COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

April 15, 2022

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

Dear Representative McCluskie:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2020-2021 Medicaid Payment Reform and Innovation Pilot Program.

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 operated two payment reform initiatives under Section 25.5-5-415 C.R.S. during fiscal year 2020-2021. This report prepared by the Department 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, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

CC: Senator Chris Hansen, Vice-Chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Bettina Schneider, Finance Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

April 15, 2022

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 2020-2021 Medicaid Payment Reform and Innovation Pilot Program.

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

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee Legislative Council Library
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

April 15, 2022

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 2020-2021 Medicaid Payment Reform and Innovation Pilot Program.

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

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Cc: Representative David Ortiz, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee Re
Representative Chris Kennedy, Health and Insurance Committee
Representative Karen McCormick, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

April 15, 2022

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

Dear Representative Michaelson Jenet:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the fiscal year 2020-2021 Medicaid Payment Reform and Innovation Pilot Program.

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 operated two payment reform initiatives under Section 25.5-5-415 C.R.S. during fiscal year 2020-2021. This report prepared by the Department 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, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Cc: Representative Emily Sirota, Vice Chair, Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, Public & Behavioral Health & Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Medicaid Payment Reform and Innovation Pilot Program Report FY 2020-21

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

April 2022

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

Contents

COLORADO
Department of Health Care Policy & Financing

Executive Summary

This report focuses on the managed care payment reform initiatives by the Department of Health Care Policy & Financing (the Department) in FY 2020-21, as required by Section 25.5-5-415, C.R.S. This type of payment reform is just one of the Department's many affordability initiatives, which include cost transparency, prescription drug cost control, telemedicine, and value-based payments.

This report is largely focused on Health First Colorado (Colorado's Medicaid program) medical/physical health managed care payment reform initiatives. This report also includes a limited scope of widely reported behavioral health measures for these specific managed care organizations and therefore do not reflect the entirety of the state's safety net behavioral health system. As such, this report does not focus on behavioral health managed care broadly, which is administered regionally through the Accountable Care Collaborative (ACC). The FY 2020-21 ACC Implementation Report can be found on our Legislator Resource Center webpage.[1]

In summary, this report examines the following:

Managed Care Payment Reform Models in FY 2020-21

During FY 2020-21, the ACC included two physical health managed care capitation initiatives: Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Enrollees (RMHP Prime).

Although both DHMC and RMHP Prime are Managed Care Organizations (MCOs), the two plans work differently within the ACC. RMHP Prime is operated as part of the Region 1 Regional Accountable Entity (RAE) contract with RMHP, whereas the Department contracts directly with Denver Health for DHMC. RMHP Prime operates on Colorado's Western Slope and DHMC is based in the Denver metro area. These two MCOs serve populations with different needs and challenges. The aim of this report is to understand and learn from each model rather than compare them.

Enrollment in MCOs

During FY 2020-21, RMHP Prime had an average monthly enrollment of 43,529 members and Denver Health had 101,750 members. For context, enrollment in the ACC averaged 1.3 million members per month.

Metrics Used to Evaluate the MCO Payment Reform Initiatives

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

To evaluate the performance of MCO initiatives, the Department looks at both cost and program performance metrics. The following four sets of performance metrics are used:

- Medical loss ratio (MLR) quality metrics. The MLR is a measure of the percentage of dollars an MCO spends on direct health care and quality improvements. Each MCO has its own set of these MLR metrics that give the MCO the opportunity to dedicate more dollars toward strengthening the organization.

- Care utilization metrics. These metrics are selected by the Department to assess how and where members are receiving care. They are the same for both MCOs and include hospital readmission rate, emergency department visits, behavioral health engagement rate, and visits to a primary care provider.

- Healthcare Effectiveness Data and Information Set (HEDIS) clinical metrics. These are a set of standardized care access and utilization measures widely used for managed care across the nation.[2] MCOs report this data according to the National Committee for Quality Assurance (NCQA) HEDIS protocols, which use the calendar year rather than the fiscal year for reporting purposes. Therefore, the HEDIS data in this report is for January to December 2020 rather than the state fiscal year (July 2020 to June 2021).

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member experience data, which is a patient experience survey widely used across the nation.[3] This data reported here focuses 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.

Many outcomes, including enrollment numbers, per-member-per-month costs and, especially, utilization of health services were affected by the COVID-19 pandemic. Utilization of most services decreased during this time as people avoided health care settings and providers reallocated staff and other resources to pandemic response activities.

RMHP Highlights

In FY 2020-21, the total cost of care for RMHP Prime members was approximately $318.7 million. This comprises $228.0 million for physical health capitation payments,

[2] https://www.ncqa.org/hedis
[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS

$30.1 million for behavioral health capitation payments, and $60.6 million for fee-for-service payments not covered under capitation. The average per-member-per-month cost was $614. It is important to keep RMHP Prime's enrollment mix in mind when looking at costs. RMHP Prime serves far fewer children (including children with disabilities) than DHMC or Medicaid as a whole, and serves more adults with disabilities, including dually eligible Medicare-Medicaid members. This increases costs simply due to the services typically needed by these populations.

Key takeaways from RMHP Prime's program performance:

- RMHP met its MLR performance measure targets for emergency department utilization and reporting and plans for members experiencing homelessness. Data for substance use treatment initiation and engagement is not yet available.
- RMHP Prime's hospital readmission rate held relatively steady compared to the previous year, and its inpatient length of stay decreased. Similarly, although behavioral health engagement decreased (21.5% compared to 22.3% the previous year), RMHP Prime's work on behavioral health access and scaling up telehealth services may have prevented a steeper drop.
- Most measures of access for some preventive services, routine care, and screening decreased this year for RMHP Prime members, which aligns with larger trends of decreased service utilization during the pandemic. Three exceptions to this are timeliness of prenatal care (increase from 42.0% in 2019 to 56.7% in 2020), cervical cancer screening (from 39.4% to 40.3%), and asthma medication management (48.4% to 51.8%), despite the challenges of the pandemic. (Women's health is an improvement area for RMHP Prime, so these accomplishments are notable.)
- All experience of care metrics, which indicate member satisfaction with care, decreased in FY 2020-21. The cause of this decrease is not clear, as it follows three years of increased satisfaction, and is something to monitor next year.

DHMC Highlights

In FY 2020-21, the total cost of care for DHMC members was about $389.3 million. This comprises $248.6 million for physical health capitation payments, $59.7 million for behavioral health capitation payments, $74.6 million for fee-for-service payments not covered under capitation, and $6.4 million in payments for newborn deliveries. The average per-member-per-month cost was $322.

