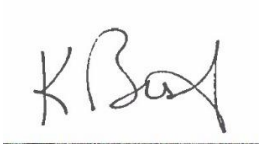
Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2018-2019 Medicaid Payment Reform and Innovation Pilot Program to the Joint Budget Committee.

*Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to submit a report by April 15, 2017 and each April 15 thereafter that a Medicaid payment reform and innovation pilot program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data.*

The Department received an extension on this year's report, which was prepared by the Colorado Health Institute. The Department operated two payment reform initiatives under Section 25.5-5-415 C.R.S. during fiscal year 2018-2019. This report provides a brief background on the initiatives, describes the payment methodologies and quality measures, provides performance data, and discusses how program design impacts clients and providers.

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

Sincerely,



Kim Bimestefer
Executive Director

KB/maq

Cc: Senator Dominick Moreno, Vice-chair, Joint Budget Committee
Representative Julie McCluskie, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

September 1, 2020

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

Dear Senator Fields:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2018-2019 Medicaid Payment Reform and Innovation Pilot Program to the Senate Health and Human Services Committee.

*Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to submit a report by April 15, 2017 and each April 15 thereafter that a Medicaid payment reform and innovation pilot program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data.*

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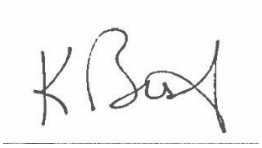

Kim Bimestefer
Executive Director

KB/maq

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

COLORADO
Department of Health Care Policy & Financing

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

September 1, 2020

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

Dear Representative Singer:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2018-2019 Medicaid Payment Reform and Innovation Pilot Program to the House Public Health Care and Human Services Committee.

*Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to submit a report by April 15, 2017 and each April 15 thereafter that a Medicaid payment reform and innovation pilot program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data.*

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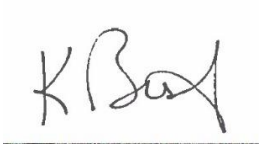

Kim Bimestefer
Executive Director

KB/maq

Cc: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Sonya Jacquez Lewis, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
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Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

September 1, 2020

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

Dear Representative Lontine:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2018-2019 Medicaid Payment Reform and Innovation Pilot Program to the House Health and Insurance Committee.

*Section 25.5-5-415 (4)(a)(III), C.R.S. requires the Department to submit a report by April 15, 2017 and each April 15 thereafter that a Medicaid payment reform and innovation pilot program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across all patients utilizing existing state department data.*

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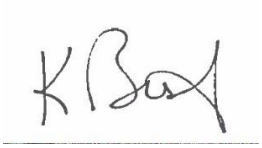

Kim Bimestefer
Executive Director

KB/maq

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
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Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

# Accountable Care Collaborative Payment Reform Program Report

## Fiscal Year 2018-19

**AUGUST 2020**

COLORADO
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# Accountable Care Collaborative Payment Reform Program Report

## Executive Summary

### Introduction and Background

The Department of Health Care Policy and Financing (HCPF) is required to provide an annual update on payment reform initiatives under Section 25.5-5-415, C.R.S. (also known as House Bill 12-1281). For Fiscal Year (FY) 2018-19, HCPF has contracted with the Colorado Health Institute (CHI) to conduct and present the results of the evaluation of payment projects as part of that requirement.

This report assesses the performance of the two existing payment reform initiatives: Rocky Mountain Health Plans (RMHP) Prime and Denver Health Medicaid Choice (DHMC). RMHP Prime operates on Colorado's Western Slope. DHMC is based in the Denver metro area. Combined, they operate in 10 counties. In FY 2018-19, they enrolled a combined average of 113,634 members (35,821 for RMHP Prime and 77,813 for DHMC) out of an average of 1,200,082 of all enrollees in Health First Colorado, the state's Medicaid program.[1]

Although both are managed care organizations (MCOs), the two plans are structured differently. RMHP Prime, a traditional MCO, contracts with a network of independent providers including primary care, adult and pediatric specialists, acute care, pharmacy, behavioral health, and emergency/urgent care. DHMC, a staff-model MCO, offers care at a main medical campus, nine family health centers, and 18 school-based health centers in the Denver metro area that are all owned and operated by Denver Health and Hospital Authority. In addition to the Denver Health network, DHMC also maintains contracts with other community providers such as STRIDE Community Health Center, UCHealth University of Colorado Hospital, and Children's Hospital Colorado.

Starting in FY 2018-19 with Phase II of the Accountable Care Collaborative, the contracts for the MCOs are part of combined administrative contracts for physical and behavioral health that HCPF has with the Regional Accountable Entities, or RAEs. HCPF pays the MCOs, via the contract with their respective RAE, a set monthly payment for enrolled members that covers a comprehensive set of physical health services, an arrangement known as full risk capitation.

HCPF also pays for behavioral health services via a set monthly payment to the RAEs. A limited number of other services and benefits, such as nursing facility costs or dental services, are not covered under the MCO capitation arrangement and are billed for and reimbursed via fee-for-service (FFS).

### Financial Performance

The entire set of services delivered to patients enrolled in the MCOs, whether paid for via capitation or FFS, makes up the total cost of care.[2]

In FY 2018-19, HCPF's total cost of care for members enrolled in RMHP Prime was $223.7 million. This is comprised of:

- $197.7 million for RMHP Prime physical health capitation payments
- $21.3 million for RAE behavioral health capitation payments, and
- $4.7 million for FFS payments for services not covered under capitation.

The physical health capitation payment amount is a slight decrease from the $198.4 million reported in FY 2017-18 (average enrollment decreased slightly as well). Behavioral health capitation payments and FFS payments for services not covered under capitation were not included in prior year reports.

HCPF's total cost of care for members enrolled in DHMC was $310.2 million. This is comprised of:

- $201.5 million for DHMC physical health capitation payments
- $41.2 million for RAE behavioral health capitation payments, and
- $67.4 million for FFS payments for services not covered under capitation.

Previous years' costs for DHMC members were not available for this evaluation. Summing individual payments does not exactly match the total cost of care due to rounding.

For each MCO, HCPF is required to set capitation rates at or below what the same population would cost under an FFS arrangement, otherwise known as the FFS equivalent. This requirement applies to the physical health services reimbursed under capitation and most directly influenceable by the MCOs.

Comparing payments between MCOs is not appropriate due to a variety of factors including differences in eligible populations and the rates paid for those populations, number of members enrolled, patient mix and acuity, and regional price variations.

## Quality Performance

One way that HCPF links plan performance to care quality is through four quality metrics tied to the Medical Loss Ratio (MLR). The MLR reflects how much money is spent on providing medical services compared to administrative services and profit. The more quality measures an MCO meets, the greater proportion of their payment they can allocate for administrative services and profit. How each MCO performed on their MLR quality measures is described in the sections on MCO-specific performance.

Other utilization measures of health outcomes and provider performance provide additional context to assess the quality of care delivered to MCO members. Both MCOs are measured on four additional metrics important to assessing health plan performance: hospital readmissions, emergency department visits, and behavioral health and primary care use.

## Quality Performance – Rocky Mountain Health Plans Prime

RMHP Prime shows improvement in most of the care quality metrics over the prior year while also reporting above average member satisfaction, with a few key areas to prioritize for improvement.

RMHP Prime exceeds the benchmark for performance on three of the four MLR metrics: measures related to chronic disease, preventive care, and patient support. When utilization

measures of health outcomes and provider performance were compared to the prior year, RMHP Prime's performance was mixed, with two measures — emergency department (ED) visits and behavioral health engagement — improving, primary care visits plateauing, and hospital readmissions increasing. RMHP Prime members reported above average satisfaction with their provider and health plan.

RMHP Prime did not meet the benchmark related to ED use for substance use disorder, and its rate of hospital readmissions following discharge increased from the prior year. These tend to be high-cost services and warrant further exploration.

## Quality Performance - Denver Health Medicaid Choice

DHMC meets or exceeds target performance on most of the care quality metrics and its providers receive above average ratings from their patients, but there are a few key areas for improvement.

DHMC exceeds the benchmark for performance set by HCPF on two of the four MLR metrics: measures related to child well-being and prenatal care. Looking at additional measures of health outcomes and provider performance identified by HCPF, DHMC outperformed a comparison group of RAE FFS members in three out of four, including hospital readmissions, ED visits, and behavioral health engagement.

Most DHMC members give favorable ratings to the plan and their provider. However, a lower proportion of DHMC members rated their health plan favorably compared to the average of all RAE members. DHMC also did not meet the MLR benchmarks related to diabetes screening and childhood immunizations, and performed worse than the comparison group on a measure of access to primary care.

This is the first year that DHMC is included in this annual update to the legislature on payment reform initiatives in Health First Colorado, the state's Medicaid program. Its inclusion provides the legislature and key audiences with greater awareness of the program as well as its performance, strengths, and opportunities for improvement.

