Medicaid Payment Reform and Innovation Pilot Program Report FY 2021-22

In compliance with Section 25.5-5-415, C.R.S.

April 2023

Submitted to:

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

COLORADO
Department of Health Care Policy & Financing

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I. Introduction

The Department of Health Care Policy & Financing (HCPF) provides health coverage to low-income Coloradans and people with disabilities through safety net programs like Health First Colorado (Colorado's Medicaid program) and the Child Health Plan Plus (CHP+). With the economic impact of the COVID-19 pandemic, HCPF now covers 1.7 million Coloradans, one in every four people in the state. Given the costs of health care, HCPF continues to pursue strategies for making care more affordable and sustainable.

This report focuses on the performance of the state's two fully capitated managed care plans for physical health in FY 2021-22, as required by Section 25.5-5-415, C.R.S. This report does not include Medicaid's behavioral health managed care program, which is discussed in a separate report.

Capitated managed care plans cover services for members in exchange for an actuarially sound, fixed per-member-per month (PMPM) fee. Two capitated managed care plans for physical health are Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Enrollees (RMHP Prime). RMHP Prime operates on the Western Slope, and DHMC operates in the Denver metro area.

During FY 2021-22, RMHP Prime had an average monthly enrollment of 46,229 members and Denver Health averaged 110,538 members per month. For context, enrollment in the Accountable Care Collaborative as a whole averaged 1,489,511 members per month. This report includes information about how the plans deliver their services and who they serve. It also includes information on program budget, program performance, and member experience.

Capitated managed care is one of the strategies HCPF uses to control costs and promote accountability, including cost transparency, prescription drug cost control, telemedicine, and value-based hospital payments. See https://hcpf.colorado.gov/affordability for more information on these and other initiatives.

II. Managed Care and Medicaid

Many states rely on managed care to administer Medicaid benefits. In 2020, nearly 84 percent of Medicaid beneficiaries in the U.S. were enrolled in some form of managed

care.[1] States use managed care because it allows them to meet health care needs while controlling the costs to the state. It is an alternative to fee-for-service payment models, in which health care providers are paid for every individual service with limited ways to connect services to quality, costs, or outcomes. Managed care allows for more accountability for outcomes and supports statewide efforts to measure and monitor performance, access, and quality. Managed care programs can also provide opportunities for better care management and care coordination.

Managed care models differ in the type and extent of accountability used to achieve results. Some managed care models use payments to incentivize better health outcomes or limit provider networks to manage service utilization.

Some managed care models, like the ones featured in this report, promote cost savings by using a per-member-per-month (PMPM) capitation rate for some or all care, requiring plans to meet the member's needs for that amount. These plans are different from most other Medicaid providers that contract with the state; they are like small health insurance companies that bear the risk for the health outcomes of their members.

These models are called *capitated managed care* or *comprehensive risk plans* because the state contracts with them to cover most of the physical health services for members in exchange for the fixed PMPM rate. The plans that use this model bear financial risk if their spending per member goes above the capitated rate, and they can benefit if their spending per member is below the rate, so long as they meet standards for quality of care.

III. Physical Health Managed Care Organizations in Colorado

Managed care takes a few different forms in Colorado Medicaid and is part of a larger constellation of payment reform initiatives the state uses to control costs and improve health outcomes.

A. Managed Care Organizations and the Accountable Care Collaborative

Capitated managed care initiatives for both physical and behavioral health operate within the structure of the Accountable Care Collaborative (ACC). Launched in 2011, the ACC is at the core of the state's Medicaid program. The ACC has a Regional Accountable Entity (RAE) that supports Medicaid members and providers in each of the seven regions of the state. The RAE contracts with primary care medical providers

[1] U.S. Center for Medicare and Medicaid Services (2020). Medicaid Managed Care Enrollment and Program Characteristics, 2020. https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf.

(PCMPs), who are paid a per-member-per-month payment by the RAEs for their medical home services in addition to fee-for-service payments for the medical care they provide.

The ACC is itself a type of managed care model, though not a capitated comprehensive risk model for physical health care. (However, the RAEs administer the behavioral health capitated managed care plan for their region, so they do assume risk for behavioral health care.)

Two capitated managed care plans for physical health operate within the ACC: Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Enrollees (RMHP Prime). RMHP Prime is operated as part of the Region 1 RAE contract with RMHP, whereas the state contracts directly with Denver Health for DHMC, which works in partnership with the Region 5 RAE to meet the needs of members in the Denver metro area. For the populations they serve, these managed care plans are held accountable for outcomes that usually fall to the RAEs, such as maternal health, complex care management, and health equity.