Key takeaways from DHMC's program performance:

- DHMC met its MLR performance measure targets for well-child care and reporting and plans for members experiencing homelessness. Data for timeliness of prenatal care and substance use treatment initiation and engagement is not yet available.
- The MCO showed a slight increase in members who accessed primary care despite the challenges of the pandemic. Behavioral health engagement decreased from 14.0% to 13.3% and is an area to watch. However, DHMC improved its performance in antidepressant medication management.
- DHMC had a large increase in pediatric counseling for nutrition (from 9.2% in 2019-20 to nearly 70% in 2020-21). This increase may reflect a change in routine practice or administrative procedures.
- Most member experience of care measures increased this year, continuing a trend of positive member experience.

Future Plans for Payment Reform

The Department plans to continue ongoing payment reform work with the two MCOs described in this report. Below are the planned growth, changes, and focus areas for MCOs in the coming year.

Expansion of Prime: RMHP Prime has submitted a proposal to expand the geographic area and member eligibility for RMHP Prime. The Department has agreed to expand the Prime program, at current eligibility, into three additional counties (San Miguel, Ouray, and Delta) starting FY 2022-23. Additional Prime expansion is being considered by the Department for FY 2023-24 and FY 2024-25.

Condition Management: The goal of condition management is to identify persons at risk for one or more chronic conditions, to promote self-management by members and to address the conditions with maximum clinical outcome, effectiveness, and efficiency. That is why condition management is an important factor in better care and outcomes, and it will continue to be a priority for both the RAEs and MCOs in the coming year. With fewer than 5% of members contributing more than 50% of claim costs, a focused approach for managing care should result in lower costs and improved outcomes. The Department will continue to work with RAEs and MCOs to strengthen condition management programs, set performance measures and goals, and improve risk stratification among members to identify members to participate in the program.

Maternal Health: Maternal and infant health outcomes are among the most important indicators of the health of the state and nation, which is why improving maternal health is among the Department's top health equity priorities. A Maternity Advisory

Committee began meeting in August 2021, comprising primarily of Black, Indigenous, and People of Color (BIPOC) with lived experience in Medicaid maternity care.[4] The Department will continue to work with MCOs and RAEs to look for innovative ways to achieve maternal health equity and meet the needs of pregnant and postpartum members, as well as improve performance on key indicators.

CMS Core Measures: The Department is shifting focus where applicable to the Adult and Child Core Measure Sets on quality of care and health outcomes set forth by the CMS for use in incentive programs.[5] The Department is working to align efforts across all programs statewide to maintain accountability while reducing measurement fatigue. Alignment efforts are happening in all Department programs, including the ACC and MCO payment reform initiatives.

Last, this pandemic year has demonstrated the importance of the care coordination and infrastructure provided by the ACC and MCOs to the necessary functioning of the broader health care delivery system. Interventions like outreach to members with chronic conditions, rapid deployment and support of telehealth services, and flexible approaches to closing the vaccination equity gap would have been difficult, if not impossible, in a fragmented fee-for-service system.

Further details are in the body of the report below.

[4] https://hcpf.colorado.gov/maternity-advisory-committee
[5] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

I. Medicaid Payment Reform and Innovation in Colorado

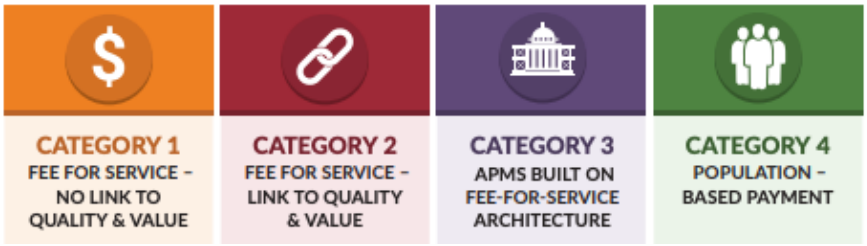
The Department provides health coverage to low income and disabled Coloradans through safety net programs like Health First Colorado (Colorado's Medicaid program) and the Child Health Plan *Plus* (CHP+). With the economic impact of the COVID-19 pandemic, the Department now covers over 1.6 million Coloradans, one in every four people in the state. Given the costs of health care, the Department continues to pursue strategies for making care more affordable and sustainable.

This report focuses on managed care payment reform initiatives in FY 2020-21, as required by Section 25.5-5-415, C.R.S. This type of payment reform is just one of the Department's many affordability initiatives, which include cost transparency, prescription drug cost control, telemedicine, and value-based payments. See https://hcpf.colorado.gov/affordability for more information on these and other initiatives.

Managed care is an alternative to fee-for-service (FFS) payment models. In FFS models, the health care provider is paid for every individual service, with limited ways to connect services to quality, costs, or outcomes. Unlike FFS, a traditional managed care model incentivizes cost savings by using a capitation (per-member-per-month fee) for some or all care and requiring plans to meet the member's needs for that amount.

Managed care models like the ones highlighted in this report also include value-based payments, which reward high-quality care and health outcomes. These models fall into Category 4 of the Health Care Payment Learning & Action Network's Alternative Payment Model Framework.

Figure 1. The Alternative Payment Model (APM) Framework[6]



[6] Health Care Payment Learning & Action Network. (2017). *Alternative Payment Model APM Framework*. Retrieved from http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

A. Managed Care Organizations in the Accountable Care Collaborative

All Medicaid payment reform initiatives in Colorado are meant to operate within the ACC. The ACC was established in 2011 and it is at the core of the state's Medicaid program. Its fundamental premise is that regional communities are in the best position to deliver the programs designed to improve member health and reduce costs.

For this reason, the ACC does not use one central administrative organization, but instead has a Regional Accountable Entity (RAE) in each of the seven regions of the state. The RAE contracts with primary care medical providers (PCMPs), which are paid fee-for-service for the medical care they provide as well as a per-member-per-month payment from the RAEs for their medical home services.

The RAEs also administer the behavior health managed care program in their region. They receive a capitated per-member-per-month fee to deliver most behavioral health services. With few exceptions, Medicaid behavioral health care services are delivered under this managed care model.

This report does not focus on behavioral health managed care, but rather on medical/physical health managed care payment reform initiatives. These initiatives are described in the next section.

B. Managed Care Payment Reform Models in FY 2020-21

During FY 2020-21, the ACC included two physical health managed care capitation initiatives: Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Enrollees (RMHP Prime).

