COLORADO
Department of Health Care Policy & Financing

Accountable Care Collaborative Payment Reform Program Report

Fiscal Year 2019-2020

APRIL 2021

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Executive Summary

Introduction and Background

The Department of Health Care Policy and Financing (HCPF) is required to provide an annual update on payment reform initiatives under Section 25.5-5-415, C.R.S. (also known as House Bill 12-1281). For Fiscal Year (FY) 2019-20, HCPF has contracted with the Colorado Health Institute (CHI) to conduct and present the results of an evaluation of payment projects as part of that requirement. This report is intended to satisfy that requirement by assessing the performance of the two existing payment reform initiatives — Rocky Mountain Health Plans (RMHP) Prime and Denver Health Medicaid Choice (DHMC).

RMHP Prime and DHMC operate in different parts of the state in very different economic and geographic environments. RMHP Prime operates on Colorado's Western Slope. DHMC is based in the Denver metro area. Combined, the two plans operate in 10 counties.

In FY 2019-20, the two managed care organizations (MCOs) enrolled a combined 124,602 members out of 1,219,244 total Health First Colorado enrollees. HCPF pays both organizations a set monthly fee in exchange for providing a comprehensive set of physical health services for its participating members, an arrangement known as full-risk capitation. The monthly fee is set prospectively based on expected health costs. If actual health costs differ from expected costs, the MCO stands to gain or lose the difference.

Although both RMHP Prime and DHMC are MCOs, the two plans are structured differently. RMHP Prime, a traditional MCO, contracts with a network of independent providers, including primary care practices, specialists, and behavioral health providers. DHMC, a staff-model MCO, offers care at a main medical campus, 10 family health centers, and 18 school-based health centers (SBHCs) in the Denver metro area that are all owned and operated by the Denver Health and Hospital Authority. These two models operate distinctly from each other and from the rest of the Accountable Care Collaborative (ACC).

Managed Care Organization Performance

Impact of the COVID-19 Pandemic

The performance period for this report is state fiscal year 2019–2020, which spanned July 1, 2019 through June 30, 2020. Starting in March 2020, the COVID-19 pandemic has had a sustained and dramatic impact on the delivery of health care in Colorado. The combined effect of public concern around virus transmission, a temporary ban on many health care providers performing voluntary or elective procedures, and state and local stay-at-home orders severely decreased care use.

Care volumes dropped 43% from March 15 through July 4 compared with the same period from the prior year among a set of Front Range providers, according to a separate CHI analysis. This decrease in care volumes had a direct impact on metrics that measure volumes of specific services, such as emergency department visits and primary care visits, both of which declined since the beginning of the pandemic. The barriers to care created by the pandemic also affected measures of chronic disease management, such as HbA1c control, since fewer patients are being seen for regular diabetes care and those who are seeking care may be more likely to have the disease less under control. In other words, the impact of the pandemic on these metrics during the last four months of the fiscal year is difficult to assess, but likely hampered performance on many metrics, such as those related to care access and chronic disease management, while improving performance on others, such as emergency department utilization.

Responding to the pandemic required providers to pull resources from other activities, such as follow-ups on positive depression screenings, to devote more effort to designing new telemedicine workflows and assisting patients with new technology and processes. Providers also faced staffing challenges as some were unable to work due to COVID-19 infection or exposure. In some cases these new demands made documentation a secondary priority to delivering safe and effective care to patients, which likely further suppressed performance on some measures.

Financial Performance

The entire set of services delivered to patients enrolled in the MCOs, whether paid for via capitation or fee-for-service (FFS), makes up the total cost of care.

In FY 2019-20, HCPF's total cost of care for members enrolled in RMHP Prime was $286.4 million. This is composed of:

- $201.8 million for RMHP Prime physical health capitation payments;
- $24.1 million for behavioral health capitation payments; and
- $60.5 million for FFS payments for services not covered under capitation.

The physical health capitation payment amount is an increase from the $197.7 million reported in FY 2018-19, due to enrollment increases during the COVID-19 pandemic. Behavioral health capitation payments and FFS payments for services not covered under capitation also increased from $21.3 million and $43.8 million respectively, due to enrollment growth in FY 2019-20 compared with FY 2018-19.

HCPF's total cost of care for members enrolled in DHMC was $318.7 million. This is composed of:

- $223.3 million for DHMC physical health capitation payments;
- $49.9 million for behavioral health capitation payments; and
- $45.5 million for FFS payments for services not covered under capitation.

The physical health capitation payment amount increased from the $201.5 million reported in the FY 2018-19 evaluation, also due to enrollment growth during the COVID-19 pandemic. There was a similar trend in behavioral health capitation payments and FFS payments for services not covered under capitation, which increased from $41.2 million and $43.0 million respectively during the previous fiscal year.

For both MCOs, the total cost of care increased from FY 2018-19 due to enrollment growth during the COVID-19 pandemic. Comparing payments between MCOs is not appropriate due to a variety of factors, including differences in eligible populations and the rates paid for those populations, number of members enrolled, patient mix and acuity, and regional price variations.

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

Program Performance – Rocky Mountain Health Plans Prime

Three key takeaways from this evaluation include:

- RMHP Prime's use of capitation and provider incentives to foster practice transformation has likely improved care coordination, chronic disease management, and behavioral health access.
- The MCO exceeded the performance benchmark or showed improved performance on the majority of metrics, including reducing the rate of emergency department visits for substance use disorder (SUD) and improving members' behavioral health engagement.
- However, inpatient average length of stay increased and rates for certain screening services important to women's health declined. These are two areas to monitor for improvement in future evaluations.

Themes that characterize RMHP Prime's strategies to improve performance and address quality include: encouraging members to use preventive and chronic care; leveraging practice transformation and provider incentives; and increasing access to behavioral health care, specifically the six short-term visits offered in a primary care setting.