Figure 1. Regions, RAEs, and Managed Care Organizations of the Accountable Care Collaborative

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B. MCO: Rocky Mountain Health Plans Prime

RMHP Prime operates on Colorado's Western Slope, covering approximately 16,000 square miles that include six counties: Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco. RMHP Prime's service area is primarily rural, though it includes the metropolitan area of Grand Junction. RMHP Prime's entire service area is designated as a Health Professional Shortage Area (HPSA) for mental health, a federal designation indicating unmet need for behavioral health provider capacity. Much of RMHP Prime's service , which includes the counties of Gunnison, Mesa, and Montrose and portions of Rio Blanco, is also a HPSA for primary care.[2]

RMHP Prime is a program of Rocky Mountain Health Plans, the RAE for Region 1. Prime receives a capitation for its members and contracts with a network of independent providers, including primary care practices and specialists to provide all medical care. In addition, as part of RAE 1, Prime members access behavioral health care through a separate capitation fee to the RAE.

Within RMHP Prime, over 50 practices participate in Prime Global Pay, a model in which providers receive a capitation payment from RMHP to cover the cost of the practice's services for its Prime members and provide additional care coordination services. The payments reflect a risk-adjusted cost of care for the practice. Shared savings that are based on quality and total cost performance are paid at the end of the year to these practices. Practices may be RMHP Prime providers even if they do not opt to participate in Prime Global Pay.

RMHP Prime uses its capitation payments and leverages other funding sources to innovate payment models and provider incentives to achieve better health outcomes for members. For example, RMHP Prime uses a tiered system of payments for primary care practices to incentivize higher quality care, better access to care (including behavioral health care), and better care integration. To be considered a Tier 1 practice, the provider must be fully open to accepting Medicaid patients, meet targets on certain performance measures, provide patients with advanced access including after-hours and telehealth services, assess patients' risks and develop care plans, and earn designation as a patient-centered medical home by the National Committee for Quality Assurance.

[2] Colorado Department of Public Health and Environment. (2015). Health professional shortage area maps and data. Retrieved from https://cdphe.colorado.gov/prevention-and-wellness/health-access/health-workforce-planning-and-assessment/health-professional. Accessed March 2022.

C. MCO: Denver Health Medicaid Choice

Denver Health Medicaid Choice (DHMC) operates in the Denver metro area in Adams, Arapahoe, Denver, and Jefferson counties. While its geographic area is relatively small, it serves a large population in a primarily urban environment, with a population density of over 850 people per square mile — much higher than Colorado's overall population density of just over 55 people per square mile. Some areas within DHMC's service area are designated as provider shortage areas: portions of the Denver metro area, as well as rural eastern Adams and Arapahoe counties, have been designated as primary care HPSAs. All four counties are designated as a low-income mental health HPSA, indicating unmet need for health care, particularly among people with low family incomes.[3] DHMC has operated in this area since 2004.

Medicaid members in DHMC's service area are automatically enrolled into DHMC. Members can opt out of DHMC and choose fee-for-service care instead, but they must take the initiative to do so.

DMHC uses a staff model: its medical/health providers are employees rather than independent providers who contract with the health plan. DHMC offers care at Denver Health's main medical campus, 10 family health centers, and 18 school-based health centers in the Denver metro area. In addition to the Denver Health network, DHMC also contracts with community providers such as STRIDE Community Health Center, University of Colorado Hospital, and Children's Hospital Colorado where members can receive services. Because DHMC has its own contracts with these entities, DHMC's rates at these facilities can differ from HCPF's. For example, DHMC pays a higher rate for services at Children's Hospital Colorado than HCPF does. There is an opportunity to explore ways to ensure that these contractual reimbursements are no higher than parallel to Health First Colorado fee-for-service reimbursements.

DHMC receives a capitated payment for physical health and another for behavioral health. It subcontracts the management of the capitated behavioral health benefit to Colorado Access, which is the region's RAE.