## Limitations and Looking Ahead

This evaluation does not attempt to quantify the amount of cost savings (if any) created for Health First Colorado by the MCOs. Additionally, comparison groups included in this analysis are not fully adjusted for patient mix and patient acuity. They are presented in that context as one comparison point but not an assessment of strong or weak performance on any given measure.

CHI is making recommendations to HCPF about how to address some of the data limitations identified in this report and expand the evaluation approach for the FY 2019-20 report.

## Introduction

The Department of Health Care Policy and Financing (HCPF) is required to provide an annual update on payment reform initiatives under Section 25.5-5-415, C.R.S. (also known as House Bill 12-1281). For Fiscal Year (FY) 2018-19, HCPF has contracted with the Colorado Health Institute (CHI) to conduct and present the results of the evaluation of payment projects as part of that requirement. This report is intended to satisfy that requirement by assessing the performance of the two existing payment reform initiatives — Rocky Mountain Health Plans (RMHP) Prime and Denver Health Medicaid Choice (DHMC). This is the first year DHMC has been included in the annual report on HCPF payment reform initiatives.

## Methods

CHI developed the evaluation design based on statutory requirements, including analysis of the data and information concerning the utilization of the payment methodology, an assessment of how the payment methodology drives provider performance and participation, the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, patient satisfaction, and comparing those outcomes across patients utilizing existing state department data.

The evaluation design also draws from annual reports from prior years, CHI's experience evaluating payment reform initiatives, and input from HCPF staff.

The overall approach for the evaluation was to assess whether the MCOs have been able to provide an improved care experience for their members, how they compare against any goals set for their own performance, and whether they show improvement over time.

CHI analyzed quantitative data from a variety of sources to evaluate MCO performance. CHI also performed qualitative data collection activities for additional context and to address gaps in the quantitative data. The qualitative approach was targeted to gain maximum insight for the purposes of the evaluation while minimizing the burden on stakeholders working on efforts related to COVID-19 response. Quantitative data is explicitly referenced throughout the report, while findings from qualitative data gathering underpin and inform the report but are not always explicitly referenced.

Much of the data included in this report was provided to CHI by HCPF's Data Analytics Section, including data on patient enrollment, care quality, provider performance, health outcomes, and plan expenditures. CHI supplemented those data with patient experience survey data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and quantitative and qualitative data provided by the MCOs themselves. Additional detail about quantitative data used for this report, including source information and details about any comparison group used, can be found in the Methods Appendix.

HCPF and the MCOs were given the opportunity to review and provide feedback on a draft version of the evaluation. Incorporating feedback from any stakeholder was done at CHI's discretion as the independent evaluator.

## Managed Care Organization Overviews

FY 2018-19 marked the beginning of Phase II for the Accountable Care Collaborative (ACC), the delivery system for all members of Health First Colorado, the state's Medicaid program. For Phase II, one entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions. In order to promote comprehensive and coordinated care for members, the RAEs contract with a network of Primary Care Medical Providers (PCMPs) to serve as members' central point of care. The RAE also provides or arranges for the delivery of mental health and substance use disorder services as the administrator of HCPF's capitated behavioral health benefit. Combining these responsibilities under one entity is intended to improve the member experience and member health by establishing one point of contact and clear accountability for treating the whole person. HCPF also implemented mandatory enrollment into the ACC for all full-benefit Health First Colorado members, excluding those enrolled in the Program of All-Inclusive Care for the Elderly.

With this new structure, HCPF intends for all payment reform initiatives to operate within the ACC model. The ACC Phase II Request for Proposal process allowed offerors to propose limited managed care capitation initiatives in accordance with Section 25.5-5-415, C.R.S. as part of proposals for RAE Regions 1 and 5. Through a procurement process, HCPF contracted with the RAEs to continue the RMHP Prime and DHMC capitated managed care programs. RMHP Prime operates on Colorado's Western Slope. DHMC is based in the Denver metro area. Combined, the two plans operate in 10 counties. In FY 2018-19, they enrolled a combined average of 113,634 members out of an average of 1,200,082 of all Health First Colorado enrollees.[3] HCPF pays both organizations a set monthly fee in exchange for covering a comprehensive set of physical health services for its participating members, an arrangement known as full risk capitation. The monthly fee is a prospectively set amount based on expected health costs. If actual health costs differ from expected costs, the MCO stands to gain or lose the difference.

Another way HCPF links plan performance to care quality is through four quality metrics tied to the Medical Loss Ratio (MLR). The MLR reflects how much money is spent providing medical services compared with the amount spent on administrative services and profit. The more quality measures an MCO meets, the greater proportion of its payment it can allocate for administrative services and profit. Each MCO has different MLR measures that change from year to year. For RMHP Prime, the MLR measures are electronic Clinical Quality Measures (eCQMs) that were provided to CHI by HCPF for the purposes of this evaluation. For DHMC, the MLR measures are annual Healthcare Effectiveness Data and Information Set (HEDIS) measures that were calculated by the MCO, validated by an external quality review organization, and provided to HCPF.

Although both are MCOs, the two plans are structured differently. RMHP Prime, a traditional MCO, contracts with a network of independent providers, including primary care practices, specialists, and behavioral health providers. DHMC, a staff-model MCO, offers care at a main medical campus, nine family health centers, and 18 school-based health centers in the Denver metro area that are all owned and operated by Denver Health and Hospital Authority.

## Program Summary – Rocky Mountain Health Plans Prime

RMHP operated the Region 1 Regional Care Collaborative Organization (RCCO) as part of the ACC from 2011 through FY 2017-18. Starting in FY 2018-19 with Phase II of the ACC, the administration of physical and behavioral health was united under one regional entity, the RAE, which was the successor to the RCCO and Behavioral Health Organization (BHO). RMHP has operated the Region 1 RAE since the beginning of ACC Phase II on July 1, 2018.

In September 2014, RMHP implemented RMHP Prime to serve members in six counties in Region 1: Garfield, Gunnison, Montrose, Mesa, Pitkin, and Rio Blanco.

RMHP Prime's network consists of a comprehensive set of independent providers, including primary care, adult and pediatric specialists, acute care, pharmacy, behavioral health, and emergency/urgent care. RMHP Prime offers PCMPs the opportunity to participate in a payment reform program. The 52 participating PCMPs receive a single sub-capitation payment each month to cover the cost of all the practice's services for the members who are under the practice's care. This payment is calculated based on the number of participating members who are attributed to the practice. Payments to each practice are risk-adjusted, so the practices are not incentivized to exclude sicker or older members. An average of 16,258 monthly members were attributed to 52 practices participating in RMHP Prime payment reform program during FY 2018-19.

Under RMHP Prime's payment reform program, PCMP practices have both *upside* and *downside* financial risk. If a PCMP practice's actual costs exceed the sub-capitation payment, RMHP Prime takes back 5% of the practice's payment for that month. However, if a PCMP practice's expenditures were lower than expected and the practice met relevant quality targets, RMHP Prime will share savings at the end of the year. Savings are also shared with community mental health centers in the region that meet contractual requirements to work with the RMHP health engagement team and to support the coordination of physical and behavioral health care.

### *Enrollment and Member Population*

The majority of RMHP Prime members are adults. The only children enrolled in RMHP Prime are those with disabilities. Eligible members are automatically enrolled in the program on an ongoing basis. Members who do not wish to participate have 90 days to opt out after their initial enrollment, and then can opt out at least once every 12 months of enrollment. In FY 2018-19, monthly enrollment in RMHP Prime averaged 35,821 members, a decrease from the monthly average of 36,487 the previous year.

## Program Summary – Denver Health Medicaid Choice

DHMC has operated as an MCO in Colorado since 2004. DHMC operates in Adams, Arapahoe, Denver, and Jefferson counties. DHMC is owned and operated by Denver Health Medical Plan, which is the fully owned subsidiary of Denver Health and Hospital Authority (DHHA). DHMC is a staff-model MCO, meaning rather than contracting with a network of providers to offer care to its enrollees, DHHA operates the medical facilities and employs the providers at those facilities. DHMC members can get care at the Denver Health main campus in downtown Denver, at any of Denver Health's nine Family Health Centers throughout metro Denver, and at the 18 school-

based health centers also operated by Denver Health.[4] In addition to the Denver Health network, DHMC also maintains contracts with community providers such as STRIDE Community Health Center, UCHealth University of Colorado Hospital, and Children's Hospital Colorado that members can receive services through with a referral from their provider. Starting in 2020, DHMC members can receive services at STRIDE Community Health Center without a referral.

During the evaluation period, DHMC was a subcontractor to Colorado Access, the RAE for Regions 3 and 5, and was responsible for delivering physical health services. HCPF's contract was with Colorado Access, as the RAE, to administer both physical and behavioral health services. Colorado Access subcontracted with DHMC to administer the physical health portion of the contract via the MCO.