RMHP Prime exceeded the performance benchmark on two of four medical loss ratio (MLR) metrics, showed improved performance on many others, and reported above-average member-satisfaction scores on several metrics. A reduction in emergency department visits for SUD is potentially a sign of improved performance; RMHP Prime did not meet the benchmark in FY 2018-19 but did meet the benchmark in FY 2019-20. RMHP Prime improved members' behavioral health engagement for the second year in a row, despite the pandemic creating new barriers to accessing care.

However, since 2017, screening rates for women for breast cancer, cervical cancer, and chlamydia are largely flat or have declined slightly. With the pandemic further reducing screenings and other types of preventive care, additional focus is needed to make sure these important services are being provided. An increase in total inpatient average length of stay, from 3.6 days in calendar year 2017 to 4.3 days in 2019, is still slightly below the Colorado Medicaid average, but should be monitored in future years and further analyzed if the trend continues.

Program Performance – Denver Health Medicaid Choice

Three key takeaways from this evaluation include:

- DHMC's network of Denver Health-operated facilities, including family health centers and SBHCs, supplemented by contracts with additional community providers, has likely contributed to a positive member experience and improved care for women and children.
- The MCO showed improved performance on child and adolescent preventive care metrics, increased rates for most women's health screening metrics, and received above-average patient satisfaction scores for provider performance.
- On certain metrics key to measuring members' access and use of behavioral health and primary care, DHMC did not show improvement.

DHMC's strategies to improve performance include multiple mechanisms for marketing, outreach, and reminders for well-child and preventive care; increasing access and connection to primary care providers by streamlining appointment scheduling, increasing office hours and clinic locations, home care, and promotion of school-based care; case management and connection to housing; and analysis of data to improve workflows and outreach.

DHMC met or exceeded the benchmark on two of four MLR metrics and showed improvement on many other metrics, including those related to screenings and preventive services and member satisfaction ratings. One MLR metric new to the FY 2019-20 evaluation reports on DHMC's progress piloting a housing program that began in January 2020. Future reports should assess the progress of this new initiative in improving health outcomes for members participating in the program, something not possible for this evaluation due to the recency of the program.

However, on certain key metrics — such as completing a follow-up service after a positive depression screening, behavioral health engagement rate, and percentage of members with one or more visits to a PCMP — DHMC either did not meet the benchmark or did not show improvement compared with FY 2018-19. These are key metrics for assessing whether members are accessing services fundamental to the Medicaid program; further attention should be paid to improving performance in future years.

Looking Ahead

CHI is working with HCPF to evaluate MCO performance on certain metrics using risk-adjusted comparison groups. These risk-adjusted data were not available at the time of this report. Once those data are available, CHI and HCPF intend to create and release a separate, stand-alone report including the findings from that risk-adjusted analysis. This report will assess whether the MCOs have improved performance on health outcomes against the FFS population.

In future evaluations, CHI recommends including a survey of providers associated with each of the MCOs. The lack of available data on provider satisfaction is a limitation of this report and of previous evaluations.

Introduction

The Department of Health Care Policy and Financing (HCPF) is required to provide an annual update on payment reform initiatives under Section 25.5-5-415, C.R.S. (also known as House Bill 12-1281). For Fiscal Year (FY) 2019-20, HCPF has contracted with the Colorado Health Institute (CHI) to conduct and present the results of an evaluation of payment projects as part of that requirement. This report is intended to satisfy that requirement by assessing the performance of the two existing payment reform initiatives — Rocky Mountain Health Plans (RMHP) Prime and Denver Health Medicaid Choice (DHMC).

Methods

CHI designed this evaluation based on statutory requirements, which include an analysis of data and information on utilization of the payment methodology, 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, and patient satisfaction. The evaluation design also draws from Accountable Care Collaborative (ACC) Payment Reform Program reports from prior years, CHI's experience evaluating payment reform initiatives, and input from HCPF staff.

The overall aim for the evaluation is to assess how the managed care organizations' (MCOs') performance compares against goals set for FY 2019-20 and whether their performance shows any improvement compared with prior years. Because this is the second year DHMC has been included in this report, this evaluation includes multiple years of data for both MCOs, which allows for a greater examination of performance over time.

CHI analyzed quantitative data from a variety of sources to evaluate MCO performance. CHI also gathered qualitative data from the MCOs for additional context and to capture any successes or address shortcomings in the quantitative performance measures. Quantitative data are provided throughout the report, while qualitative data add detail and context about some metrics where available.

Much of the data included in this report were provided to CHI by HCPF's Data Analytics Section, including data on patient enrollment, care quality, provider performance, health outcomes, and plan expenditures. This report also includes patient experience survey data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and quantitative and qualitative data provided by the MCOs.

New in this year's report are additional measures from the Healthcare Effectiveness Data and Information Set (HEDIS) annual report. These new measures assess performance on specific populations of interest served by the MCOs. This approach, based on a similar method in a 2012 managed care plan performance evaluation from New York State, measures access to

care for women, children, and adolescents enrolled in Medicaid managed care.[1] The metrics to assess performance in measures specific to women are: breast cancer screening, cervical cancer screening, and chlamydia screening. The measures to assess preventive care for children and adolescents are: well-child visits in the first 15 months of life, well-child visits in the third, fourth, fifth, and sixth years of life, adolescent well-care visits, and counseling for nutrition. Two HEDIS measures related to access to care and inpatient utilization were also included to supplement the analysis in these topic areas.

CHI trended HEDIS measures over time using the most recent three years of data to assess if MCOs have been able to improve performance. For additional context, CHI also included the state Medicaid average value for each HEDIS measure. These measures were selected from a larger set of measures selected by HCPF to evaluate MCO performance. All measures come from the standard Medicaid HEDIS 2020 reporting set. HCPF required MCOs to report data following the National Committee for Quality Assurance's (NCQA's) HEDIS protocols. 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.