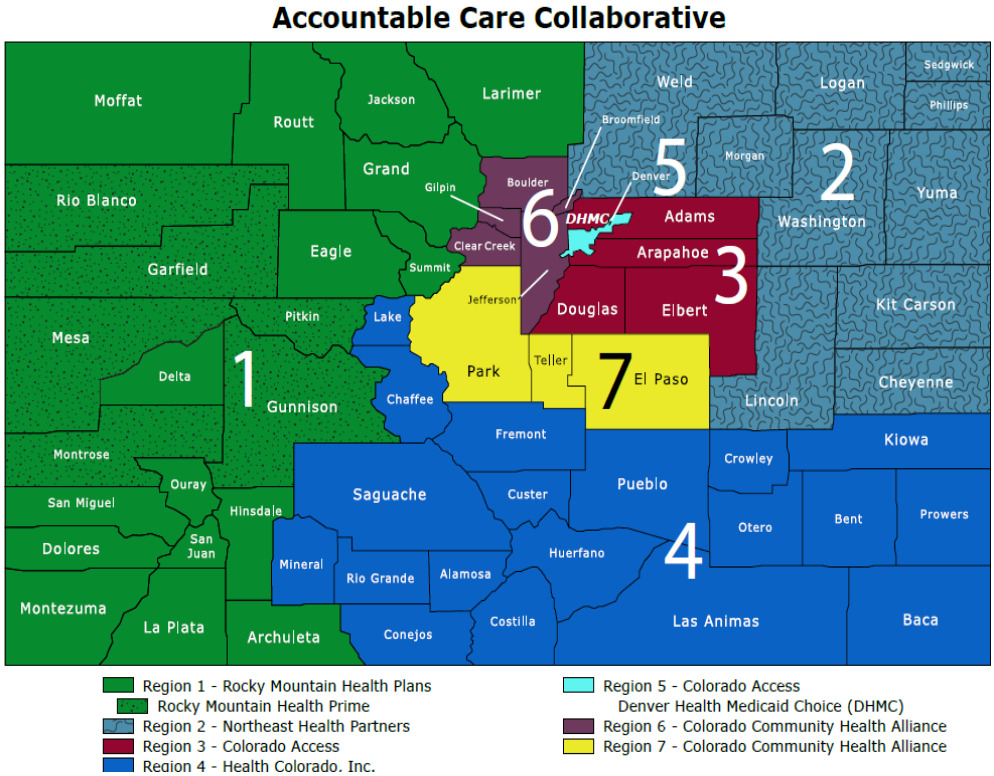
Although both DHMC and RMHP Prime are MCOs, the two plans work differently within the ACC. RMHP Prime is operated as part of the Region 1 RAE contract with RMHP, whereas the Department contracts directly with Denver Health for DHMC. More details about the structure of each MCO may be found in the program-specific sections of this report.

RMHP Prime and DHMC operate in different parts of the state in different economic and geographic environments. 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 area — including Gunnison, Mesa, and Montrose counties, and portions of Rio Blanco county — is also a HPSA for primary care.[7]

DHMC is based in the Denver metro area, covering about 2,900 square miles 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.[8]

Figure 2. Regions, RAEs, and Managed Care Organizations of the Accountable Care Collaborative



[7] 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.
[8] Colorado Department of Public Health and Environment. (2015). Accessed March 2022.

These two MCOs serve populations with different needs and challenges, so the aim of this report is to understand and learn from each model rather than compare them.

C. Enrollment in MCOs

During FY 2020-21, RMHP Prime had an average monthly enrollment of 43,529 members and Denver Health had 101,750 members. For context, enrollment in the entire ACC averaged 1.3 million members per month. As with all of the Department's programs, RMHP Prime saw an increase in monthly members in FY 2020-21 due to the expanded eligibility (extended continuous eligibility federally required during the public health emergency) and economic challenges during the COVID-19 pandemic. To accommodate this increase in eligibility, both MCOs also had their enrollment cap increased.

Figure 3. Average Enrollment in ACC and MCOs by Eligibility, FY 2020-21

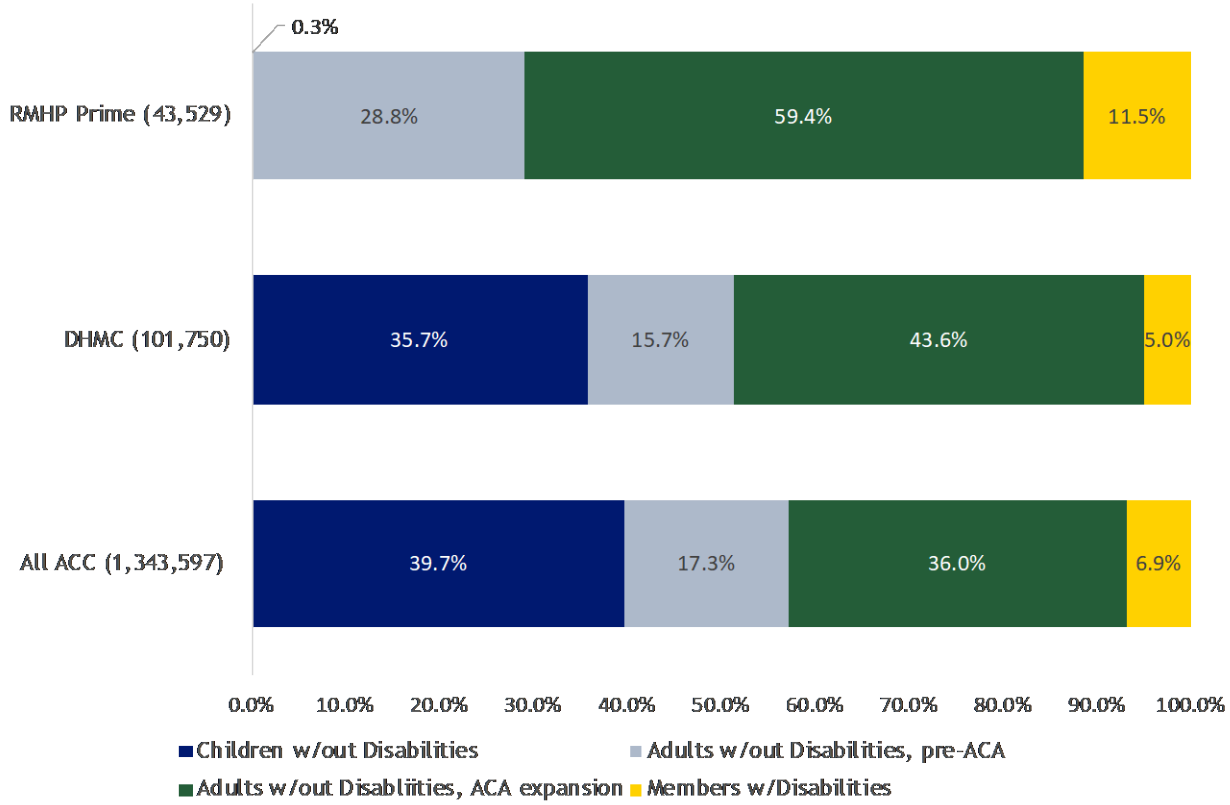


Figure 3 reveals another way the two managed care plans differ: the enrollment mix. RMHP Prime does not include children without disabilities and includes only a small number of children with disabilities. It also serves more adults with disabilities, including dually eligible Medicare-Medicaid members. This affects the priorities, strategies, and per-member-per-month costs of the two plans.