Starting in January 2020, HCPF contracted directly with DHMC to provide both physical and behavioral health services to its members. DHMC subcontracts with Colorado Access for most behavioral health services.

### *Enrollment and Member Population*

DHMC monthly enrollment averaged 77,813 members in FY 2018-19. Eligible members are automatically enrolled in the program on an ongoing basis. Although DHMC operates in Adams, Arapahoe, Denver, and Jefferson counties, only members in Denver County are automatically enrolled. Members outside of Denver County must opt in to DHMC coverage. New members have 90 days to opt out of their enrollment. Unlike RMHP Prime, children can be enrolled in DHMC regardless of their health status.

## Managed Care Organization Performance

### Financial Performance

Under Phase II of the ACC, the contracts for the MCOs are part of combined administrative contracts for physical and behavioral health that HCPF has with the RAEs. HCPF pays the MCOs a set monthly payment for enrolled members that covers a comprehensive set of physical health services via the contract with their respective RAE. HCPF also pays for behavioral health services via a set monthly payment to the RAEs. A limited number of other services and benefits, such as nursing facility costs or dental services, are not covered under the MCO capitation arrangement and are billed for and reimbursed via fee-for-service (FFS). With the transition to Phase II, HCPF implemented a new policy that enabled PCMPs to bill via FFS for six short-term behavioral health visits. The cost of these visits has been calculated as part of the physical health capitation payments MCOs receive from HCPF.

The entire set of services delivered to patients enrolled in the MCOs, whether paid for via capitation or FFS, makes up the total cost of care.[5]

In FY 2018-19, HCPF's total cost of care for members enrolled in RMHP Prime was $223.7 million. This is comprised of:

- $197.7 million for RMHP Prime physical health capitation payments
- $21.3 million for RAE behavioral health capitation payments, and
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The physical health capitation payment amount is a slight decrease from the $198.4 million reported in FY 2017-18 (average enrollment decreased slightly as well). Behavioral health capitation payments and FFS payments for services not covered under capitation were not included in prior year reports.

HCPF's total cost of care for members enrolled in DHMC was $310.2 million. This is comprised of:

- $201.5 million for DHMC physical health capitation payments
- $41.2 million for RAE behavioral health capitation payments, and
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Previous years' costs for DHMC members were not available for this evaluation. Summing individual payments does not exactly match the total cost of care due to rounding.

For each MCO, HCPF is required to set capitation rates at or below what the same population would cost under an FFS arrangement, otherwise known as the FFS equivalent. This requirement applies to the physical health services reimbursed under capitation and most directly influenceable by the MCOs.

Comparing payments between MCOs is not appropriate due to a variety of factors including differences in eligible populations and the rates paid for those populations, number of members enrolled, patient mix and acuity, and regional price variations.

Initiatives the MCOs have implemented to produce savings while maintaining care quality are described in later sections of this report, as well as pattern of care metrics such as emergency department (ED) visits and hospital readmissions that can provide an indirect view into how the MCOs may be able to drive savings.

## The Importance of Using the Right Comparison

Identifying a valid comparison is important in evaluating MCO performance. In this report, CHI applied three types of comparisons depending on the metrics. MCO performance on the MLR metrics, for example, (Tables 1 and 4) is compared against benchmark values established by HCPF and each MCO. Health outcomes and provider performance metrics for RMHP Prime (Table 2) are compared over time, when available, to those in the FY 2017-18 report. Similar measures for DHMC are assessed against a comparison group of RAE FFS members (Table 4). Patient experience measures reported for both MCOs (displayed in Tables 3 and 6) are compared against the aggregate performance of all RAEs.

Identifying a valid comparison group is challenging because the populations being compared may differ in fundamental ways. For example, comparing hospital admission rates between a group that has a disproportionate number of older adults and a group with a disproportionate number of younger adults may not be valid, as the older group will likely have greater health needs that result in hospitalizations.

Quantitative methods can be applied to approximate an apples-to-apples comparison. These methods — such as normalization or risk adjustment — attempt to control for underlying differences in age, health status, or other characteristics. HCPF and CHI continue to refine their

approach to identifying valid comparison groups for assessing MCO performance. See the appendix for more detail on comparison groups used in this evaluation.

## Program Performance – Rocky Mountain Health Plans Prime

### *Evaluator Assessment*

RMHP Prime exceeds 3 of the 4 MLR metrics and receives high scores from members on their experience with the health plan. When utilization measures of health outcomes and provider performance were compared to the prior year, RMHP Prime's performance was mixed, with two measures — ED visits and behavioral health engagement — improving, PCMP visits plateauing, and hospital readmissions increasing.

RMHP's performance is likely due to a combination of structural, strategic, and contextual factors. Structurally, the capitated, sub-capitated, and shared savings arrangements within RMHP Prime allow contracted providers a degree of flexibility in care provision not available to those outside of RMHP Prime contracts. Two primary areas of flexibility include: 1) The ability to perform additional assessments and screenings like the Patient Activation Measure (PAM®), which measures a patient's ability to self-manage their health; and 2) Support for integrated behavioral health. RMHP Prime practices were better prepared to overcome barriers to offering integrated behavioral health services through supports from RMHP Prime including behavioral health credentialing.

RMHP Prime has also employed a variety of strategic measures to achieve its goals. RMHP Prime pushed HCPF to move metrics away from HEDIS and toward eCQM measures, which allow practices to have greater ability to make course corrections. RMHP Prime has equipped practices with a variety of data and reports to optimize care for patients. The MCO further supports practices through practice transformation staff and educational opportunities intended to spread the use of best practices.

Contextual factors — those not necessarily within RMHP Prime's control — are important to acknowledge as well. Many practices in RMHP Prime's network also participate in the national Comprehensive Primary Care Plus (CPC+) program. RMHP Prime members may experience carry-over effect from practice transformation efforts incentivized by CPC+ and other payers. Finally, the launch of ACC Phase II and the RAEs in FY 2018-19 may have improved RMHP Prime's scores on behavioral health metrics. For example, depression screenings may have gone up because primary care practices now have the ability to be reimbursed for up to six short-term behavioral health visits.

There are a few key areas to prioritize for improvement. RMHP Prime did not meet the benchmark related to ED use for substance use disorder (SUD), and its rate of hospital readmissions following discharge increased from the prior year. These tend to be high-cost services and deserve to be explored further.

### *Care Quality and Medical Loss Ratio Metrics*

RMHP Prime's MLR is adjusted based on its performance on four quality measures across the care domains of ED use, chronic disease, preventive care, and patient support. The benchmarks are established in negotiations between RMHP Prime and HCPF and are typically set at what the

parties determine is a reasonable target for improvement based on past performance. Overall, RMHP Prime performed above the established benchmark for three of the four measures.

In FY 2018-19, a metric measuring how many adult RMHP Prime members received a body mass index (BMI) assessment was replaced with the rate of ED visits for SUD. This change was made because RMHP Prime was performing at a very high level (performing BMI assessments on 97.5% of adults in FY 2017-18), which left little opportunity for improvement. The new metric, Rate of ED visits for Substance Use Disorder (SUD), was selected by HCPF to align RMHP Prime with a RAE behavioral health benefit and metric and provide an additional lever to advance HCPF's efforts to improve SUD treatment performance across its delivery system. This change also increased alignment with RAE performance measurement. Under the Behavioral Health Incentive Program, RAEs are incentivized to increase member engagement with outpatient SUD treatment and to follow-up after members visit the ED for SUD.

In FY 2018-19, RMHP Prime did not achieve the benchmark on this new measure (Rate of ED visits for SUD). It did meet the other three benchmarks (see Table 1).

**Table 1. RMHP Prime Performance on Care Quality and MLR Metrics compared to Performance Benchmarks, FY 2018-19**

| Metric | Performance | Benchmark |
|---|---|---|
| Rate of ED visits for SUD | 19.1/1,000 | 17.5/1,000 |
| HbA1c poor control (>9.0%) | 20.1% | 23.5% |
| Depression screening and follow up | 66.4% | 64.0% |
| Patient Activation Measure (PAM®) | 43.2% | 41.0% |