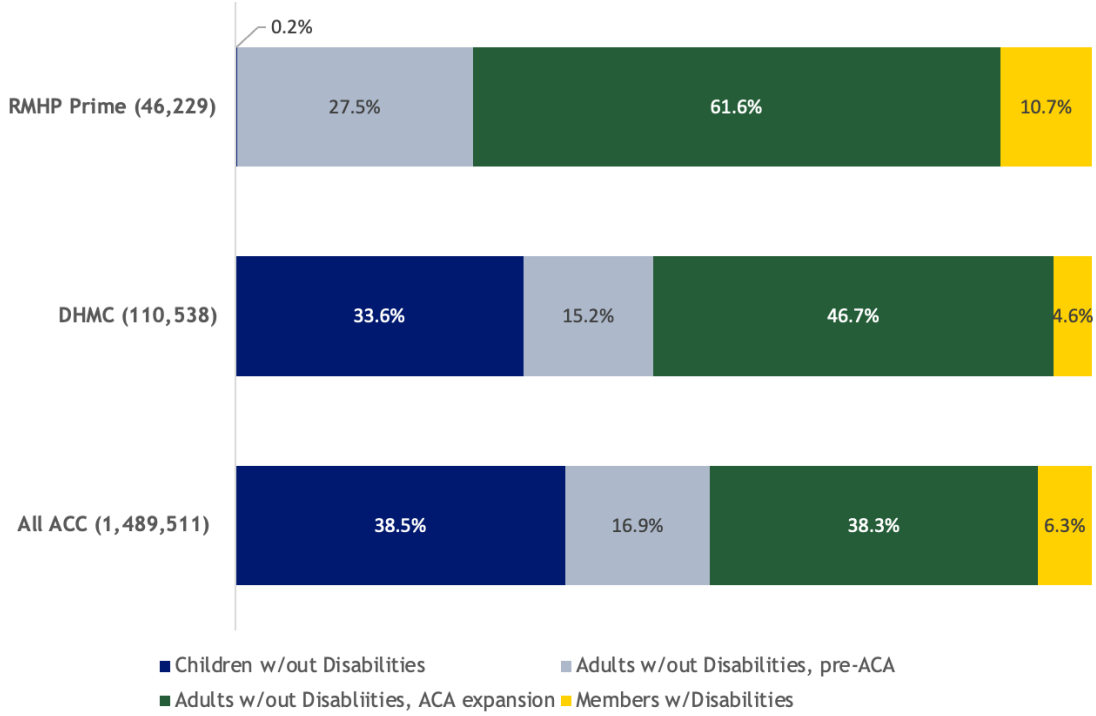
D. Enrollment in MCOs

During FY 2021-22, RMHP Prime had an average monthly enrollment of 46,229 members and Denver Health averaged 110,538 members per month. For context, enrollment in the Accountable Care Collaborative as a whole averaged 1,489,511 members per month.

[3] Colorado Department of Public Health and Environment. (2015). Accessed March 2022.

Figure 2 reveals another way the two managed care plans differ: the enrollment mix. RMHP Prime does not include children without disabilities and includes only a small number of children with disabilities. It also serves more adults with disabilities, including dually eligible Medicare-Medicaid members. This affects the priorities, strategies, and PMPM costs of the two plans.

Figure 2. Average Enrollment in ACC and MCOs by Eligibility, FY 2021-22



IV. Cost of Care

The cost of care for members in capitated managed care plans include all costs for members' care, regardless of who provides it. The cost is comprised of these elements: the physical health PMPM for members, the behavioral health PMPM for members, and the cost of any services that are not covered by the PMPM (fee-for-service payments). These include long-term services and supports, medical transportation, dental care, pharmacy, and some EPSDT services for children.

Capitated MCOs are designed to be budget neutral; capitation payments must be at or below 98% of the fee-for-service equivalent. RMHP Prime's costs are shown in Table 1 below.

Table 1. RMHP Prime Cost of Care, FY 2021-22

Cost	Description	Amount
Physical Health Capitation	Per-member-per-month fee for medical care	$ 251,650,693
Behavioral Health Capitation	Per-member-per-month fee for mental health care and substance use treatment	$ 38,775,053
Fee-for-Service Payments	Payments for services not covered under the capitation (e.g., long-term services and supports, dental care, medical transportation)	$ 53,677,921
Total cost of care		**$ 344,103,667**
Cost of care per member per month		**$622 per member**

Table 2 shows the total cost of care for DHMC. In addition to capitations and fee-for-service payments, cost of care for DHMC includes "Delivery Paid Amounts." These are encounter fees to a Federally Qualified Health Centers (FQHC), rural health center (RHC), or Indian Health Services (IHS) clinic.