D. Metrics Used to Evaluate the MCO Payment Reform Initiatives

To evaluate the performance of MCO initiatives, the Department looks at both cost and program performance metrics. The following four sets of performance metrics are used: medical loss ratio (MLR) quality metrics, care utilization metrics, Healthcare Effectiveness Data and Information Set (HEDIS) clinical metrics, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience data. Each is described below.

Medical Loss Ratio Quality Metrics

The 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.

Care Utilization Metrics

Care utilization metrics were selected by the Department 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, with the exception of some conditions (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 worsening of conditions that lead to unnecessary and avoidable readmissions, which are also 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.

Utilization of these and other health services was affected by the COVID-19 pandemic. Utilization of most services decreased during this time as people avoided health care settings and providers reallocated staff and other resources to pandemic response activities. Hospital readmissions may have been affected due to readmissions for COVID-19 patients and the pandemic's effect on decisions about hospital beds and acuity during periods of constrained capacity.[9] Emergency department visits declined along with most other utilization of health services.

HEDIS Clinical Metrics

MCO evaluation includes some measures from the HEDIS, a set of care access and utilization measures widely used for managed care.[10] MCOs report this data according to the National Committee for Quality Assurance (NCQA) HEDIS protocols, which use the calendar year rather than the fiscal year for reporting purposes. Therefore, the HEDIS data in this report is for January to December 2020 rather than the state fiscal year (July 2020 to June 2021).

When historical data is available, this report looks at HEDIS measures over time using the most recent four years of data to assess if MCOs have been able to improve performance. For additional context, the state Medicaid average value for each HEDIS 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 HEDIS clinical measures used this year.

- Preventive care for children and adolescents (DHMC only)

[9] Salzberg, C. and Kahn, C. (2021, May 24). COVID-19 will upend hospital reporting and value-based programs for years to come. *Health Affairs Blog*. DOI: 10.1377/hblog20210520.815024.
[10] "Major Health Plan Quality Measurement Sets." Agency for Healthcare Quality and Research. Accessed at https://www.ahrq.gov/talkingquality/measures/setting/health-plan/measurement-sets on March 3, 2022.

- **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.
- **Adult Access to Preventive/Ambulatory Health Services.** Percentage of members ages 20+ who had an ambulatory or preventive care visit.
- **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.
- **Inpatient Length of Stay**. Average number of days members spent in inpatient care across members of all ages for total surgery, medicine, and maternity days (psychiatric inpatient care excluded).

CAHPS® Member Experience Survey Data

The Department contracts with the Health Services Advisory Group, Inc. (HSAG) to administer a standardized survey to Medicaid members annually to understand different aspects of members' experience of care. This year, HSAG administered a

modified Consumer Assessment of Healthcare Providers and Systems Clinician & Group (CG-CAHPS®) 3.0 Survey. This year's analysis focuses 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.

II. Rocky Mountain Health Plans Prime

This section of the report describes the RMHP Prime MCO, including its program design, costs for FY 2020-21, and program performance.

A. Rocky Mountain Health Plans Prime Program Design

RMHP Prime is a program of Rocky Mountain Health Plans, which is 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.

B. RMHP Prime Cost of Care

RMHP Prime is designed to be budget neutral; capitation payments must be at or below 98% of the fee-for-service equivalent.

Table 1 shows the total cost of care, which includes these medical/physical health capitations as well as the behavioral health capitation. It also includes FFS payments for services that are not included in the capitation, such as long-term services and supports, medical transportation, and some Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children. Average per-member-per-month cost was $614 in FY 2020-21.

Table 1. RMHP Prime Cost of Care, FY 2020-21[11]

Cost	Description	Amount

[11] The total cost of care included in this table reflects the Physical Health and Behavioral Health Capitation payments and Fee-for-Service claims with runout through November 2021. This may differ from numbers reported elsewhere.

Physical Health Capitation	Per-member-per-month fee for medical care	$ 228,025,094
Behavioral Health Capitation	Per-member-per-month fee for mental health care and substance use treatment	$ 30,115,158
Fee-for-Service Payments	Payments for services not covered under the capitation (e.g., long-term services and supports, medical transportation)	$ 60,589,188
Total		**$ 318,729,440**

C. RMHP Prime Program Performance

This section includes results of the four sets of metrics used to assess program performance: MLR quality metrics, care utilization metrics, HEDIS clinical metrics, and member experience data.

RMHP Prime Medical Loss Ratio Quality

The following metrics were used to incentivize a lower MLR for RMHP Prime in FY 2020-21:

1. **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.
2. **Emergency Department Rate**. This measures number of emergency department visits per-thousand members per-year.
3. **Housing and Health**. This requires RMHP Prime to submit quarterly reports and attend quarterly check-in forums to explore how housing impacts health and cost outcomes.

In state FY 2020-21 RMHP Prime's MLR floor began at 89%, 4% above the federally required standard of 85%. Prime can lower its MLR floor by 1% for meeting the target for the first metric, 2% for meeting the target for the second one, and 1% for meeting the third.

Table 2 shows the performance benchmark (target) and Prime's performance for FY 2020-21. The target for metric 1 reflects a 5% increase in performance from the

previous year. The data are not yet available because this is a HEDIS metric that is measured for the 2021 calendar year; data will be available later in 2022. The target for metric 2 represents a 3% improvement from the previous year. RMHP met this metric target. Metric 3 is a reporting and collaboration requirement.