Some metrics included in this analysis, such as data from HEDIS and CAHPS, measure performance on a calendar year basis, with 2019 being the most recent year for which data are available. Other metrics capture information on a fiscal year basis. The most recent fiscal year, FY 2019-20, ran from July 1, 2019 through June 30, 2020. The impact of the COVID-19 pandemic during the last four months of the fiscal year had the effect of improving performance on some metrics while worsening performance on others. To analyze how the MCOs were performing prior to the pandemic, CHI included an analysis of the eight-month period covering July 1, 2019 to February 29, 2020, prior to the announcement of the state's first confirmed case of COVID-19 in March 2020. The eight-month metrics are not meant to be compared with full fiscal year performance due to differences in the length of performance period and seasonality, which have not been adjusted for. Instead, the eight-month metrics are compared against the same eight-month period from the year prior.

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

Managed Care Organization Overviews

Colorado's Accountable Care Collaborative (ACC) aims to improve quality of and access to care, while attempting to reduce costs for the state's Medicaid program, Health First Colorado. In July 2018, Health First Colorado began Phase II of the ACC, with the overarching goal to continue its efforts to coordinate health care services and connect members to primary and

behavioral health care. In Phase II of the ACC, one entity, the Regional Accountable Entity (RAE), became responsible for administering physical and behavioral health care in each of seven regions — a change from the ACC's previous phase, during which HCPF contracted with separate entities known as Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) to carry out physical health and behavioral health responsibilities, respectively, across the state.

To promote comprehensive and coordinated care for members, the seven RAEs contract with a network of primary care medical providers (PCMPs) to serve as members' central point of care. Each RAE also provides or arranges for the delivery of mental health and substance use disorder services as the administrator of HCPF's capitated behavioral health benefit. Combining these responsibilities under one entity was intended to improve members' experience and health by establishing a single point of contact and clear accountability for treating each person. HCPF implemented mandatory enrollment in the ACC for all full-benefit Health First Colorado members, excluding those enrolled in the Program of All-Inclusive Care for the Elderly.

HCPF intends for all payment reform initiatives to operate within the ACC model. The ACC Phase II Request for Proposal process allowed offerors to propose limited managed care capitation initiatives in accordance with Section 25.5-5-415, C.R.S. as part of proposals for the RAEs. Through a procurement process, HCPF contracted with the RAEs in Regions 1 and 5 to continue the RMHP Prime and DHMC capitated managed care programs, which were created before the introduction of the ACC Phase II. House Bill 19-1285 requires HCPF to contract with Denver Health to operate a Medicaid MCO.

RMHP Prime and DHMC operate in different parts of the state in very different economic and geographic environments. RMHP Prime operates on Colorado's Western Slope. DHMC is based in the Denver metro area. Combined, the two plans operate in 10 counties.

In FY 2019-20, the two MCOs enrolled a combined 124,602 members out of 1,219,245 total Health First Colorado enrollees.[2] HCPF pays both organizations a set monthly fee in exchange for providing a comprehensive set of physical health services for its participating members, an arrangement known as full-risk capitation. The monthly fee is set prospectively based on expected health costs. If actual health costs differ from expected costs, the MCO stands to gain or lose the difference.

One way HCPF links plan performance to care quality is via four quality metrics tied to the MCOs' medical loss ratio (MLR). The MLR reflects how much money is spent providing medical services compared with the amount spent on administrative services and profit. The more quality measures an MCO meets, the greater proportion of money it can spend on administrative services and collect in profit. Each MCO has its own set of MLR measures that are specific to their membership and aligned with the overall goals of the ACC. Benchmark performance values the MCOs aim to achieve for each metric are set by HCPF in coordination

with the MCOs, and are generally based on prior year performance with some amount of improvement relative to HCPF's goals.

Although both RMHP Prime and DHMC are MCOs, the two plans are structured differently. RMHP Prime, a traditional MCO, contracts with a network of independent providers, including primary care practices, specialists, and behavioral health providers. DHMC, a staff-model MCO, offers care at a main medical campus, 10 family health centers, and 18 school-based health centers (SBHCs) in the metro Denver area that are all owned and operated by Denver Health and Hospital Authority. These two models operate distinctly from each other and from the rest of the ACC. Evaluating their strengths and weaknesses can identify ways to improve care and experience for members in each MCO. Evaluation of the MCOs can also identify initiatives that drive performance improvement and could be applied to the broader ACC.

Program Summary – Rocky Mountain Health Plans Prime

RMHP operated the Region 1 RCCO as part of the ACC from 2011 through FY 2017-18. RMHP has operated the Region 1 RAE since the beginning of ACC Phase II. RMHP Prime's network consists of a comprehensive set of independent providers, including primary care, adult and pediatric specialists, acute care, pharmacy, behavioral health, and emergency/urgent care.

RMHP Prime's service area — covering approximately 16,000 square miles on Colorado's Western Slope — includes six counties in Region 1: 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. The population density of RMHP Prime's service area is about 19 people per square mile — lower than Colorado's population density of about 55 people per square mile.[3] All of RMHP Prime's 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. Most of RMHP Prime's service area — including Gunnison, Mesa, and Montrose counties, as well as portions of Garfield and Rio Blanco counties — is designated as a primary care HPSA.[4]

RMHP Prime offers PCMPs the opportunity to participate in a payment reform program. Participating PCMPs receive a single sub-capitation payment each month to cover the cost of all the practice's services for the Prime members who are under the practice's care. This payment is based on the number of participating members who are attributed to the practice and is a function of the provider's capacity to implement delivery innovations. Payments to each practice are risk-adjusted, so the practices are not incentivized to exclude sicker or older members. An average of 17,017 monthly members were attributed to 54 practices participating in RMHP Prime payment reform program during FY 2019-20. This is a slight increase in both patient and provider participation compared with FY 2018-19, when an average of 16,258 monthly members were attributed to 52 participating practices. PCMPs who choose not to participate in the payment reform program receive fee-for-service (FFS) payments rather than sub-capitation payments.