*Source: HCPF*

### *Rate of ED Visits for SUD*

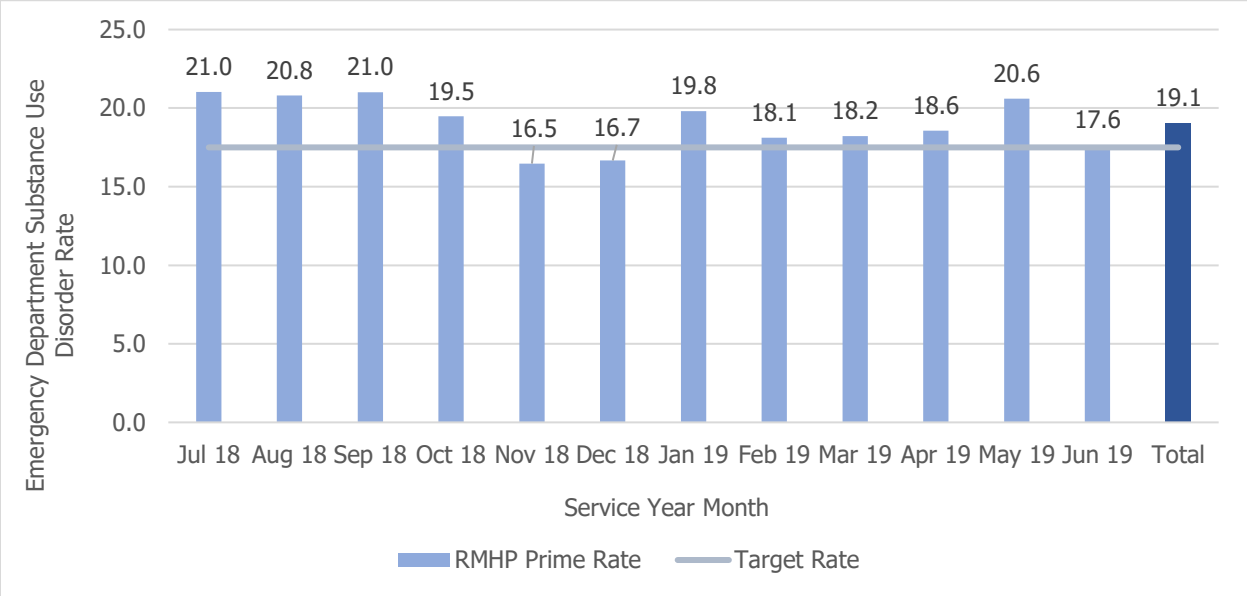
This metric is defined as the number of ED visits for SUD per 1,000 member months per year. The rate of ED visits due to SUD among RMHP Prime members was 19.1 ED visits per 1,000 member months in FY 2018-19. Prime did not meet the benchmark of 17.5 visits per 1,000 member months.

Although RMHP Prime did not meet the benchmark the entirety of FY 2018-19, Figure 1 shows that Prime either outperformed the benchmark or was within one visit per 1,000 member months for five of 12 months. This suggests that the metric is within reach of RMHP Prime and begs the question of whether temporal patterns or other considerations associated with SUD-related ED use may inform how to improve performance on this metric.

RMHP Prime has employed strategies to make sure practices have the tools they need to monitor ED utilization for individuals with behavioral health issues. These strategies include

using RMHP's Practice Transformation Team to conduct one-on-one coaching, learning events focused on particular topics like SUD eCQMs, and education with practices to ensure they have strong care coordination. RMHP also built upon past strategies, such as coordinating with behavioral health providers and increasing practices' capacity to serve members with complex needs. During the evaluation period, RMHP Prime practices also had the ability to filter reports by mental health diagnosis to ensure that patients who use the ED received the appropriate level of care coordination.

**Figure 1. Monthly ED Visit Rate for SUD per 1,000 Member Months, RMHP Prime, FY 2018-19**




*Source: HCPF*

### *HbA1c Poor Control*

This metric measures the percentage of members with a diagnosis of diabetes whose HbA1c level was above 9.0%, suggesting poor control of the disease. In FY 2018-19, RMHP Prime performed better than the benchmark of 23.5%, with 20.1% of members with diabetes scoring above 9.0%. RMHP Prime showed improvement from FY 2017-18 performance of 27.9%, which also outperformed that year's benchmark. RMHP Prime has shown improvement in this measure and outperformed the benchmark every year since FY 2015-16.

RMHP's Practice Transformation Team offers support to providers in the form of resources and education on HbA1c and other chronic conditions. RMHP develops eCQM-specific toolkits that include clinical recommendations, rationale behind the measures, and considerations for clinical workflows. RMHP also employs clinical informaticists to train physicians in how to document, pull reports, and leverage health information technology to help patients manage diabetes.

### *Depression Screening and Follow Up*

The third metric considered for the MLR measures the percentage of members ages 12 years and older for whom an age-appropriate clinical depression screening was conducted and, if

positive, a follow-up was documented. Follow-ups may include a referral to therapy, medication initiation, or additional screenings. In FY 2018-19, RMHP Prime's performance (66.4%) was better than the benchmark of 64.0%. RMHP Prime met this benchmark in FY 2017-18 as well.

RMHP Prime conducted education and in-person learning collaboratives for clinicians on approaches for conducting screenings and follow up. RMHP Prime also attributes its success on this depression screening metric to the advent of the RAEs and the ability of primary care practices to be reimbursed for up to six short-term behavioral health visits. This change also increases alignment of performance measures between MCO and RAE—the metric is also used to measure RAE performance under the Behavioral Health Incentive Program.

### *PAM®: Coaching for Activation*

The PAM® is a 22-item assessment of a patient's knowledge, confidence, and skill in managing their health. The MLR measure for RMHP Prime establishes a benchmark of at least 41.0% of members who had an initial PAM® score of 1, 2, or 3 — signaling a lower level of patient "activation" — completed a follow-up PAM® by the end of June 2019. For the second year in a row, RMHP Prime has performed better than the benchmark. In FY 2018-19, 43.2% of patients with a low activation score received a follow-up assessment within the measurement period.

Of RMHP Prime practices participating in the payment reform program, 40 (about 71%) use the PAM® and around half of Prime members have received the assessment.[6] Because the PAM is not currently reimbursed for by Health First Colorado, staff at RMHP Prime said that many practices would not use this assessment were it not for the flexibility of the capitated model within RMHP Prime. The PAM® represents an investment of clinical time and resources, and there is a fair amount of subjectivity in how it is completed. Uptake has also been uneven throughout the network, with the high score attributable to a subset of practices that have embraced the utility of the PAM®. RMHP Prime is working with high-performing providers to disseminate best practices in the use of the PAM®. In July 2019, RMHP Prime launched a PAM® pilot program with a subset of practices. The pilot ran through June 2020. The goal is to provide support to practices and encourage the use of best practices with the PAM® to improve members' management of their health. Although outside of the evaluation period of this report, the success of the pilot will be a consideration for RMHP Prime's subsequent performance on this metric.

### *Health Outcomes and Provider Performance Metrics*

Additional metrics provide context to assess the quality of RMHP Prime members' care and how it has changed over time. Overall, RMHP Prime's performance improved on two out of four metrics and stayed the same on a third. Performance worsened in only one metric, hospital all-cause readmission rate.

**Table 2. RMHP Prime Performance on Health Outcomes and Provider Performance Metrics, FY 2018-19 and FY 2017-18**

| Metric | FY 2018-19 Performance | FY 2017-18 Performance |
|---|---|---|
| Hospital all-cause readmission rate | 10.6% | 9.5% |
| Emergency department visits | 862 visits per 1,000 members | 898 visits per 1,000 members |
| Behavioral health engagement rate | 22.9% | 19.7% |
| Members with one or more visits to a Primary Care Medical Provider | 69.1% | 69.2% |

*Source: HCPF*

### *Hospital All-cause Readmission Rate*

A readmission to a hospital after discharge is likely to be expensive and may signal that a patient required additional care management after initially being discharged. This metric measures the rate of hospital readmissions for any cause within 30 days of hospital discharge. It assesses a plan's ability to effectively care for high-risk members and prevent unnecessary high cost services. The following conditions are not included: pregnancy, perinatal conditions, chemotherapy, rehabilitation, organ transplants, and planned procedures.

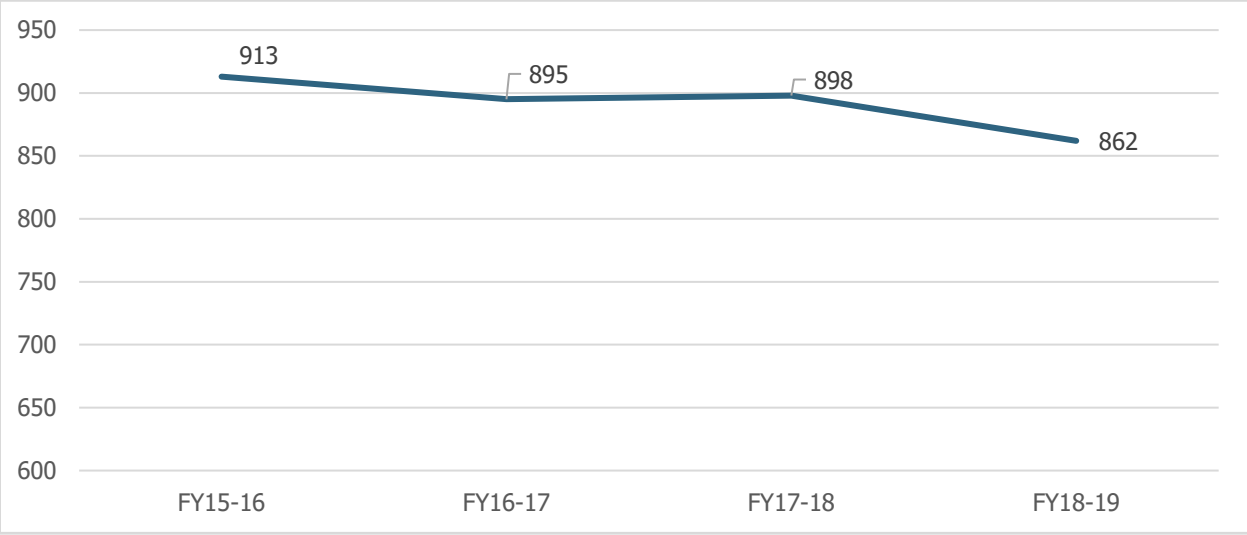
In FY 2018-19, RMHP Prime had a readmission rate of 10.6%, compared to 9.5% in FY 2017-18. Reasons for the higher readmission rate in FY 2018-19 compared to FY 2017-18 are unclear. RMHP Prime calls members within seven days of a hospital discharge, making sure that the member understands their discharge plan, has a follow-up appointment scheduled, and explores if medication management is needed. RHMP Prime is examining how these strategies can be used to improve this metric.