Table 2. RMHP Prime Performance on MLR Metrics Compared to Benchmarks, FY 2020-21

MLR Metric	Performance	Benchmark	Met?
Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Data not yet available.	12.92%	**TBD**
Metric 2: Emergency Department Utilization Rate: visits per 1,000 members per year (goal is to decrease utilization; not risk-adjusted)	486.45	747.99	**Met**
Metric 3: Housing and Health	Quarterly reports and check-in meetings (4 total)	Quarterly reports and check-in meetings (4 total)	**Met**

Metric 3 does not yet have quantitative measures. The intention at this point is to learn about the impact of housing insecurity on member health and foster innovation for addressing it. However, RMHP is seeing important changes anecdotally. For example, one of their members had been experiencing homelessness since release from incarceration. The member was at high risk for COVID-19 and had several complex chronic health conditions, including diabetes, depression, and hypertension. The RMHP Prime care coordinator worked with RMHP's housing and health program to find bridge housing for the member and, eventually, stable housing. Once the member had a place to live, the member could partner more effectively with the care coordinator to access mental health care, manage his blood sugars, improve his diet, and engage in other recommended self-care. As a result, the member has decreased his use of the ED and, equally important, is making progress toward his long-term life goals. We will continue to collect such quantitative information to better identify trends and patterns that may enable more quantitative measures in the future.

RMHP Care Utilization

Care utilization metrics provide insight into how and where people are receiving care. Table 3 shows the trend in these measures for the current and past two fiscal years.

Note that the ED 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 below is risk-adjusted while the MLR measure above is not.

Table 3. Care Utilization for RMHP Prime, FY 2018-19 to FY 2020-21

Care Utilization Metric	2018-19	2019-20	2020-21
Hospital All-Cause Readmission (goal is to decrease utilization)	10.6%	10.1%	10.2%
Behavioral Health Engagement Rate (goal is to increase utilization)	22.9%	22.3%	21.5%
Percentage of members with 1+ visits to a PCMP (goal is to increase utilization)	69.1%	68.0%	65.4%
Risk-adjusted emergency department visits per 1,000 members per year (goal is to decrease utilization)	862	777	683

The hospital readmissions rate held steady (10.2% compared to 10.1% in FY 2019-20), and the behavioral health engagement rate fell only slightly (21.5% compared to 22.3% in FY 2019-20). The percentage of members with at least one visit to a PCMP fell to 65.4% from 68% in FY 2019-20. ED visits also decreased this year for RMHP Prime members, from 777 visits per thousand members per year to 683.

As discussed in an earlier section, utilization for many health services declined during the pandemic. Behavioral health engagement decreased slightly but a steeper drop was likely prevented by RMHP's work to increase availability of behavioral health telehealth and connect members to needed services. In one example of how RMHP Prime does this, a member needed a range of behavioral health services, such as detox, therapy, recovery coaching, and medical care. An RMHP care coordinator worked with the member to facilitate access to all needed services, and helped the member find stable housing. As a result, the member was able to reconnect with family and receive their support—an important protective factor and determinant of health.

RMHP Prime HEDIS Clinical Measures

This section includes a table that shows RMHP Prime's results on HEDIS clinical measures for calendar years 2017–2020. (HEDIS measures are reported for calendar years rather than the state fiscal year.) For additional context, the state Medicaid average values are also included for each measure. Medicaid averages are weighted (adjusted) for each measure so that the rate for an MCO with many members has a greater impact on the overall Colorado Medicaid statewide weighted average rate than the rate for an MCO with fewer members. However, results have not been risk-adjusted to account for potential differences in the acuity of each MCO's enrolled population and the state.

For more information about the HEDIS measures, see the description of these measures in Section I, reference Part D of this report.

Note that these HEDIS measures are based on administrative claims data only, without medical 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.

Table 4. HEDIS Measures for RMHP Prime, Calendar Years 2017-2020

HEDIS Measure	2017	2018	2019	2020	CO Medicaid Average 2020*
Timeliness of Prenatal Care	22.7%	44.7%	42.0%	56.7%	70.5%
Postpartum Care	27.2%	28.6%	35.9%	32.9%	51.7%
Adult Access to Preventive/ Ambulatory Health Services (for members ages 20+)	70.9%	71.8%	72.1%	69.5%	59.1%
Breast Cancer Screening	50.4%	50.1%	48.0%	44.8%	43.8%
Cervical Cancer Screening	43.2%	41.9%	39.4%	40.3%	40.7%
Chlamydia Screening	49.3%	46.5%	47.8%	45.0%	60.2%
Antidepressant Medication Management: Acute	52.3%	52.2%	73.7%	55.5%	58.1%

HEDIS Measure	2017	2018	2019	2020	CO Medicaid Average 2020*
Antidepressant Medication Management: Continuation	34.5%	33.9%	64.9%	42.5%	41.7%
Asthma Medication Ratio	52.1%	53.7%	48.4%	51.8%	51.6%
Total Inpatient Length of Stay	3.6 Days	3.7 Days	4.3 Days	4.2 Days	4.7 Days

*Medicaid averages are weighted (adjusted) for each measure. Weighting the rates by eligible population sizes ensured that the rate for an MCO with many members had a greater impact on the overall Colorado Medicaid statewide weighted average rate than the rate for an MCO with fewer members

The percentage of pregnant members who received timely prenatal care increased quite a bit, from 42.0% in 2019 to 56.7%. The percentage of members who had a live birth delivery that had a postpartum visit on or between 21 and 56 days after delivery decreased (32.9% compared to 35.9% in 2019). Both measures were below the Medicaid average for 2020. However, RMHP Prime exceeded the Medicaid average for Adult Access to Preventive/Ambulatory Services with 69.5% of members 20 years of age and older who had an ambulatory or preventive care visit during the year. Performance on all measures was low compared to national standards; all were in the 25th percentile for national Medicaid standards.

RMHP Prime's rate of breast cancer screening (44.8%) was above the Medicaid average of 43.8%. The cervical cancer screening rate of 40.3% was an increase from the previous year and about the same as the Medicaid average of 40.7%. Women's health is a growth area for RMHP, so this increase during a pandemic year is notable. The rate of chlamydia screening for women (45.0%) was lower than the Colorado Medicaid average of 60.2%.

In FY 2020-21, the percentage of members who stayed on their antidepressant medication in the acute phase was 55.5%, lower than the Medicaid average 58.1%. For the continuation phase, 42.5% of members remained on their medication, a bit higher than the Medicaid average of 41.7%. Both measures were above the national Medicaid 50th percentile.

The Asthma Medication Ratio measures what 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. The asthma medication ratio measure increased

slightly to 51.8%, about the same as the Colorado Medicaid average of 51.6%, but in the 25th percentile for Medicaid nationally.