Under RMHP Prime's payment reform program, RMHP Prime enhances PCMP sub-capitation payments, as long as the total cost of Prime services does not exceed 100% of what HCPF would have paid for equivalent services under FFS. This means that PCMP practices have proportionate, limited accountability for the total cost performance of the plan. If a PCMP practice's actual costs exceed the sub-capitation payment, RMHP Prime may recoup up to 5% of the practice's payment enhancement (above 100% of Medicaid reimbursement) for the performance period. However, if a PCMP practice's expenditures were lower than expected and the practice met relevant quality targets, RMHP Prime would share savings at the end of the year. Savings are also shared with Community Mental Health Centers in the region that meet contractual requirements to work with the RMHP Prime health engagement team and to support the coordination of physical and behavioral health care. RMHP Prime has not exceeded rating parameters set by HCPF since the inception of the program in FY 2014-15. Because of this, shared savings incentives have been distributed each year, and recoupments of enhanced revenue from PCMPs has never occurred.

Enrollment and Member Population

The majority of RMHP Prime members are adults. The only children enrolled in RMHP Prime are those with disabilities. Eligible members are automatically enrolled in the program on an ongoing basis. Members who do not wish to participate have 90 days to opt out after their initial enrollment, and then can opt out at least once every 12 months of enrollment. Members who opt out remain enrolled in Health First Colorado, but their care is no longer managed by the MCO. In FY 2019-20, monthly enrollment in RMHP Prime averaged 37,625 members, an increase from the monthly average of 35,821 for the previous fiscal year.

Medicaid enrollment has grown during the COVID-19 pandemic. Reasons for that growth include a federal ban on states disenrolling Medicaid members while the public health emergency declaration is active, widespread loss of jobs and associated insurance due to the economic fallout of the pandemic, and an increased desire for insurance coverage during the pandemic. RMHP Prime enrollment in June 2020 was 40,025, an increase of 3,110 members from March 2020 when the federal public health emergency declaration began.

Program Summary – Denver Health Medicaid Choice

DHMC has operated as an MCO in Colorado since 2004. DHMC operates in Adams, Arapahoe, Denver, and Jefferson counties. DHMC's service area is largely urban. It covers about 2,900 square miles, an area with a population density of about 850 people per square mile — much higher than Colorado's overall population density of about 55 people per square mile.[5] 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 providers, particularly among people with low family incomes.[6]

DHMC is owned and operated by Denver Health Medical Plan, which is the fully owned subsidiary of Denver Health and Hospital Authority (DHHA). DHMC is a staff-model MCO, meaning that DHHA operates medical facilities and employs the providers at those facilities rather than contracting with a network of providers to offer care to its enrollees. DHMC members can get care at the Denver Health main campus in downtown Denver, at any of Denver Health's 10 family health centers throughout metro Denver, and at the 18 SBHCs also operated by Denver Health.[7] In addition to the Denver Health network, DHMC also contracts with community providers such as STRIDE Community Health Center, UCHealth University of Colorado Hospital, and Children's Hospital Colorado where members can receive services with a referral from their provider. DHMC members can also receive services at STRIDE Community Health Center without a referral as of 2020.

In FY 2018-19 and the first six months of FY 2019-20, DHMC was a subcontractor of Colorado Access, the RAE for Regions 3 and 5, and was responsible for delivering physical health services. HCPF's contract was with Colorado Access, which subcontracted with DHMC to administer the physical health portion of its contract with HCPF.

Starting in January 2020, HCPF contracted directly with DHMC to provide both physical and behavioral health services to its members. This change was required by House Bill 19-1285. DHMC subcontracts with Colorado Access for most behavioral health services.

Enrollment and Member Population

DHMC monthly enrollment averaged 86,977 members in FY 2019-20, an increase from the monthly average of 77,813 for the previous fiscal year. Eligible members in Denver County are automatically enrolled in the program on an ongoing basis. Members outside of Denver County must opt into DHMC coverage, which is also available to members in Adams, Arapahoe, and Jefferson counties. New members have 90 days to opt out of their enrollment. Unlike RMHP Prime, children can be enrolled in DHMC regardless of their health status.

Medicaid enrollment has grown during the COVID-19 pandemic. DHMC enrollment in June 2020 was 90,771, an increase of 6,251 members from March 2020 when the federal public health emergency declaration began. In previous fiscal years, DHMC's enrollment was capped at 90,000 members, but the cap was increased to 100,000 during the FY 2019-20.

Managed Care Organization Performance

Impact of the COVID-19 Pandemic

Since March 2020, the COVID-19 pandemic has had a sustained and dramatic impact on the delivery of health care in Colorado. The combined effect of public concern around virus transmission, a temporary bar on many health care providers performing voluntary or elective procedures, and state and local stay-at-home orders severely decreased care use. Care volumes dropped 43% from March 15 through July 4 of 2020 compared with the same period from the prior year among a set of Front Range providers, according to a separate CHI analysis.[8]

The performance period for this report is state FY 2019–2020, which spanned July 1, 2019 through June 30, 2020. MCO performance for the last four months of the fiscal year (March through June 2020) was greatly affected by the wide-ranging impacts of the pandemic. Where data availability allows, CHI isolated MCO fiscal year performance into a period prior to the pandemic and during the pandemic to assess pre-pandemic performance and also determine how the pandemic affected performance.

This decrease in care volumes has a direct impact on metrics that measure volumes of specific services, such as emergency department visits and primary care visits. Analysis of the data shows both emergency department visits and primary care visits declined since the beginning of the pandemic. The analysis did not find a significant decrease in behavioral health care use, potentially due to the rapid increase in tele-behavioral health and a pandemic-driven increase in demand for behavioral health services.