### *Emergency Department Visits*

Like hospital readmissions, visits to a hospital ED can be costly and may indicate that improvements are needed in care management services and/or access to primary care services. It has been used to measure RMHP Prime performance since FY 2015-16. In FY 2018-19, RMHP Prime had 862 ED visits per 1,000 members, compared to 898 ED visits per 1,000 members in FY 2017-18. Figure 2 shows that ED visits among RMHP Prime members have generally trended downward since FY 2015-16.

The strategies RMHP Prime uses to address ED visits include coaching and education with practices, coordinating with behavioral health providers, and increasing practices' capacity to serve members with complex needs. These approaches are discussed earlier in the MLR section. Finally, practices receive alerts from Quality Health Network (QHN) — the region's health information exchange — when a member visits the ED.

**Figure 2. Emergency Department Visits per 1,000 Members, RMHP Prime, 2015-2019**




*Source: HCPF*

### *Behavioral Health Engagement Rate*

FY 2018-19 marked the launch of ACC Phase II and the RAEs. One of the biggest changes brought about by Phase II was the administrative integration of the physical health and behavioral functions performed by the RCCOs and the BHOs. The intention was to improve access to behavioral health services for Health First Colorado members while improving efficiency. Although the RAE structure was new in FY 2018-19, RMHP Prime has been measured on behavioral health engagement since FY 2015-16. Another change in Phase II allowed PCMPs to bill for up to six short-term behavioral health visits.

The behavioral health engagement metric is a Key Performance Indicator (KPI) throughout the ACC. For RMHP Prime, it measures the percentage of RMHP Prime members who received at least one behavioral health service. Behavioral health services counting toward this measure could include visits to a behavioral health provider under RAE capitation or the short-term behavioral health visits provided by a PCMP in the past 12 months. In FY 2018-19, 22.9% of Prime members received a behavioral health service, an increase from 19.7% in FY 2017-18.

Overall, the behavioral health engagement rate for RMHP Prime has gone up since the measure was first reported in FY 2015-16. This may be due to a combination of factors. The six short-term behavioral health visits provided by the PCMP may be a driver of behavioral health engagement. Practices report that RMHP Prime's shared savings programs — in combination with the capitation — provides them with more flexibility in terms of how they use their integrated behavioral health providers. This may increase access to behavioral health services for RMHP Prime members. RMHP Prime supports practices trying to integrate care in a variety of ways described in the Provider Support section.

### *Members With at Least One Visit to a PCMP*

Access to a primary care provider is a proxy for effective utilization of the medical home model, which is a key tenet of the ACC. In FY 2018-19, 69.1% of RMHP Prime members visited a PCMP, virtually unchanged from the FY 2017-18 rate, 69.2%.

A number of factors may contribute to the percentage of RMHP Prime members who engaged with their PCMP. First, the strategies Prime uses to ensure patients have access to primary care — such as attribution reports and care coordination, as described in the Provider Support and Experience section — likely have an effect.

A number of practices in RMHP Prime's network are also participating in the national CPC+ program. CPC+ incentivizes participating practices to improve continuity of care, care management, comprehensiveness of care, patient engagement — among other strategies — with a variety of value-based payments.[7]

### *Provider Support and Experience*

Given that RMHP Prime is a network MCO, it maintains contractual relationships with a variety of providers throughout its six-county region. There was not quantitative data available on provider experience or provider support, so CHI's evaluation in this area is based on qualitative interviews with providers and RMHP Prime staff. It is unclear how representative the provider perspectives gained through the interviews are of the entire provider network.

Overall, providers cited positive aspects of contracting with RMHP Prime. Key themes included:

- Overall, capitation in RMHP Prime has produced care flexibility and good outcomes for patients.
- Initial concern over the capitation rate has diminished over time, though there is still concern that the rate is too low for complex patients.
- RMHP Prime care managers assist practices with contact and care management for patients who are hard to reach.
- RMHP provides support for behavioral health credentialing and setting up integrated practices. Members' adherence to behavioral health treatment improves once the service is brought in-house at the practice.

CHI identified three primary strategies that RMHP uses to engage and support practices. Except where noted, this support is available to all practices in Region 1 and not only those contracted with RMHP Prime. Strategies include:

- *Support and Education*. RMHP provides staff expertise and resources for its practices on a regular basis.
    - Value-Based Contract Office Hours — which RMHP started at the beginning of FY 2018-19 — give practices dedicated time each month to connect with RMHP, ask questions, learn about changes in metrics, engage with other practices, and engage in dialogue. A recent session was focused on best practices for helping patients manage diabetes.
    - RMHP convenes periodic learning events focused on integrating behavioral health and care coordination that are open to all practices in Region 1.

    - RMHP's Practice Transformation Team supports the development of team-based care and patient-centered medical home model. Practices have the opportunity to move through a four-stage "practice transformation trajectory" — incorporating best practices of team-based care, risk stratification, etc. — with the eventual goal of achieving patient-centered medical home recognition by the National Committee on Quality Assurance.
    - RMHP Prime provides training and regular reports to support practices in the use of the PAM®, described earlier in this report.
- *Data and Reports*. RMHP Prime's Monthly Attribution Report provides a variety of data tools and insights to practices in its network.
    - RMHP Prime uses a stratification model to inform the level of care coordination that patients may need. The MCO provides practices with regular risk-stratification data.
    - The Prime Monthly Attribution Report contains member-level and practice-level cost and utilization financial information for monitoring performance.
    - Every RMHP Prime practice receives individual patient risk scores, other performance scores, and claims history. This enables practices to identify patients who use a high number of health services, which, when used with the risk stratification process, can identify what interventions may be needed.
- *Contracting and Shared Savings*. The contracting and shared savings arrangements between RMHP and practices are intended to incentivize practices to provide quality care and promote efficiency. Two examples include:
    - RMHP Prime supports practices participating in CMS' CPC+ program through flexible contracts that allow practices to decide how to reinvest dollars into their practice to expand integrated care.
    - Region 1 practices participate in RMHP's tiering program. Practices have the ability to move along the "practice transformation trajectory," meeting established criteria and moving between four tiers. Criteria address access to care, continuity of care, care management, patient/caregiver engagement, and quality improvement. The higher the tier, the greater the financial incentives.

### *Member Experience*

A majority of RMHP Prime members surveyed through the 2019 CAHPS gave favorable ratings to their providers and health care experiences. When a comparison is available, these ratings are higher than the comparison group of all RAE members (Table 3).

In particular, almost all respondents (95.1%) were pleased with how their provider communicated with them, compared to 73.9% in the comparison group. Four out of five RMHP Prime members (82.6%) reported receiving care as soon as needed. One area for further exploration was the 69.1% of RMHP Prime members who rated their health plan favorably. This was the lowest of the scores, though it still represents almost seven out of 10 RMHP Prime members and is nearly nine percentage points higher than the comparison group.

The 2019 CAHPS scores for RMHP Prime are similar to consumer ratings from FY 2017-18. With one exception, RMHP Prime's scores improved from the previous year. The exception was the percentage of respondents reporting that they received care as soon as needed, which dropped from 85.8% in FY 2017-18 to 82.6% in FY 2018-19, a difference of 3.2 percentage points.