The average length of an inpatient hospital stay captures the average number of days members spent in inpatient care across members of all ages for total surgery, medicine, and maternity days (psychiatric inpatient care is excluded). Studies on managed care have analyzed the impact of enrollment of members in managed care plans compared to fee-for-service members and found associations between enrollment and preventable hospitalization rates and average length of inpatient hospital stays. These results point to an important relationship between managed care and prevention or reduction of unwanted or unnecessary utilization of services. This metric decreased slightly from the previous year and was below the Colorado Medicaid average.

RMHP Prime CAHPS® Member Experience

Table 5 summarizes the results of the 2021 CAHPS® member experience survey. Member ratings on all measures decreased this year, and two were below the Colorado Medicaid average (ratings of provider and health plan). However, provider communication continued to be rated highly among members and was above the Colorado Medicaid average.

About 80% of members reported that they received care as soon as they needed it, while about 84% of members reported receiving the care they needed. No analysis has been conducted to assess statistical significance of any changes in percentages from year to year.

Table 5. Ratings of Care Experience for RMHP Prime, FY 2017-18 to FY 2020-21

Experience of Care Metric	2017-18	2018-19	2019-20	2020-21	Colorado RAE Aggregate 2020-21*
Percentage of respondents rating their provider favorably	68.7%	74.4%	75.1%	67.9%	68.0%
Percentage of respondents rating their health plan favorably	56.5%	69.1%	68.3%	55.1%	65.8%
Percentage of respondents pleased with how their provider communicates with them	92.2%	95.1%	93.4%	92.1%	76.2%

Percentage of respondents reporting receiving care as soon as needed	85.8%	82.6%	83.1%	80.2%	N/A
Percentage of respondents reporting receiving the care they needed	82.5%	84.2%	84.5%	83.5%	N/A

*Comparison group is all Colorado Medicaid members.
Source: 2021 Colorado Patient-Centered Medical Home Survey Adult Report

III. Denver Health Medicaid Choice

This section describes the Denver Health Medicaid Choice (DHMC) MCO, including its program design, costs for FY 2020-21, and program performance.

A. DHMC Program Design

Denver Health Medicaid Choice (DHMC) is a staff-model MCO that has operated in Colorado since 2004. 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.

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

B. DHMC Cost of Care

DHMC is designed to be budget neutral; capitations do not exceed more than what comparable services would have cost fee-for-service.

Table 6 shows the total cost of care, which includes medical/physical health capitations as well as the behavioral health capitation. It also includes separate payments for newborn deliveries and fee-for-service payments for services that are not included in the capitation (e.g., long-term services and supports, medical transportation, and some EPSDT services for children). Average per-member-per-month cost was $322 in FY 2020-21.

Table 6. DHMC Cost of Care, FY 2020-21[12]

Cost	Description	Amount
Physical Health Capitation	Per-member-per-month fee for medical care	$ 248,559,068
Behavioral Health Capitation	Per-member-per-month fee for mental health care and substance use treatment	$ 59,691,752
Fee-for-Service Payments	Payments for services not covered under the capitation (e.g., medical transportation, long-term services and supports)	$ 74,628,893
Delivery Paid Amounts	Payments made to clinics that charge an encounter fee for care (e.g., FQHCs)	$ 6,404,634
Total		**$ 389,284,347**

C. DHMC Program Performance

This section includes results of the four sets of metrics used to assess program performance: medical loss ratio (MLR) quality metrics, care utilization metrics, HEDIS clinical metrics, and member experience data.

DHMC Medical Loss Ratio Quality

The following metrics were used to incentivize a lower MLR for DHMC in FY 2020-21:

1. **Well-Child Care.** This measures the percentage of children (aged 0–20 years) receiving at least one periodic screening under the EPSDT benefit.
2. **Timeliness of Prenatal Care.** This measures the percentage of members who received a prenatal visit during pregnancy.
3. **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.

[12] The total cost of care included in this table reflects the Physical Health and Behavioral Health Capitation payments and Fee-for-Service claims with runout through November 2021. This may differ from numbers reported elsewhere.

4. **Housing and Health.** This requires DHMC to submit quarterly reports and attend quarterly check-in forums to explore how housing impacts health and cost outcomes.

In state FY 2020-21, DHMC's MLR began at 89%, 4% above the federally required standard of 85%. It can lower its MLR by 1% for meeting each metric's target shown in Table 7.

Table 7. DHMC Performance on MLR Metrics Compared to Benchmarks, FY 2020-21

DHMC MLR Metric	Performance	Benchmark	Met?
Metric 1: Well-Child Care (goal is to increase utilization)	43%	41.4%	**Met**
Metric 2: Timeliness of Prenatal Care (goal is to increase utilization)	Data not yet available	77.1%	**TBD**
Metric 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (goal is to increase utilization)	Data not yet available.	Initiation (ages 13-17): 53.2% Engagement (13-17): 23.9% Initiation (18+): 44.0% Engagement (18+): 7.4%	**TBD**
Metric 4: Housing and Health	Quarterly reports and check-in meetings (4 total)	Quarterly reports and check-in meetings (4 total)	**Met**

The target for metric 1 reflects an 8% increase in performance from the previous year. The target for metric 2 is a 10% increase over the previous year. The data for metric 2 is not yet available because it is measured for the 2021 calendar year; it will be available later in 2022. The targets for metric 3 reflect a 5% increase in performance from the previous year for each sub-metric. The data for metric 3 is not yet available because it is a HEDIS metric that is measured for the 2021 calendar year; it will be available later in 2022. Metric 4 is a reporting and collaboration requirement.

DHMC Care Utilization

Care utilization metrics provide insight into how and where members are receiving care. Table 8 shows the trend in these measures for the current and past two fiscal years.

Table 8. Care Utilization for DHMC, FY 2018-19 to FY 2020-21

Care Utilization Metric	2018-19	2019-20	2020-21
Hospital All-Cause Readmission (goal is to decrease utilization)	10.5%	10.1%	11.9%
Behavioral Health Engagement Rate (goal is to increase utilization)	14.6%	14.0%	13.3%
Percentage of members with 1+ visits to a PCMP (goal is to increase utilization)	64.1%	55.1%	55.3%
Emergency department visits per 1,000 members per year (goal is to decrease utilization)	641	576	482

The hospital readmissions rate increased slightly (11.9% compared to 10.1% in FY 2019-20), and the behavioral health engagement rate fell (13.3% compared to 14.0% in FY 2019-20). Emergency department visit rates decreased this year for DHMC members, from 576 visits per thousand members per year to 482. As discussed in an earlier section on Care Utilization Metrics, utilization of many health services declined during the pandemic.