Table 2. DHMC Cost of Care, FY 2021-22

Cost	Description	Amount
Physical Health Capitation	Per-member-per-month fee for medical care	$288,032,858
Behavioral Health Capitation	Per-member-per-month fee for mental health care and substance use treatment	$ 78,573,478
Fee-for-Service Payments	Payments for services not covered under the capitation (e.g., dental care, medical transportation, long-term services and supports)	$ 74,479,473
Delivery Paid Amounts	Payments made to clinics that charge an encounter fee for care (e.g., FQHCs)	$ 6,588,196
Total cost of care		**$ 447,674,004**

Cost of care per member per month		**$339 per member**

V. Program Performance

Cost of care is not the only metric that matters. It is important that cost savings are not achieved by denying care to members or providing a lower quality of care. For this reason, program performance is also assessed and tracked. To evaluate the performance of MCO initiatives, HCPF looks at four different types of performance metrics: medical loss ratio quality metrics, care utilization metrics, CMS Core Quality Measures, and member experience data. Each is described below.

A. Medical Loss Ratio Quality Metrics

The medical loss ratio (MLR) refers to how much money an MCO spends on providing medical services compared with administrative services and profit. The higher the MLR, the greater the percentage of money spent on care. For example, a health plan with an MLR of 89% spent 89% of its revenue on services; a health plan with an MLR of 83% would have more dollars for administration and profit.

MCOs are required to have a certain MLR floor, a percentage of revenue they are required to spend directly on care. They are given the opportunity to lower this MLR floor if they meet certain care quality goals. Each MCO has its own set of MLR quality metrics specific to their membership and aligned with the goals of the ACC. The metrics for each MCO are explained in each MCO's section of this report.

The following MLR metrics were used to incentivize performance for RMHP Prime in FY 2021-22:

- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.** This measures the percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or dependence (AOD) who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
- **Emergency Department Rate**. This measures number of emergency department visits per-thousand-members-per-year (PKPY).
- **Housing and Health**. This metric has two parts. RMHP Prime must submit the results of quarterly surveys among members experiencing housing instability and measure the behavioral health engagement rate for these members.

RMHP Prime's MLR floor began at 89%, 4% above the federally required standard of 85%. Prime could lower its MLR floor by 1% for meeting the target for Metric 1, 2% for meeting the target for the Metric 2, and 1% for meeting Metric 3.

Table 3 shows the performance benchmark (target) and Prime's performance for FY 2021-22.

Table 3. RMHP Prime Performance on MLR Metrics Compared to Benchmarks, FY 2021-22

MLR Metric	Performance	Benchmark	Met?
Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	55.69% 63 Practices	15.91% 28 Practices	**Yes**
Metric 2: Emergency Department Utilization	686 per 1,000 members per year	747.99 per 1,000 members per year	**Yes**
Metric 3: Housing and Health 1. Survey report 2. Behavioral health engagement for members with housing instability	1. Survey report submitted 2. 57.7%	1. Survey report submitted 2. 49.4%	**1. Yes** **2. Yes**

For DHMC, the following MLR metrics were used to incentivize performance in FY 2021-22:

- **Well Child Care.** This measures the percentage of children (aged 0–20 years) receiving at least one periodic screening under the EPSDT benefit.
- **Timeliness of Prenatal Care.** This measures the percentage of members who received a prenatal visit during pregnancy.
- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.** This measures the percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or dependence (AOD) who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

- **Housing and Health.** This metric has two parts. DHMC must submit the results of quarterly surveys and measure the behavioral health engagement rate for members who receive services from the Colorado Coalition for the Homeless.

DHMC's MLR began at 89%, 4 percentage points above the federally required standard of 85%. It could lower its MLR by 1 percentage point for meeting each metric's target shown in Table 4. Metrics 2 and 3 are measured using HEDIS data, which will not be available until August 2023, so these are not yet available.

Table 4. DHMC Performance on MLR Metrics Compared to Benchmarks, FY 2021-22

DHMC MLR Metric	Performance	Benchmark	Met?
Metric 1: Well Child Care	43%	40%	**Yes**
Metric 2: Timeliness of Prenatal Care	Not yet available	94.4%	TBD
Metric 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Not yet available	38.8%	TBD
Metric 4: Housing and Health 1. Quarterly survey report 2. Behavioral health engagement for population served CO Coalition for the Homeless	1. Quarterly survey reports submitted 2. 55%	1. Quarterly survey reports submitted 2. 27%	**1. Yes** **2. Yes**

B. Care Utilization Metrics

HCPF selected care utilization metrics to assess how and where members are receiving care. These measures provide insight into whether members are receiving needed primary care to prevent unnecessary and costly care. These measures are the same for both MCOs:

- **Hospital all-cause readmission rate**. This measures the percentage of members readmitted to the hospital within 30 days after discharge for any reason, except for certain conditions, such as pregnancy and perinatal conditions, chemotherapy, rehabilitation, organ transplants, and planned procedures. This measure assesses a plan's ability to effectively care for high-risk members and prevent unnecessary high-cost services.
- **Emergency department visits**. This measures how many emergency department (ED) visits were made per 1,000 members per year. ED visits are costly and may indicate that improvements are needed in primary care and care management.
- **Behavioral health engagement rate**. This measures the percentage of members who had at least one behavioral health visit during the year, an important indicator of how well the MCOs are administering behavioral health and partnering with providers to ensure access to needed behavioral health care.
- **Visits to a primary care medical provider.** This measures the percentage of members who visited a primary care provider at least once during the performance period. This is a proxy for effective utilization of the medical home, which is a key design element of the ACC.