**Table 3. Patient Ratings of Their Care Experience, RMHP Prime and Comparison Group, 2019**

| Metric | FY 2018-19 Performance | FY 2018-19 Comparison Group* |
|---|---|---|
| Percentage of respondents rating their provider favorably | 74.4% | 63.6% |
| Percentage of respondents rating their health plan favorably | 69.1% | 60.3% |
| Percentage of respondents pleased with how their provider communicates with them | 95.1% | 73.9% |
| Percentage of respondents reporting receiving care as soon as needed. | 82.6% | N/A |
| Percentage of respondents reporting receiving the care they needed | 84.2% | N/A |

**Comparison group is all RAE members*
*Source: 2019 Colorado Patient-Centered Medical Home Survey Adult Report*

RMHP Prime staff attribute the scores to a variety of factors:

- RAE staff generally struggle to obtain contact information from members. However, staff reaching out to RMHP Prime members have a better success rate of outreach and engagement compared to staff reaching out to RAE FFS members.
- The relationship between RMHP Prime payment reform program practices and their members is generally stronger and more structured due to value-based arrangements such as the shared savings program.
- A number of practices in RMHP Prime also participate in the CPC+ program and are eligible for a larger amount of shared savings if they meet certain targets. The CPC+ program emphasizes CAHPS scores and ties value-based payments from Medicare to the scores. The changes that practices are putting into place are benefiting RMHP Prime members even if they are coming from a different program (Medicare).

United Healthcare, which owns RMHP, administers its own consumer satisfaction assessment, called the Net Promoter Score (NPS). The NPS measures the likelihood that a member will recommend RHMP Prime to somebody else. The NPS ranges from -100 to +100. A score of -100 means that everybody surveyed was a "detractor," while a score of +100 signifies that everybody surveyed was a "promoter." In 2019, United Healthcare's assessment of 96 RMHP Prime members resulted in a score of 43, signifying that most people were satisfied with the plan, its coverage, access, and availability of customer service. A score of 50 is considered to be excellent performance. RMHP Prime's goal is to increase its score to 70 by 2023.

### *Challenges*

CHI identified several challenges in evaluating RMHP Prime. First, a wide variety of providers participate in RMHP Prime's network over a vast geographic area. Practices range from independent solo practitioners to large multi-site Federally Qualified Health Centers. It is difficult to assess the impact of RMHP Prime across this broad network. For example, many providers shared that there is no difference in their care coordination approach for members inside or outside of RMHP Prime. Additionally, RMHP Prime supports practices' participation in CPC+, and it is difficult to understand the extent to which CPC+ serves as a confounding influence on evaluation metrics.

Limitations in metrics and data availability make it difficult to obtain an accurate picture of what is happening in the MCO. For example, a limitation of the behavioral health engagement rate metric is that it does not directly account for the fact that some members do not need behavioral health services. Changes in comparison group definitions and limitations of risk adjustment methods make apples-to-apples comparisons difficult.

Finally, due to external constraints, formal qualitative data collection on the patient perspective was limited to one patient. Although the interview with the patient provided a valuable perspective, concerns about the representativeness and anonymity of a single patient perspective limited the usability of those findings.

## Program Performance – Denver Health Medicaid Choice

### *Evaluator Assessment*

DHMC meets or exceeds targets and benchmarks on most of the care quality measures that HCPF has prioritized. This could be a result of DHMC's close relationship with DHHA (DHMC is owned and operated by Denver Health Medical Plan which is the wholly owned subsidiary of DHHA). DHMC aligns with DHHA's multidisciplinary quality improvement activities that apply data and evidence to inform and continually improve care delivery. Its 2019 Quality Improvement Plan cited the plan's collaboration with Denver Health's Ambulatory Care Services leadership and clinical quality work groups on its Medical Loss Ratio measures, which it has met benchmarks for two of the four in FY 2018-19.[8]

DHMC contracts with Denver Health providers who deliver care in this unique multispecialty ambulatory and acute care setting. DHMC providers cite benefits of operating in a closed system, such as efficient care coordination and communication across providers. DHMC outperforms the comparison group on several metrics that can be responsive to this type of care delivery environment, such as hospital readmissions and ED visits. Most patients give favorable ratings to the plan and their providers.

That said, DHMC lags the benchmark or shows little or no improvement over time on several key measures. DHMC recognizes these challenges and has identified strategies for improvement. Changes in large systems take time and should be monitored for and assessed in the next evaluation.

This is the first year that DHMC is included in this annual update to the legislature on payment reform initiatives in Health First Colorado, the state's Medicaid program. Its inclusion provides the legislature and key audiences with greater awareness of the program as well as its performance, strengths, and opportunities for improvement.

### *Care Quality and Medical Loss Ratio Metrics*

DHMC's Medical Loss Ratio is adjusted based on its performance on four quality measures across care domains including pediatric care, chronic disease, and access to care (see Table 4). The benchmarks are established based on the National Committee for Quality Assurance's 90$^{th}$ percentile (of national performance on the measure), with DHMC required to close the gap between its current performance and the 90$^{th}$ percentile performance by at least 10%. Overall, administrative data find that DHMC performed above the established benchmark on two of the four measures (well-child checks and timeliness of prenatal care).

The performance period cited here, however, reflects calendar year 2018, which includes just six months of the evaluation period (July – December 2018) due to the data source. DHMC's performance in the first six months of 2019 are not yet available. Therefore, these scores may not reflect its actual performance during FY 2018-19.

**Table 4. DHMC Performance on Care Quality and MLR Metrics and Performance Benchmarks, CY 2018**

| Metric | Performance | Benchmark |
|---|---|---|
| Diabetes screening | 82.1% | 83.1% |
| Childhood immunizations | 56.6% | 57.3% |
| Well-child checks | 63.6% | 62.0% |
| Timeliness of prenatal care | 71.9% | 64.9% |

*Source: 2019 HEDIS Aggregate Report for Health First Colorado*

### *Diabetes Screening*

This metric is defined as the percentage of diabetic (type 1 and type 2) members 18 to 75 years of age with an HbA1c test performed during 2018. The percentage of those members receiving an HbA1c test in 2018 was 82.1%, short of the benchmark of 83.1%.

DHMC's performance on this measure has not changed significantly from the previous two calendar years (82.6% and 82.2%, respectively). DHMC's quality improvement team is identifying strategies to leverage prompts and orders in its electronic medical record to improve screening rates.

### *Childhood Immunizations*

This metric measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP (diphtheria, tetanus, pertussis), three IPV (inactivated polio vaccine), one MMR (measles, mumps, rubella), three Hib (Haemophilus influenzae type b), three Hepatitis B, one VZV (varicella-zoster virus), four PCV (pneumococcal conjugate vaccine), one Hepatitis A, and two or three rotavirus. In 2018, 56.6% of those members received the relevant vaccines by their second birthday, a lower percentage than the benchmark of 57.3%.

Performance has not changed significantly from past years (59.4% and 56.8% in 2016 and 2017, respectively). Recently, DHMC's quality improvement team identified a key driver for metric performance (timing of the first rotavirus vaccine) and is working to improve timeliness and ensure patients are identified in the system as needing vaccines.

### *Well-Child Checks*

The third metric considered for the MLR measures the percentage of members three to six years old who received one or more well-child visits with a PCMP during calendar year 2018. DHMC's performance of 63.6% exceeded the benchmark of 62.0%.

DHMC's performance on this measure was similar in previous years (58.6% and 60.9%). Outside the evaluation period, DHMC notes that well-child checks continue to be a priority during the coronavirus pandemic.

### *Timeliness of Prenatal Care*

Timeliness of prenatal care is defined as the percentage of live births that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the MCO. DHMC performance of 71.9% exceeded the benchmark of 64.9%.

DHMC's 2018 calendar year performance increased significantly from the previous calendar year's performance (64.6%).

### *Health Outcomes and Provider Performance Metrics*

Additional quality metrics provide further context about how DHMC members' care compares relative to similar patient populations in Health First Colorado. Because this is the first year DHMC has been included in this evaluation, the analysis focuses only on performance against the comparison group and does not include performance in previous years. Future evaluations will analyze how DHMC performance has changed over time. Overall, DHMC outperformed the comparison group of non-DHMC enrolled RAE FFS members in three out of four measures (see Table 5).

However, these comparisons should be interpreted with caution as these metrics are sensitive to member characteristics not accounted for in these calculations. The comparison group used for all four metrics included in this section of the analysis is the same. DHMC performance is contrasted with a comparison group of RAE FFS members eligible but not enrolled in DHMC. This comparison provides additional context, but without applying robust risk adjustment only limited conclusions can be drawn.

**Table 5. DHMC Performance on Health Outcomes and Provider Performance Metrics, FY 2018-19**

| Metric | Performance | Comparison Group* |
|---|---|---|
| Hospital all-cause readmission rate | 10.5% | 11.9% |
| Emergency department visits | 641 visits per 1,000 members | 810 visits per 1,000 members |
| Behavioral health engagement rate | 22.9% | 20.2% |
| Percentage of members with one or more visits to a primary care medical provider | 64.0% | 69.6% |

**Comparison group is RAE FFS members meeting DHMC eligibility requirements in Adams, Arapahoe, Denver, and Jefferson counties but not enrolled in DHMC.*

*Source: HCPF*

### *Hospital All-Cause Readmission Rate*

A readmission to a hospital after discharge is likely to be expensive and may signal that a patient required additional care management after initially being discharged. This metric measures the rate of hospital readmissions for any cause within 30 days of hospital discharge. It assesses a plan's ability to effectively care for high-risk members and prevent unnecessary high cost services. The following conditions are not included: pregnancy, perinatal conditions, chemotherapy, rehabilitation, organ transplants, and planned procedures.