The percentage of members with at least one visit to a PCMP held steady (55.3% compared to 55.1% in FY 2019-20) during a year when many people were going to the doctor less often due to the pandemic. This may be due in part to the work that DHMC does to keep members connected to primary care. In addition to communicating the importance of primary care to members, DHMC addresses obstacles that may get in the way of accessing this care. For one member with challenges due to obesity and poor mobility, the care manager addressed the logistical challenges and member's fears about finding transportation and medical facilities that could accommodate the member's size. For another, it was a language barrier that DHMC worked with translators to address. Care managers work collaboratively with primary care providers to ensure that members stay connected to their care, especially when they have multiple complex conditions.

DHMC HEDIS Clinical Measures

This section includes a table that shows DHMC's results on HEDIS clinical measures for calendar years 2017–2020. (HEDIS measures are reported for calendar years rather than the state fiscal year.) For additional context, the state Medicaid average values are also included for each measure. However, results have not been risk-adjusted to account for potential differences in the acuity of each MCO's enrolled population and the state. For all but the last of the clinical measures in the below chart, the goal is to increase utilization; for the last measure – total inpatient length of stay – the goal is to decrease utilization.

For more information about the HEDIS measures, see the description of these measures in Section I, Part D of this report.

Table 9. HEDIS Measures for DHMC, Calendar Years 2017–2020

HEDIS Measure	2017	2018	2019	2020	CO Medicaid Average 2020*
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: New Measure			54.7%	54.7%
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: New Measure			57.1%	57.2%
Child and Adolescent Well Care Visits (members ages 3–21 who received one well visit)	N/A: New Measure			39.3%	38.3%
Counseling for Nutrition (members ages 3–17 who received nutrition counseling)	6.0%	7.5%	9.2%	69.9%	69.0%
Timeliness of Prenatal Care	64.6%	71.9%	84.5%	83.4%	70.5%

HEDIS Measure	2017	2018	2019	2020	CO Medicaid Average 2020*
Postpartum Care	49.1%	56.7%	66.5%	69.2%	51.7%
Adult Access to Preventive/ Ambulatory Health Services (for members ages 20+)	55.2%	53.9%	55.3%	51.5%	59.1%
Breast Cancer Screening	50.7%	46.5%	46.0%	42.6%	43.8%
Cervical Cancer Screening	43.0%	43.1%	45.6%	41.1%	40.7%
Chlamydia Screening	66.7%	69.6%	72.9%	67.4%	60.2%
Antidepressant Medication Management: Acute	54.9%	54.2%	57.2%	61.1%	58.1%
Antidepressant Medication Management: Continuation	33.5%	34.0%	37.7%	40.7%	41.7%
Asthma Medication Ratio	63.8%	46.6%	46.6%	51.4%	51.6%
Total Inpatient Length of Stay	4.7 Days	4.6 Days	4.4 Days	5.1 Days	4.7 Days

*Medicaid averages are weighted (adjusted) for each measure. Weighting the rates by eligible population sizes ensured that the rate for an MCO with many members had a greater impact on the overall Colorado Medicaid statewide weighted average rate than the rate for an MCO with fewer members.

HEDIS redesigned some of its well-child visit measures, so comparisons to past years are not possible. DHMC's outcomes were about the same as the Colorado Medicaid average on every measure. Both DHMC and Colorado Medicaid as a whole made dramatic gains in child nutrition counseling, and both were just below the 50th percentile for Medicaid nationally. This increase may reflect a change in routine practice or administrative procedures.

DHMC exceeded the Colorado Medicaid average for both timeliness of prenatal care and for postpartum care (69.2% compared to 51.7% Medicaid average). This is a promising sign during a pandemic year in which many people sought fewer routine

care services. However, both measures were in the 25th percentile for national Medicaid standards, so there is room for growth, especially given Colorado's focus on improving maternal and child health.

The percentage of adult members with at least one preventive or ambulatory health care visit dropped from 55.3% to 51.5% in 2020, which is consistent with lower utilization of most health services during the first year of the pandemic.

Like most prevention services, women's health screenings decreased for DHMC and Medicaid as whole during 2020. However, DHMC was slightly below the Medicaid average for breast cancer screening (42.6% compared to the Medicaid average of 43.8%), slightly above the Medicaid average for cervical cancer screening (41.1% compared to the Medicaid average of 40.7%), and well above for chlamydia screening (67.4% compared to the Medicaid average of 60.2%). By national Medicaid standards, DHMC was in the 25th percentile for the first two measures but above the 50th percentile for chlamydia screening.

In FY 2020-21, the percentage of DHMC members who stayed on their antidepressant medication in the acute phase was 60.1%, higher than the Colorado Medicaid average 58.1%. For the continuation phase, 40.7% of members remained on their medication, a bit below the Colorado Medicaid average of 41.7%. Both measures were above the 50th percentile for Medicaid nationally and both improved from the previous calendar year.

The Asthma Medication Ratio measures what 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. DHMC's performance improved in 2020 compared with 2019.

The average length of hospital stay increased in 2020 after falling the previous three years. It was higher than the Colorado Medicaid average (4.7 days), which increased in 2020 as well.

DHMC CAHPS® Member Experience

Table 10 summarizes the results of the 2021 CAHPS® member experience survey. Member ratings on all measures but one increased (improved) this year, and most were above the Colorado Medicaid average.

Nearly 80% of members reported that they received care as soon as they needed it, while about 84% of members reported receiving the care they needed. No analysis has

been conducted to assess statistical significance of any changes in percentages from year to year.

Table 10. Ratings of Care Experience for DHMC, FY 2017-18 to FY 2020-21

Experience of Care Metric	2017-18	2018-19	2019-20	2020-21	Colorado RAE Aggregate 2020-21*
Percentage of respondents rating their provider favorably	70.9%	66.0%	69.6%	77.7%	68.0%
Percentage of respondents rating their health plan favorably	59.1%	56.4%	60.3%	58.0%	65.8%
Percentage of respondents pleased with how their provider communicates with them	92.5%	92.0%	94.2%	94.2%	76.2%
Percentage of respondents reporting receiving care as soon as needed	78.0%	74.7%	73.5%	79.9%	N/A
Percentage of respondents reporting receiving the care they needed	77.5%	71.8%	74.5%	84.1%	N/A

*Comparison group is all Medicaid members.
Source: 2021 Colorado Patient-Centered Medical Home Survey Adult Report

IV. Evaluation Challenges and Limitations

A. Challenges with Comparing MCO Populations to Others

Analysis of the MCO program performance in this report is limited to comparing the MCO's performance over time rather than against any benchmark or comparison group. It is difficult to identify appropriate comparison groups given the unique population mix in each MCO and variations in geographic, economic, and health access factors. In addition, the Department is working on various payment reform initiatives, so there is no comparison group that is under a fee-for-service model alone with no other intervention.