Care utilization metrics provide insight into how and where people are receiving care. Table 5 shows these measures for the current and past two fiscal years for RMHP.

Note that the emergency department utilization number reported below is different from the one reported in the MLR section above. This is because the measurement methodologies differed: the care utilization measure is risk-adjusted while the MLR measure is not.

Table 5. Care Utilization for RMHP Prime, FY 2019-20 to FY 2021-22

Care Utilization Metric	2019-20	2020-21	2021-22
Hospital All-Cause Readmission (goal is to decrease utilization)	10.1%	10.2%	9.3%
Behavioral Health Engagement Rate (goal is to increase utilization)	22.3%	21.5%	20.5%
Percentage of members with 1+ visits to a PCMP (goal is to increase utilization)	68.0%	65.4%	65.1%

Emergency department visits per 1,000 members per year (goal is to decrease utilization)	777	683	686

Table 6 shows DHMC's care utilization measures for the current and past two fiscal years.

Table 6. Care Utilization for DHMC, FY 2019-20 to FY 2021-22

Care Utilization Metric	2019-20	2020-21	2021-22
Hospital All-Cause Readmission (goal is to decrease utilization)	10.1%	11.9%	11.4%
Behavioral Health Engagement Rate (goal is to increase utilization)	14.0%	13.3%	15.4%
Percentage of members with 1+ visits to a PCMP (goal is to increase utilization)	55.1%	55.3%	54.9%
Emergency department visits per 1,000 members per year (goal is to decrease utilization)	576	482	537

C. CMS Core Quality Measures

MCO evaluation includes some of the Core Quality Measures from the Centers for Medicare and Medicaid Services (CMS). These measures align with the measures from Healthcare Effectiveness Data and Information Set (HEDIS), a set of care access and utilization measures widely used for managed care that HCPF has used in the past to assess the quality of its managed care programs.[4] These measures are reported for a calendar year rather than the fiscal year for reporting purposes. Therefore, the clinical quality data in this report is for January to December 2021 rather than the state fiscal year (July 2021 to June 2022).

[4] "Major Health Plan Quality Measurement Sets" (2022). Agency for Healthcare Quality and Research. Accessed at https://www.ahrq.gov/talkingquality/measures/setting/health-plan/measurement-sets on March 3, 2022.

When historical data is available, this report looks at these quality measures over time using the most recent four years of data to assess MCO performance. For additional context, the state Medicaid average value for each measure is also included. However, results have not been risk-adjusted to account for potential differences in the acuity of each MCO's enrolled population and the state Medicaid population. Thus, the state Medicaid average value is provided as a point of context but should not be considered a direct performance benchmark.

Below are the clinical measures used this year.

- Preventive care for children and adolescents (DHMC only)
    - **Well-child visits in the first 30 months of life**. Percentage of members who received six or more well-child visits before turning 15 months of age, and the percentage of members who received two or more well-child visits before turning 30 months of age.
    - **Child and adolescent well-care visits**. Percentage of members aged 3 to 21 who had at least one well-care visit.
    - **Nutrition counseling for children and adolescents.** Percentage of members aged 3 to 17 who had an outpatient primary care visit and received counseling for nutrition.
- **Timeliness of Prenatal Care**. Percentage of live birth deliveries that received a prenatal care visit in the first trimester, on the enrollment date, or within 42 days of enrollment in the MCO.
- **Postpartum Care**. Percentage of deliveries of live births that had a postpartum visit between 7 and 84 days after delivery.
- **Chlamydia Screening.** Percentage of female members aged 16 to 24 who were identified as sexually active and received at least one test for chlamydia.
- **Breast Cancer Screening**. Percentage of female members aged 50 to 74 who had a mammogram.
- **Cervical Cancer Screening**. Percentage of female members aged 21 to 64 who were screened for cervical cancer according to clinical guidelines.
- **Antidepressant Medication Management, Acute and Continuation Phases.** Percentage of members aged 18 years+ who were treated with antidepressant medication, were diagnosed with major depression, and remained on the medication for at least 84 days (acute phase) and 180 days (continuation phase).