DHMC had a hospital all-cause readmission rate of 10.5%, which is lower than the rate among the comparison group of RAE members. DHMC provides 30 days of transitional care follow-up for individuals with hospital stays and promotes a nurse advice line.

### *Emergency Department Visits*

Like hospital readmissions, visits to a hospital ED can be costly and may indicate that improvements are needed in care management services and/or access to primary care services. DHMC members visited the ED at a rate of 641 visits per 1,000 members in FY 18-19.

This is a lower rate than the comparison group. DHMC promotes its nurse advice line as a resource for patients to use in lieu of ED visits and conducts outreach to people who frequently utilize the ED. Care coordination team members also conduct follow up with patients who visit the ED.

### *Behavioral Health Engagement Rate*

FY 2018-19 marked the launch of ACC Phase II and the RAEs. One of the biggest changes brought about by Phase II was the administrative integration of the physical health and behavioral functions performed by the RCCOs and the BHOs. The intention was to improve access to behavioral health services for Health First Colorado members while improving efficiency. Another Phase II change was the provision allowing PCMPs to bill for up to six short-term behavioral health visits. The behavioral health engagement metric is a Key Performance Indicator throughout the ACC.

More than one of five (22.9%) DHMC members were engaged with behavioral health services in FY 2018-19, a slightly higher rate than the comparison group. Behavioral health services counting toward this measure could include visits to a behavioral health provider under RAE capitation or the short-term behavioral health visits provided by a PCMP in the past 12 months. The six short-term behavioral health visits may be a factor influencing access to behavioral health services. Colorado Access (as the RAE) was responsible for facilitating much of DHMC members' access to behavioral health care during this performance period. DHMC has implemented universal depression and anxiety screening into its clinical workflows as well as an integrated behavioral health provider in the clinic who is available to respond to positive screens by providing services or facilitating a referral to another provider.

### *Members With at Least One Visit to PCMP*

Access to a primary care provider is a proxy for effective utilization of the medical home model, which is a key tenet of the ACC. A lower percentage of DHMC members visited their PCMP, 64.0%, compared with a similar population.

DHMC's performance on this metric should be assessed in future reports. In 2020, DHMC contracted with a vendor to engage new members in completing a health needs assessment (in addition to whatever outreach that HCPF provides to new enrollees). If a member indicates they would like help connecting with a provider through that process, DHMC conducts a warm hand-off to the Denver Health Appointment line, which connects members with a Denver Health network provider.

Increasing this percentage could impact some of the other quality measures on which DHMC is currently lagging.

### *Provider Support and Experience*

DHMC includes providers employed by DHHA who share patients with one another. There was not quantitative data available on provider experience or provider support, so CHI's evaluation in this area is based on qualitative interviews with providers and DHMC staff. Provider feedback suggests that many enjoy being able to follow their patients throughout Denver Health's integrated system, having direct access to patients' complete medical records, and having the ability to coordinate and oversee patients' care plans.

DHMC providers also have access to data support and analytics to inform quality activities as well as operations coordinators within clinics to facilitate change processes. Providers can also engage in multidisciplinary quality improvement work groups on specific clinical topics or issues (pediatric care, immunizations, cancer screenings, infectious disease, etc.). These work groups develop ideas and interventions to achieve desired outcomes on strategic care measures such as HEDIS.

Providers also identified challenges when patients need to go outside the Denver Health system for care that the system does not provide. Specific challenges include provider-to-provider communication, less efficiency in coordinating care services, and patients' reluctance to leave the Denver Health system for care.

### *Member Experience*

A majority of DHMC members surveyed through HCPF's 2019 CAHPS gave favorable ratings to their providers and health care experiences. DHMC members are more likely to provide favorable ratings on their care experiences (rating a nine or 10 on a 1-to-10 scale) on two of three measures compared to the RAE aggregate score (Table 6).

These ratings included 92.0% of DHMC members indicating they were pleased with how their provider communicates with them, compared with 73.9% of the comparison group. A slightly higher percentage of DHMC members rated their primary care provider favorably (66.0%) versus the comparison group (63.6%). Three of four (74.7%) of DHMC members reported receiving care as soon as needed. A majority of DHMC members (71.8%) reported receiving the care they needed. However, a lower percentage of DHMC members rated the health plan

favorably: Just 56.4% compared with 60.3% of Health First Colorado members overall. DHMC has identified opportunities to improve these scores, including auditing of customer service representatives with follow-up trainings as needed, as well as staying in regular dialogue with the quality management committee for monitoring.

**Table 6. Patient Ratings of Their Care Experience, DHMC and Comparison Group, 2019**

| Metric | Performance | Comparison Group |
|---|---|---|
| Percentage of respondents rating their provider favorably | 66.0% | 63.6% |
| Percentage of respondents rating their health plan favorably | 56.4% | 60.3% |
| Percentage of respondents pleased with how their provider communicates with them | 92.0% | 73.9% |
| Percentage of respondents reporting receiving care as soon as needed | 74.7% | N/A |
| Percentage of respondents reporting receiving the care they needed | 71.8% | N/A |

**Comparison group is all RAE members*
*Source: 2019 Colorado Patient-Centered Medical Home Survey Adult Report*

### *Challenges*

CHI identified several challenges in evaluating DHMC. Actual FY 2018-19 performance on several quality measures specific to the MLR are unavailable due to the data source (HEDIS), which reports on a calendar year basis. This meant CHI had to assume that CY 2018 performance data was representative of FY 2018-19 performance. This discrepancy will continue to hamper future evaluations as long as HEDIS is the source for DHMC's MLR metrics.

While DHMC patient experience data suggest higher levels of satisfaction relative to the overall ACC on several metrics, having additional opportunities to engage with patients and patient representatives directly may uncover additional nuances and context for these measures, including the relatively lower levels of patients rating the health plan favorably. Similarly, greater understanding of DHMC providers' experiences, including the processes and structures in place for supporting care delivery, may yield insights into deliberate steps the plan takes to encourage, support, and reward or incentivize care quality.

Lastly, the current methodologies for calculating comparison groups make it difficult to assess DHMC's performance relative to other ACC entities. DHMC members could have higher or lower

acuity and health risks that influence DHMC's performance against a benchmark or comparison group. The limitations of risk adjustment methods make apples-to-apples comparisons difficult.

## Limitations

This evaluation does not attempt to quantify the amount of cost savings (if any) created for Health First Colorado by the MCOs. An examination of the potential benefits or drawbacks of managed care in Colorado would be bolstered by further examining whether the model is able to deliver higher quality care at equal or lesser cost. Given the complexity in determining actual savings performance within managed care and the limitations of the approaches available for this evaluation, this type of analysis could not be included in the evaluation.

Additionally, comparison groups included in this analysis are not fully adjusted for patient mix and patient acuity. They are presented in that context as one comparison point but not an assessment of strong or weak performance on any particular measure.

Much of the data used for this evaluation was calculated by HCPF and provided to CHI. However, as the report author for many years, HCPF is capable of efficiently and accurately producing the data needed to complete this report.

All activities for this project were performed remotely to ensure compliance with regulations related to the COVID-19 pandemic. This likely had the largest impact on qualitative data gathering, which often benefits from in-person engagement to gain trust and better communicate nuance. However, remote meeting technology provided a reasonable proxy for in-person engagement.

There were not quantitative data available on provider experience or provider support, so CHI's evaluation in this area is based on qualitative interviews with providers and MCO staff. The providers interviewed for the evaluation were selected by the MCOs. It is unclear how representative the provider perspectives gained through the interviews are of the entire provider network.

## Looking Ahead

As part of its scope of work, CHI is making recommendations to HCPF about how to address some of the limitations identified in this report and expand the evaluation approach for the FY 2019-20 report.

The FY 2019-20 evaluation will need to address the effect of the COVID-19 pandemic and subsequent economic downturn on MCO performance in March-June of 2020. CHI will also discuss considerations related to the anticipated increase in Health First Colorado enrollment due to the economic downturn.

# Appendix: Methods

## Metrics: The Importance of Using the Right Comparison

Tables 7 and 8 display two approaches used for the health outcomes and provider performance metrics: 1) a comparison group comprised of all RAE FFS members; and 2) a comparison group of RAE FFS members selected to be similar in geography and population characteristics to those enrolled in the MCO.

- For RMHP Prime, that group is RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE Region 1 where RMHP Prime does not operate.
- For DHMC, that group is RAE FFS members meeting DHMC eligibility requirements in Adams, Arapahoe, Denver, and Jefferson counties but not enrolled in DHMC.