The barriers to care created by the pandemic also impact chronic care management. A prior CHI analysis found services related to diabetes, hypertension, asthma, and hyperlipidemia all decreased by at least two thirds from March 15 through July 4, 2020 compared with the same period from the prior year. Measurement of vitals, diagnostic screenings, lab tests, and preventive visits were also down significantly.[9] This negatively impacts measures of chronic disease management, such as HbA1c control, since fewer patients are being seen for regular diabetes care and those who are seeking care may be more likely to have the disease less under control.

In addition to the pandemic's impact on care use, it also created new resource and workflow challenges for providers. Responding to the pandemic sometimes required pulling resources from other activities, such as follow-ups on positive depression screenings, to designing new telemedicine workflows and assisting patients with new technology and processes. These new demands in some cases necessarily made documentation a secondary priority to delivering needed care to patients safely and effectively, which likely further suppressed performance on some measures. Providers also faced resource challenges as staff were unable to work due to

COVID-19 infection or exposure, and in some cases were furloughed due to lower-than-expected care volumes and associated revenue.

Financial Performance

Under Phase II of the ACC, the contracts for the MCOs are part of combined administrative contracts for physical and behavioral health. The contracting arrangements are different for the two MCOs. RMHP Prime is part of the Region 1 RAE contract. HCPF contracts directly with DHMC in accordance with House Bill 19-1285. In both contract arrangements, HCPF distributes two separate payments:

1. Monthly capitation payments for a comprehensive set of physical health services.
2. Monthly capitation payments for behavioral health services.

The MCOs administer the physical health capitation while partnering with the RAEs in their regions to administer the behavioral health capitation. A limited number of other services and benefits are not covered under a capitation arrangement and are billed for and reimbursed via FFS. PCMPs are also able to bill via FFS for six short-term behavioral health visits (a change made with the beginning of ACC Phase II). The cost of these visits has been calculated as part of the physical health capitation payments MCOs receive from HCPF.

The entire set of services delivered to patients enrolled in the MCOs, whether paid for via capitation or FFS, makes up the total cost of care.[10]

In FY 2019-20, HCPF's total cost of care for members enrolled in RMHP Prime was $286.4 million. This is comprised of:

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The physical health capitation payment amount increased from the $201.5 million reported in the FY 2018-19 evaluation, also due to enrollment growth during the COVID-19 pandemic. There was a similar trend in RAE behavioral health capitation payments and FFS payments for services not covered under capitation, which increased from $41.2 million and $43.0 million respectively during the previous fiscal year.[11]

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

Comparing payments between MCOs is not appropriate due to a variety of factors, including differences in eligible populations and the rates paid for those populations, number of members enrolled, patient mix and acuity, and regional price variations. Initiatives that each MCO has taken to help reduce cost and increase care performance are mentioned where applicable in subsequent sections of this report.

Program Performance – Rocky Mountain Health Plans Prime

Evaluator Assessment

RMHP Prime exceeded the performance benchmark on two of the four MLR metrics. Performance was either steady or improved on the other two compared with FY 2018-19. The impact of the COVID-19 pandemic on these metrics during the last four months of the fiscal year is difficult to assess. The pandemic likely created measurement challenges for documenting metrics built on provider-based, in-person workflows, and exacerbated challenges associated with care coordination, quality improvement, and chronic disease management, topics related to the two metrics where RMHP Prime did not meet the benchmark.

When utilization measures of health outcomes and provider performance were compared to past performance, RMHP Prime's performance generally improved. RMHP Prime continues to improve access to behavioral health care for members through practice transformation, network expansion, and financial incentives. Total emergency department visits as well as emergency department visits for substance use disorder (SUD) are both down for FY 2019-20. A reduction in emergency department visits for SUD is potentially a sign of improved performance; RMHP Prime did not meet the benchmark in FY 2018-19 but did meet the benchmark in FY 2019-20. Total emergency department use has consistently trended downward for RMHP Prime members since FY 2015-16, indicating continued improvements in care coordination and care management, particularly for members with complex health needs. The size of the reduction in emergency department visits, the largest year-to-year reduction for which data are available for this evaluation, may also reflect less emergency department utilization across the country due to the pandemic.[12]

New to this year's evaluation are HEDIS metrics measuring access to preventive care for women and adults. Overall adult access to preventive and ambulatory services is up slightly since 2017. However, since 2017, screening rates for women for breast cancer, cervical cancer, and chlamydia are largely flat or slightly lower. With the pandemic further reducing screenings and other types of preventive care, additional focus is needed to make sure these important services are being provided.

Survey data from patients regarding their experience as an RMHP Prime member also showed improvement and demonstrated above average performance relative to the overall Medicaid population in several metrics.

RMHP Prime's strategies to improve performance and address quality include: reaching out to members to encourage use of preventive and chronic care; leveraging practice transformation and provider incentives; working with practices to optimize workflows; and increasing access to behavioral health care, specifically the six short-term visits offered in a primary care setting. An ongoing pilot program assessing the Patient Activation Measure (PAM®) has identified best practices and challenges related to provider burden in administering the instrument.

Care Quality and Medical-Loss-Ratio Metrics

RMHP Prime's MLR is adjusted based on its performance on four quality measures across the care domains of emergency department use, chronic disease, preventive care, and patient engagement. These benchmarks are established in negotiations between RMHP Prime and HCPF and are determined based on agreed-upon targets for each metric.

RMHP Prime performed above the established benchmark for two of the four MLR metrics (Table 1). All four of the metrics were also used to evaluate RMHP Prime performance in FY 2018-19, meaning performance can be measured over time. On the two metrics that RMHP Prime did not meet the benchmark, a diabetes control metric and a metric assessing the percentage of patients who receive a follow-up service after a positive depression screening, performance was steady or improved compared with FY 2018-19.