- **Asthma Medication Ratio.** Percentage of members aged 5 to 64 with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater.

Tables 7 and 8 show RMHP Prime's and DHMC's results on clinical measures for calendar years 2018–2021. These clinical measures are based on administrative claims data only, without chart review. This can lead to artificially low utilization rates for some service categories such as prenatal and postpartum care, which include services that use global billing and do not have a claim submitted individually for each service.

Note: For additional context, the state Medicaid average values are also included for each measure, but this number should be used with caution. The statewide Medicaid averages are weighted (adjusted) for each measure, but the MCO's measures are not weighted. The statewide averages are weighted to reflect that an MCO with many members should have a greater impact on the overall Colorado Medicaid statewide average rate than an MCO with fewer members.

Table 7. Clinical Quality Measures for RMHP Prime, Calendar Years 2018-2021

Clinical Measure	2018	2019	2020	2021	Medicaid Average 2021
Timeliness of Prenatal Care	44.7%	42.0%	56.7%	56.5%	68.8%
Postpartum Care	28.6%	35.9%	32.9%	37.0%	54.9%
Breast Cancer Screening	50.1%	48.0%	44.8%	40.9% ages 50-64 39.0% ages 65-74	41.3% ages 50-64 34.3% ages 65-74
Cervical Cancer Screening	41.9%	39.4%	40.3%	42.3%	40.7%
Chlamydia Screening	46.5%	47.8%	45.0%	41.7% ages 16-20 45.1% ages 21-24	74.1% ages 16-20 57.9% ages 21-24

Clinical Measure	2018	2019	2020	2021	Medicaid Average 2021
Antidepressant Medication Management: Acute (ages 18-64 years)	52.2%	73.7%	55.5%	57.4%	60.9%
Antidepressant Medication Management: Continuation (ages 18-64 years)	33.9%	64.9%	42.5%	36.7%	41.1%
Asthma Medication Ratio (ages 19-64 years)	53.7%	48.4%	51.8%	57.2%	52.0%

Table 8. Clinical Quality Measures for DHMC, Calendar Years 2018-2021

Clinical Measure	2018	2019	2020	2021	Medicaid Average 2021
Well Child Visits in First 30 Months of Life: Members who received 6 or more visits on or before 15 months of age	N/A: Measure started in 2020.		54.7%	54.3%	54.3%
Well Child Visits in First 30 Months of Life: Members who received 2 or more visits between 15 and 30 months of age	N/A: Measure started in 2020.		57.1%	54.4%	54.4%
Child and Adolescent Well Care Visits (members ages 3–21	N/A: Measure started in 2020.		39.3%	41.9%	41.2%

Clinical Measure	2018	2019	2020	2021	Medicaid Average 2021
who received one well visit)					
Counseling for Nutrition (members ages 3–17 who received nutrition counseling)	7.5%	9.2%	69.9%	74.4%	73.5%
Timeliness of Prenatal Care	71.9%	84.5%	83.4%	79.5%	68.8%
Postpartum Care	56.7%	66.5%	69.2%	70.7%	54.9%
Breast Cancer Screening	46.5%	46.0%	42.6%	41.7% ages 50-64 years 39.0% ages 65-74 years	41.3% ages 50-64 years 34.3% ages 65-74 years
Cervical Cancer Screening	43.1%	45.6%	41.1%	39.4%	40.7%
Chlamydia Screening	69.6%	72.9%	67.4%	76.8% ages 16-20 years 68.5% ages 21-24 years	75.1% ages 16-20 years 57.9% ages 21-24 years
Antidepressant Medication Management: Acute	54.2%	57.2%	61.1%	64.5% ages 18-64 years 78.0% ages 65+ years	60.9% ages 18-64 years 74.4% ages 65+ years
Antidepressant Medication Management: Continuation	34.0%	37.7%	40.7%	42.6% ages 18-64 years 72.0% ages 65+ years	41.1% ages 18-64 years 64.1% ages 65+ years
Asthma Medication Ratio	46.6%	46.6%	51.4%	59.9% ages 5-18 years	59.7% ages 5-18 years

Clinical Measure	2018	2019	2020	2021	Medicaid Average 2021
				47.4% ages 19-64 years	52.0% ages 19-64 years

D. Member Experience

A member's experience of care is another important measure of how well MCOs are meeting member needs. HCPF contracts with the Health Services Advisory Group, Inc. (HSAG) to administer an annual standardized survey to Medicaid members to understand different aspects of members' experience of care.