HCPF's past evaluation reports have generally applied Approach #1 for these or similar health outcome and provider performance metrics (in FY17-18, HCPF used both approaches to analyze ED visit data). Approach #2 includes a comparison group with further refinements by geography and limited to members whose characteristics (such as age, disability status, etc.) would make them eligible for enrollment in the MCO. Despite these refinements, comparisons should be interpreted with caution as these metrics are sensitive to member characteristics not accounted for in these calculations.

The figures in Tables 7 and 8 are displayed to provide greater context on how other populations perform on these metrics. Without applying robust risk adjustment, however, only limited conclusions can be drawn.

**Table 7. Existing Comparison Group Approaches: Health Outcomes and Provider Performance Metrics, RMHP Prime, FY 2018-19**

| Metric | RMHP Prime | Approach #1: RAE Average* | Approach #2: RAE Subpopulation** |
|---|---|---|---|
| Hospital all-cause readmission rate | 10.6% | 10.1% | 8.5% |
| Emergency department visits | 862 visits per 1,000 members | 755 visits per 1,000 members | 795 visits per 1,000 members |
| Behavioral health engagement rate | 22.9% | 17.6% | 20.2% |
| Members with one or more visits to a Primary Care Medical Provider | 69.1% | 69.6% | 67.1% |

**Comparison group is all RAE FFS members enrolled in the ACC.*
***Comparison group is RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE region 1 where RMHP Prime does not operate.*
*Source: HCPF*

**Table 8. Existing Comparison Group Approaches: Health Outcomes and Provider Performance Metrics, DHMC, FY 2018-19**

| Metric | DHMC | Approach #1: RAE Average* | Approach #2: RAE Subpopulation** |
|---|---|---|---|
| Hospital all-cause readmission rate | 10.5% | 10.1% | 11.9% |
| Emergency department visits | 641 visits per 1,000 members | 755 visits per 1,000 members | 810 visits per 1,000 members |
| Behavioral health engagement rate | 22.9% | 17.6% | 20.2% |
| Members with one or more visits to a Primary Care Medical Provider | 64.0% | 69.6% | 69.6% |

** Comparison group is all RAE FFS members enrolled in the ACC.*
***Comparison group is RAE FFS members meeting DHMC eligibility requirements in Adams, Arapahoe, Denver, and Jefferson counties but not enrolled in DHMC.*
*Source: HCPF*

## Metrics: Rocky Mountain Health Plans Prime

| Metric | Detail | Time Period | Source | Comparison Group |
|---|---|---|---|---|
| Rate of emergency department visits for substance use disorder | Emergency department visits for substance use disorder per 1,000 member months per year | FY 2018-19 | HCPF Calculated | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| HbA1c poor control | Percentage of members with HbA1c, a measure of average blood sugar levels used to assess how well diabetes is being controlled, above 9.0% | FY 2018-19 | HCPF Calculated | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| Depression screening and follow-up plan | Members 12 years and older were screened for clinical depression on the date of the encounter AND, if positive, a follow-up was documented | FY 2018-19 | HCPF Calculated | Performance compared against benchmark value set by HCPF in negotiation with the MCO |

| | | | | |
|---|---|---|---|---|
| Patient Activation Measure (PAM®) | For practices actively using the PAM® tool, what percentage of attributed members who had an initial PAM® level of 1 or 2 completed a follow up PAM® by June 2019 | FY 2018-19 | HCPF Calculated | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| Hospital all-cause readmission rate | Percentage of patients with a readmission to a hospital for any cause within 30 days of hospital discharge, with the exception of the following conditions: pregnancy; perinatal conditions; chemotherapy; rehabilitation; organ transplants; rehabilitation; and planned procedures | FY 2018-19 | HCPF Calculated | RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE region 1 where RMHP Prime does not operate |
| Emergency department visits | Number of emergency department visits per thousand members | FY 2018-19 | HCPF Calculated | RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE region 1 where RMHP Prime does not operate |
| Behavioral health engagement rate | Percentage of members enrolled in a health plan received behavioral health services over the course of a year | FY 2018-19 | HCPF Calculated | RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE region 1 where RMHP Prime does not operate |

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|---|---|---|---|---|
| Members with one or more visits to a primary care medical provider (PCMP) | Percentage of members enrolled for 12 continuous months who received services from a Primary Care Medical Provider during that time period | FY 2018-19 | HCPF Calculated | RAE FFS members who are either eligible but not enrolled in RMHP Prime or would otherwise be eligible but live in one of the counties in RAE region 1 where RMHP Prime does not operate |
| Percentage of respondents rating their provider favorably | Adult members were asked to rate their provider on a scale of 0 to 10, with 0 being the "worst provider possible" and 10 being the "best provider possible." Percentage reported is percentage of responses with a rating of 9 or 10 | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |
| Percentage of respondents rating their health plan favorably | Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Percentage reported is percentage of responses with a rating of 9 or 10 | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |
| Percentage of respondents pleased with how their provider communicates with them | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |
| Percentage of respondents reporting receiving care as soon as needed | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | N/A |

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|---|---|---|---|---|
| Percentage of respondents reporting receiving the care they needed | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | N/A |

## Metrics: Denver Health Medicaid Choice

| Metric | Detail | Time Period | Source | Comparison Group |
|---|---|---|---|---|
| Diabetes screening | Percentage of diabetic (type 1 and type 2) members 18 to 75 years of age with an HbA1c test performed during the measurement year | CY 2018 | 2019 HEDIS Aggregate Report for Health First Colorado | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| Childhood immunizations | The percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP (diphtheria, tetanus, pertussis), three IPV (inactivated polio vaccine), one MMR (measles, mumps, rubella), three Hib (Hemophilus influenzae type b), three Hepatitis B, one VZV (varicella-zoster virus), four PCV (pneumococcal conjugate vaccine), one Hepatitis A, and two or three rotavirus. (Known as Combination 7) | CY 2018 | 2019 HEDIS Aggregate Report for Health First Colorado | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| Well-child check | Percentage of members 3 to 6 years old who received one or more well-child visits with a primary care provider during calendar year 2018 | CY 2018 | 2019 HEDIS Aggregate Report for Health First Colorado | Performance compared against benchmark value set by HCPF in negotiation with the MCO |

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|---|---|---|---|---|
| Timeliness of prenatal care | Percentage of live births that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the MCO | CY 2018 | 2019 HEDIS Aggregate Report for Health First Colorado | Performance compared against benchmark value set by HCPF in negotiation with the MCO |
| Hospital all-cause readmission rate | Percentage of patients with a readmission to a hospital for any cause within 30 days of hospital discharge, with the exception of the following conditions: pregnancy; perinatal conditions; chemotherapy; rehabilitation; organ transplants; rehabilitation; and planned procedures | FY 2018-19 | HCPF Calculated | RAE FFS members eligible but not enrolled in DHMC |
| Emergency department visits | Number of emergency department visits per 1,000 members | FY 2018-19 | HCPF Calculated | RAE FFS members eligible but not enrolled in DHMC |
| Behavioral health engagement rate | Percentage of members enrolled in a health plan received behavioral health services over the course of a year | FY 2018-19 | HCPF Calculated | RAE FFS members eligible but not enrolled in DHMC |
| Members with one or more visits to a Primary Care Medical Provider (PCMP) | Percentage of members enrolled for 12 continuous months who received services from a Primary Care Medical Provider during that time period | FY 2018-19 | HCPF Calculated | RAE FFS members eligible but not enrolled in DHMC |
| Percentage of respondents rating their provider favorably | Adult members were asked to rate their provider on a scale of 0 to 10, with 0 being the "worst provider possible" and 10 being the "best provider possible." Percentage reported is percentage of responses with a rating of 9 or 10 | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |

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|---|---|---|---|---|
| Percentage of respondents rating their health plan favorably | Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Percentage reported is percentage of responses with a rating of 9 or 10 | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |
| Percentage of respondents pleased with how their provider communicates with them | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | 2019 Colorado RAE aggregate performance |
| Percentage of respondents reporting receiving care as soon as needed | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | N/A |
| Percentage of respondents reporting receiving the care they needed | The CAHPS Health Plan Adult Survey 5.0 asked enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan | FY 2018-19 | 2019 Colorado Patient-Centered Medical Home Survey Adult Report | N/A |

[1] Colorado Department of Health Care Policy & Financing. (2019). "Accountable Care Collaborative FY 2018-19." https://www.colorado.gov/pacific/sites/default/files/HCPF%202019%20Accountable%20Care%20Collaborative%20Implementation%20Report.pdf.
[2] Home and Community Based Services waiver expenses are not included in the total cost of care.
[3] Colorado Department of Health Care Policy & Financing. (2019). "Accountable Care Collaborative FY 2018-19." https://www.colorado.gov/pacific/sites/default/files/HCPF%202019%20Accountable%20Care%20Collaborative%20Implementation%20Report.pdf.
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