Starting in March 2020 many patients began postponing care due to concerns about the safety of in-person contact and temporary bans on nonemergent procedures. This pandemic-driven decrease in most types of care utilization may be reflected in performance on the metrics. Providers adjusted to pandemic safety concerns by transitioning to providing more care via telemedicine. Because two of the four metrics in Table 1 are electronic Clinical Quality Measures (eCQMs) — HbA1c control and depression screening — the underlying data come from electronic medical record (EMR) systems from a subset of participating providers. The transition to care delivery via telemedicine and associated change in workflows complicated documentation for these metrics, which could negatively affect performance measurement.

Table 1. RMHP Prime Performance on Care Quality and MLR Metrics Compared with Performance Benchmarks, FY 2019-20

Metric	FY 2019-20 Performance	FY 2019-20 Benchmark	FY 2018-19 Performance
Rate of ED visits for SUD	16.7/1,000	17.5/1,000	19.1/1,000
HbA1c poor control (>9.0%)	20.0%	19.5%	20.1%
Depression screening and follow up service	67.3%	70.0%	66.4%
Patient Activation Measure (PAM®)	49.7%	45.0%	43.2%

Source: HCPF

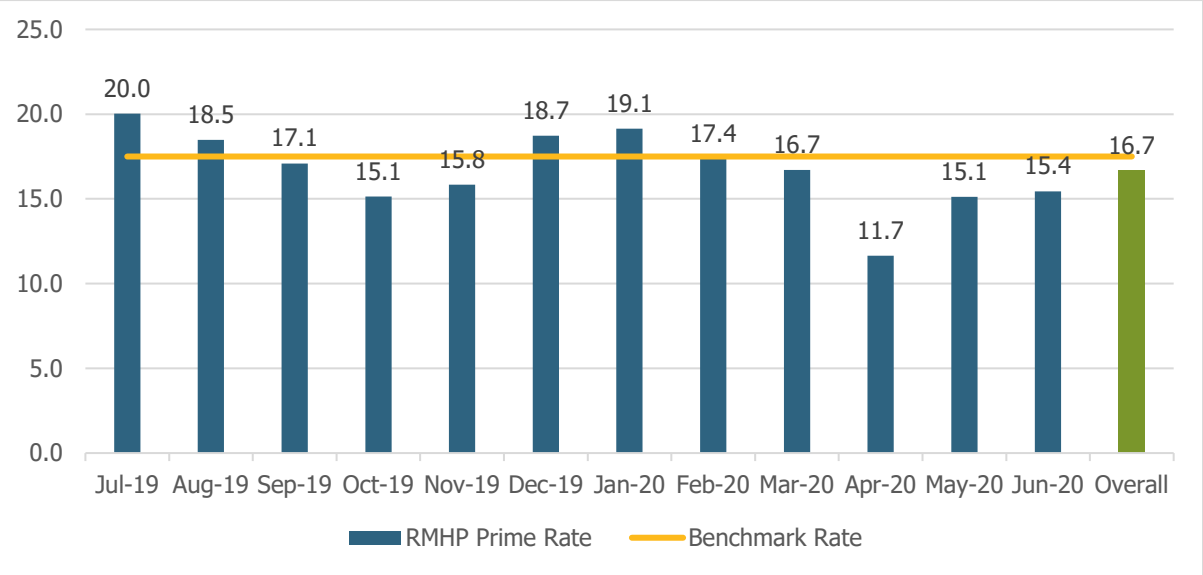
Rate of Emergency Department Visits for Substance Use Disorder

This metric is defined as the number of emergency department visits for substance use disorder per 1,000 member months per year. RMHP Prime's performance of 16.7 in FY 2019-20 was an improvement compared with FY 2018-19 and met the benchmark of 17.5.

RMHP Prime implemented multiple programs to decrease emergency department visits for SUD, including outreach to members with high emergency department use and efforts to increase member access to telemedicine for preventive and on-demand care. RMHP Prime practices screen all members with two or more emergency department visits and an identified social need for social determinants of health and care coordination needs. RMHP Prime also performs outreach to high-risk members after receiving a real-time alert from Quality Health Network — the regional health information exchange organization — about an emergency department admission.

RMHP Prime outperformed the benchmark in four of the eight months in the fiscal year prior to the impact of the pandemic (July 2019 through February 2020, see Figure 1). The average rate of emergency department visits for SUD in those eight months was 17.7 per 1,000 member months, just above the benchmark of 17.5. In seven of those eight months, RMHP Prime outperformed its rate from the same month in FY 2018-19 (not displayed in Figure 1). These data suggest RMHP Prime's efforts to reduce emergency department visits for SUD were having an effect prior to the impact of the pandemic.

Figure 1. Monthly Emergency Department Visit Rate for SUD per 1,000 Member Months, RMHP Prime, FY 2019-20



Source: HCPF

The impact of the COVID-19 pandemic also played a role in decreasing emergency department use, including for SUD. RMHP Prime's average rate for this metric was 14.7 from March through June 2020, and the rate was lowest, 11.7, in April 2020, the first full month of pandemic-related restrictions in Colorado. However, an analysis by HCPF of all Medicaid members found emergency department visits for SUD during the pandemic did not decrease as much as total emergency department visits, though visits for SUD still declined compared with the same months from the year prior (HCPF's analysis used the dates of March 15, 2020 through August 31, 2020, a slightly different period than that of this analysis and including some months outside of FY 2019-20).[13]

Despite the decreases in emergency department use during the pandemic, evidence suggests the pandemic and associated economic downturn exacerbated the prevalence of SUD nationally. A survey by KFF from June 2020 found 13% of adults reported new or increased substance use due to coronavirus-related stress.[14] While total emergency department visits decreased significantly, likely because of the pandemic, visits for SUD may not have decreased to the same extent due to a pandemic-related increase in drug and alcohol use.

Future evaluations should continue to monitor RMHP Prime performance on this metric to assess whether the reduction in visits continues in future years.