For FY 2021–22, HSAG administered the Health Plan Survey, which focused on the survey questions from the adult care survey about overall satisfaction with one's provider and health plan, the provider's communication skills, and the ability to get needed and timely care.

Tables 9 and 10 summarize RMHP's and DMHC's survey results for adult members, respectively.[5]

Table 9. Care Experience for Adults, RMHP Prime, FY 2018-19 to FY 2021-22

Experience of Care Metric	2018-19	2019-20	2020-21	2021-22	Colorado RAE Aggregate 2021-22*
Percentage of respondents rating their provider favorably	74.4%	75.1%	67.9%	61.2%	66.2%
Percentage of respondents rating their health plan favorably	69.1%	68.3%	55.1%	58.5%	55.2%

[5] 2022 Colorado Adult Regional Accountable Entity (RAE) Member Experience Report. Access the report at https://hcpf.colorado.gov/client-satisfaction-surveys-cahps.

Percentage of respondents pleased with how their provider communicates with them	95.1%	93.4%	92.1%	87.4%	91.3%
Percentage of respondents reporting receiving care as soon as needed	82.6%	83.1%	80.2%	80.2%	78.9%
Percentage of respondents reporting receiving the care they needed	84.2%	84.5%	83.5%	83.6%	80.9%

*Comparison group is all Medicaid members.

Table 10. Care Experience for Adults, DHMC, FY 2018-19 to FY 2021-22

Experience of Care Metric	2018-19	2019-20	2020-21	2021-22	Colorado RAE Aggregate 2021-22*
Percentage of respondents rating their provider favorably	66.0%	69.6%	77.7%	68.9%	66.2%
Percentage of respondents rating their health plan favorably	56.4%	60.3%	58.0%	58.6%	55.2%
Percentage of respondents pleased with how their provider communicates with them	92.0%	94.2%	94.2%	92.1%	91.3%

Percentage of respondents reporting receiving care as soon as needed	74.7%	73.5%	79.9%	71.3%	78.9%
Percentage of respondents reporting receiving the care they needed	71.8%	74.5%	84.1%	71.7%	80.9%

*Comparison group is all Medicaid members.

One aspect of member experience is the MCO's responsiveness to the member, which can be assessed through call center metrics. During this fiscal year, data was collected on speed of answer, or how long it took for the member to speak to someone. The figures below show these averages for every month of the 2021-22 fiscal year.

Figure 3. Average Speed of Answer for RMHP (RAE 1 and PRIME) by month, FY 2021-22