The Department regularly looks for lessons learned across all its payment reform work and assesses which aspects are working, which ones can be scaled up to include additional populations, and which work best as regional initiatives to meet the specific needs of the population they serve. Below are some learnings from the MCOs:

- Both RMHP Prime and DHMC continue to demonstrate that complex condition management is important and effective. Complex conditions require a skilled care coordinator or manager to navigate multiple solutions simultaneously. For example, at DHMC, a member with a traumatic brain injury and no family support needed medical care and behavioral health care, but also needed help with finding a suitable living situation and doing household chores. The care manager drew on Medicaid benefits and community resources to meet the client's health, financial, and transportation needs. As a result, the member was able to continue accessing care to prevent further decline.
- The MCOs are focused on addressing equity issues that are prevalent in their region. While all MCOs and RAEs worked to scale up telehealth during COVID-19, RMHP Prime responded to the needs of its rural populations to ensure that the service was accessible to them. DHMC promotes equity in a number of ways, including culturally and linguistically responsive care management. For example, in the process of helping a family get the help they needed for their autistic son, a care manager also worked with an Amharic interpreter to explain how to navigate the health system for themselves and their child. The child received needed care and the rest of the family was connected to primary and dental care.
- Both MCOs are invested in solving issues with housing and health. Stable housing increases the chances that members can take care of their health and decreases unnecessary emergency department use. RMHP Prime's care coordinators work closely with Rocky Mountain Health Plan's Housing and Health program to connect members to stable housing through community partnerships throughout the region. DHMC care managers use a number of approaches and city resources, including a home sharing nonprofit, job and housing programs through faith-based organizations, a protective action housing program (for safe housing during COVID-19, and community shelters.

B. Impact of the COVID-19 Pandemic

The performance period for this report is July 2020 to June 2021, a year of unpredictability and uncertainty in health care and the economy due to the ongoing COVID-19 pandemic. Like other Medicaid programs across the country, Colorado's Medicaid program has been affected in countless large and small ways. Enrollment, costs, and service utilization were all affected by the pandemic, so the data in this

report are not necessarily comparable to past years or always helpful for guiding policy decisions.

Nevertheless, this pandemic year has demonstrated the importance of the care coordination and infrastructure provided by the ACC and MCOs to the necessary functioning of the broader health care delivery system. Interventions like outreach to members with chronic conditions, rapid deployment and support of telehealth services, and flexible approaches to closing the vaccination equity gap would have been difficult, if not impossible, in a fragmented fee-for-service system.

For example, an RMHP Prime member who lived in a rural area had a history of behavioral issues and chronic conditions that put the member at high risk for COVID-19. A care coordinator was able to connect the member to both primary care and behavioral health services via telehealth, ensuring that the member could get needed care while also managing COVID-19 exposure.

At DHMC, care managers worked to get their members care in a range of challenging situations. In one instance during the pandemic, a member was visiting family in another state and was admitted to the hospital during lockdown after contracting COVID-19. The member was not well enough to travel and was still testing positive for COVID-19 when it was time for hospital discharge. The DHMC care manager worked with the hospital and the member's family to have the member approved for long-term acute care until the member could safely return to Colorado.

V. Future Plans for Managed Care Payment Reform Initiatives

As part of its ongoing work in payment reform, the Department plans to continue with the two MCOs described in this report. The section below describes the planned growth, changes, and focus areas for MCOs in the coming year.

A. Expansion of Prime

RMHP Prime began in 2015 in six counties on Colorado's Western Slope (Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco). RMHP Prime has submitted a proposal to expand the geographic area and member eligibility for RMHP Prime. The Department has agreed to expand the Prime program, at current eligibility, into three additional counties (San Miguel, Ouray, and Delta) starting FY 2022-23. Additional Prime expansion is being considered by the Department for FY 2023-24 and FY 2024-25.

B. Condition Management

Condition management is an important factor to achieving better care and outcomes; as such, it will continue to be a priority for both the RAEs and MCOs in the coming year. With fewer than 5% of members contributing over 50% of claim costs, a focused approach for managing care should result in lower costs and improved outcomes.

The Department will continue to work with RAEs and MCOs to strengthen condition management programs, set performance measures and goals, and improve risk stratification among members to identify members to participate in the program. It will facilitate and share innovations from RAEs and MCOs, such as RMHP's work on risk assessment and extended care coordination for higher acuity members.

As condition management efforts evolve, performance will be assessed using outcome measures that align with other existing performance measures, such as the Core Measures of quality and health outcomes from the Centers for Medicare and Medicaid Services (CMS).

C. Maternal Health

Maternal and infant health outcomes are among the most important indicators of the health of the state and nation. Providing prenatal care for more than 40% of births in the state each year, the Department is focused on improving health outcomes for parents and newborns. Given that preterm birth rates continue to rise and racial and ethnic disparities in outcomes persist, a broad selection of initiatives will be required to improve health outcomes and change the current state and national trajectory. See the Department's Fall 2021 report on maternal health for more data and information. A Maternity Advisory Committee was created in 2021, comprising primarily of Black, Indigenous, and People of Color (BIPOC) with lived experience in Medicaid maternity care.

The Department is also implementing payment reform initiatives for maternal health. In 2020, the Department worked with stakeholders to develop and implement the voluntary Maternity Bundled Payment. The goals of this alternative payment model (APM) are to improve maternal outcomes and to lower the total cost of care. The bundle includes prenatal care, care related to labor and delivery, and postpartum care. It holds the obstetrical provider who either delivered the baby or provided some prenatal services accountable for a parent's prenatal, delivery and postpartum care.

Given this high priority, the Department will continue to work with MCOs and RAEs to look for innovative ways to achieve maternal health equity and meet the needs of pregnant and postpartum members.

D. Measurement: CMS Core Measures

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

Some of the data for these measures will be collected from claims, but other data sources are required as well. The Department is already reporting or building reporting capabilities on all measures regardless of the data source while also working to access supplemental data, such as the immunization registry and lab data, to accurately capture services and values to supplement claims data. See the CMS Core Measures website for a list of the measures.[13]

[13] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html