HbA1c Poor Control

This metric reflects the percentage of members with a diagnosis of diabetes whose HbA1c level was above 9.0%, suggesting poor control of the disease. A lower percentage on this measure indicates better performance. In FY 2019-20, RMHP Prime performance was 20.0%, above the benchmark value of 19.5%. RMHP Prime's FY 2019-20 percentage is similar to FY 2018-19's value of 20.1%. The impact of the pandemic may have prevented RMHP Prime from meeting benchmark performance. Had performance between the third and fourth quarters of FY 2019-20 — in other words, during the pandemic — followed the same trend of improvement as FY 2018-19, RMHP Prime would have outperformed the benchmark.

Management of chronic diseases such as diabetes was complicated by the pandemic. Many people postponed needed care for reasons related to safety, and others struggled to manage their conditions due to pandemic-related stressors such as job loss and health issues. [15] Providers worked to build new, virtual ways of connecting with their patients, but measuring patient HbA1c was not always possible in a remote setting.[16] Resources for diabetes management were constrained by the pandemic as practices shifted to focus on respiratory care, COVID-19 testing, and telemedicine capabilities. Providers' capacity was also constrained by virus-related staff absences, as well as furloughs due to a drop in patient visits and practice revenue.

In addition, the pandemic strained providers' resources, priorities, and workflows in ways that likely made documentation of this eCQM metric more challenging, negatively impacting performance measurement. Operating during a public health emergency with limited time and resources, some providers may simply not have had time or resources to complete documentation for services they provided.

However, providers in RMHP Prime's network also created new processes to continue to manage patients' diabetes during the pandemic. Some clinics offered drive-thru HbA1c testing to continue to monitor patients' diabetes while minimizing their potential exposure to the virus. RMHP Prime also performed outreach to diabetes patients with gaps in care.

Depression Screening and Follow Up Service

The depression screening and follow-up metric measures the percentage of members ages 12 years and older for whom an age-appropriate clinical depression screening was conducted and, if positive, a follow-up plan is documented on the date of the encounter. Just over two in three (67.3%) of members with a positive screen for depression had a follow-up plan documented, such as a referral to therapy, medication initiation, or additional screenings, below the benchmark of 70.0%. RMHP Prime's performance increased from FY 2018-19, when the percentage was 66.4%.

RMHP's Practice Transformation Team has worked with Prime practices to develop workflows to identify and follow-up with members who receive a positive depression screening. The transition to telemedicine disrupted those workflows and redeployed staff to COVID-19-related tasks. However, RMHP Prime practices with integrated behavioral health maintained behavioral health access for members despite a significant uptick in demand during COVID-19. RMHP Prime member use of services related to the six short-term behavioral health visits benefit increased 14%, and individual and group psychotherapy increased 27% in Q4 of FY 2019-20 compared with Q4 of FY 2018-19.[17]

PAM®: Coaching for Activation

The PAM® is a 22-item assessment of a patient's knowledge, confidence, and skill in managing their health. The MLR measure for RMHP Prime establishes a benchmark of at least 45.0% of members who had an initial PAM® score of 1, 2, or 3 — signaling a lower level of patient activation — having completed a follow-up PAM® assessment by the end of June 2020.

Almost half of those members (49.7%) completed a follow-up PAM®, above the benchmark value of 45.0% and above RMHP Prime's FY 2018-19 performance of 43.2%. In July 2019, RMHP Prime launched a pilot program providing support and best practices related to the PAM® to improve members' management of their health. A subset of RMHP Prime practices participated in the pilot, which ran through June 2020. While the pilot identified some best practices, providers participating in the pilot generally found administration of the PAM® to be burdensome and reported disinterest from members in completing the survey multiple times. COVID-19 affected the participating practices' ability to complete the surveys and attempts to administer the PAM® via mail or email were met with little success.[18]

Health Outcomes and Provider Performance Metrics

Two different analyses were conducted to illustrate the impact of the COVID-19 pandemic on health outcome metrics. The first tracked health outcome metrics over the entire fiscal year, from July 2019 to June 2020, compared with metrics during the previous fiscal year. The second assessed performance during the eight months when access to care and patient and provider behavior were not impacted by the pandemic — July 2019 to February 2020 (Table 2) — compared with performance during a comparable time frame in the previous fiscal year. Performance from the full fiscal year periods should not be compared against performance from eight-month periods.

Taking the entire year into account, RMHP Prime's performance improved on three of four metrics: Hospital all-cause readmission rate, emergency department visits, and behavioral health engagement rate. Performance decreased for members with one or more visits to a primary care medical provider metric, though performance improved on this metric when

looking at the pre-COVID eight-month period compared with the same period from the prior year. Analyzing performance for only the first eight months of the two fiscal years shows RMHP's performance improved on three of four metrics. More focused analysis on each of these metrics is provided in the sections below.

Table 2. RMHP Prime Performance on Health Outcomes and Provider Performance Metrics, FY 2018-19 and FY 2019-20

Metric	FY 2019-20 Performance	FY 2018-19 Performance	July 2019 – Feb. 2020 (Pre-COVID) Performance*	July 2018 – Feb. 2019 Performance*
Hospital all-cause readmission rate	10.1%	10.6%	10.6%	8.7%
Emergency department visits	777 visits per 1,000 members	862 visits per 1,000 members	851 visits per 1,000 members	865 visits per 1,000 members
Behavioral health engagement rate	23.3%	22.9%	21.3%	18.6%
Members with one or more visits to a primary care medical provider	68.0%	69.1%	60.7%	58.5%

Source: HCPF
*Includes data from the eight-month pre-pandemic period of FY 2019-20, from July 2019 through February 2020, and the same period of months in FY 2018-19. These two columns can only be compared with each other and should not be compared with full performance year data.

Hospital All-Cause Readmission Rate

A readmission to a hospital after discharge is likely to be expensive and may signal that a patient required additional care management after initially being discharged. This metric captures the rate of hospital readmissions for any cause within 30 days of hospital discharge.