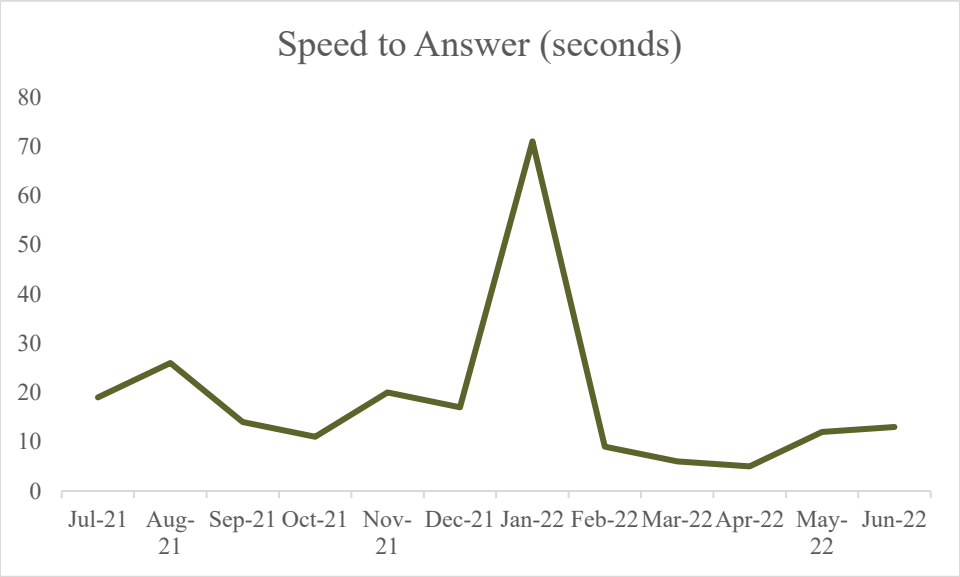


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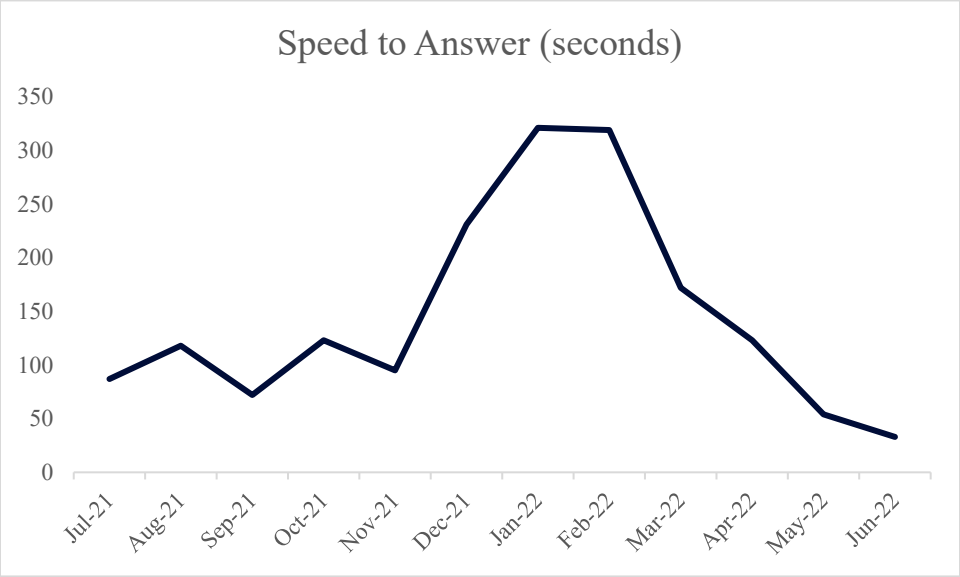
Figure 4. Average Speed of Answer for DHMC by month, FY 2021-22



VI. Future Plans for Managed Care Initiatives

As part of its ongoing work in payment reform and affordability, HCPF plans to continue with the two MCOs described in this report, keeping in mind that the entire ACC system is in the process of redesign in preparation for the RAE request for proposals in fall 2023, which will take effect in July 2025. This section describes the planned growth, changes, and focus areas for MCOs in the coming year. (Note that this does not include any changes that may come from the ACC redesign process.)

A. Continued Innovation in Value-Based Payments

Capitated managed care plans are a good place to test and advance different ways to incentivize better, more efficient, and more integrated care for members. In the coming year, HCPF will look at how its physical health MCOs are already using their PMPM budget along with other funding sources to implement innovative programs, so it may learn from these programs and scale or adapt them. For example, RMHP Prime's system has a system of tiered incentives for primary care practices to incentivize better integration of care. HCPF looks forward to learning the outcomes of such innovations in Region 1 and exploring how this work can inform statewide policy.

HCPF will also continue to explore trends in value-based payments and ways MCOs can implement payment models that increase provider investment in, and accountability for, health outcomes. For example, HCPF's FY 2023-24 approved budget includes funding for a 16% rate increase for providers that select the option to receive at least

a quarter of their revenue upfront, so they are invested in the cost and quality of care for members.

While payment models are an important part of payment innovation, it is also necessary and appropriate for HCPF to provide tools that assist providers in achieving the shared goals that are rewarded through value-based payments. MCOs are required to implement these tools to leverage HCPF's advances and maintain consistency across providers. One such tool is the Prescriber Tool, which was implemented in January 2021 (OpiSafe module) and June 2021 (affordability module). Another is the emerging eConsult Platform, which will allow primary care providers to collaborate electronically with specialty providers so they can work together to diagnose and manage a member's health care needs. Finally, the Colorado Providers of Distinction Program features cost and quality indicators to give providers timely feedback and insights.

B. Expansion of RMHP Prime

RMHP Prime began in 2015 in six counties on Colorado's Western Slope (Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco). Prime is building on its work by expanding into three additional Region 1 counties in FY 2022–23 (Delta, San Miguel, and Ouray). RHMP Prime is also working with HCPF to explore the possibility of expanding eligibility to include Medicaid-eligible children. This would give RMHP Prime the opportunity to leverage the infrastructure it has built to improve access and outcomes for members and create a better experience of care for members and providers alike.

C. Quality and Experience Metrics

Starting in FY 2022–23, quality metrics for the MCOs will be based on the Adult and Child Core Measure Sets set forth by the Centers for Medicare and Medicaid Services (CMS). CMS core measures are being adopted across programs to align efforts and maintain accountability while reducing measurement fatigue.

Another important change in data collection is in member experience data. In FY 2022–23, MCOs began collecting call center data, including average speed of answer, to better understand member experience and gain insight into whether members are receiving the support they need. The FY 2022-23 MCO report will include more of these call center metrics.