It assesses a plan's ability to effectively care for high-risk members and prevent unnecessary high-cost services. The following conditions are not included: pregnancy, perinatal conditions, chemotherapy, rehabilitation, organ transplants, and planned procedures.

Data included for the entire fiscal year show a decrease in readmission rates from 10.6% to 10.1%. The readmission rate for only the first eight months of FY 2019-20 was 10.6%. People's care-seeking behavior changed after the start of the pandemic, with many delaying or forgoing care. Hospitals also worked to keep patients out of beds when appropriate, including by creating hospital-at-home programs, to avoid transmission risk and free up beds for COVID-19 patients with the most serious health needs.

Emergency Department Visits

Like hospital readmissions, visits to a hospital emergency department can be costly and may indicate that improvements are needed in care management services and/or access to primary care services.

RMHP Prime's performance in this measure has continued to improve, decreasing from 898 visits per 1,000 members in FY 2017-18 to 777 visits per 1,000 members in FY 2019-20. This measure was likely impacted by changes in utilization and care-seeking behaviors during the pandemic. Emergency department visits declined sharply during the early weeks of the pandemic. An analysis by HCPF found emergency department use for all Medicaid members decreased by almost 30% from March 15 through August 31, 2020 compared with the same period from 2019.[19]

However, data from the eight-month pre-COVID period show emergency department visits were trending downward prior to those changes in care-seeking behavior. From July 2019 through February 2020, the rate was 851 emergency department visits per 1,000 members. This rate is lower than the same eight-month period from FY 2018-19, 865 visits per 1,000 members. This indicates that RMHP Prime had success in reducing emergency department visits before steeper decreases driven by the COVID-19 pandemic.

Behavioral Health Engagement Rate

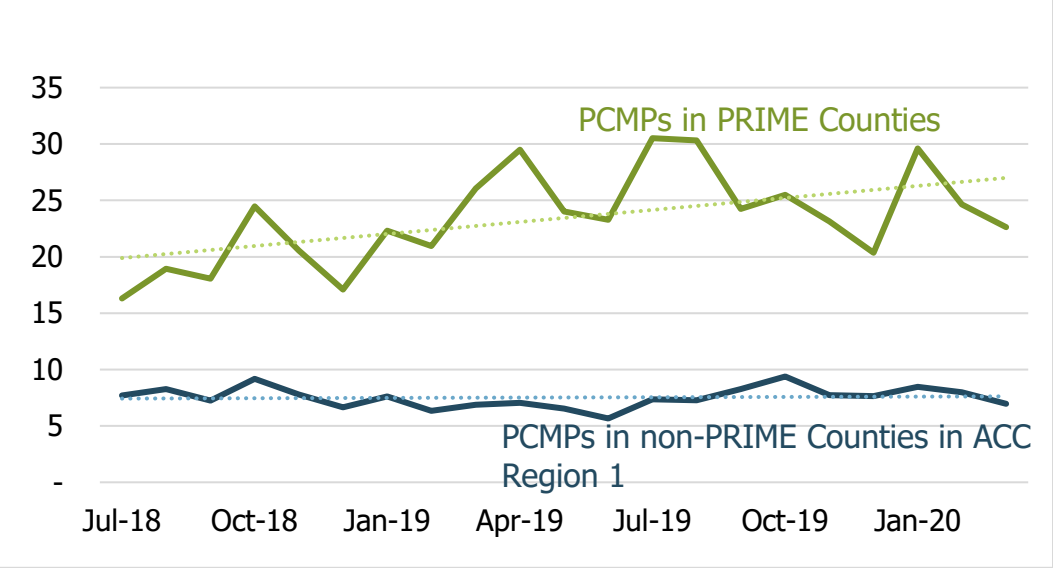
The behavioral health engagement rate performance metric tracks the number of members who have at least one behavioral health visit during the measurement period, an important indicator of behavioral health service reach.

RMHP Prime's performance in behavioral health engagement improved between FY 2018-19 and FY 2019-20, regardless of whether data are from pre-pandemic or full fiscal year performance. For the entire fiscal year, the rate increased from 22.9% in FY 2018-19 to 23.3% during FY 2019-20. RMHP Prime also made gains in this metric before the pandemic

started, from 18.6% during the first eight months of FY 2018-19 to 21.3% during the same period (pre-pandemic) in FY 2019-20.

RMHP Prime expanded behavioral health access for members by adding to its network of behavioral health providers and developing referral systems between PCMPs, Community Mental Health Centers, and other stakeholders. RMHP Prime's practice transformation efforts to integrate behavioral health into the primary care setting may also help explain the multiyear growth in members receiving behavioral health services. Through its global payment model and community reinvestment funding, RMHP Prime has provided PCMPs with technical assistance and other supports to expand use of the six short-term behavioral health visit benefit offered by HCPF. PCMPs in RMHP Prime counties show higher adoption of the benefit compared with PCMPs in non-RMHP Prime counties in ACC Region 1 (see Figure 2).

Figure 2. Psychotherapy Visits Billed Via FFS in Primary Care Settings (visits per 1,000 member months), 2018-2020[20]



Source: RMHP Prime

The pandemic created new norms in care delivery: The use of telemedicine became significantly more common, especially for some types of behavioral health providers. The shift to telemedicine may also help explain why performance improved even during the months of COVID-19 impact.

Members With at Least One Visit to a Primary Care Medical Provider

Access to a primary care provider is a proxy for effective utilization of the medical home model, which is a key tenet of the ACC. This metric measures the percentage of members who visited a primary care provider during the performance period.

RMHP Prime saw a decrease in this metric, from 69.1% of members in FY 2018-19 to 68.0% in FY 2019-20. The pandemic likely impacted performance — many Coloradans postponed or skipped care due to concerns about the safety of in-person visits. Performance on this metric for the months of FY 2019-20 prior to the pandemic indicates this is the case; 60.7% of members had one or more visits to a PCMP from July 2019 to February 2020, more than the 58.5% during the same period from the prior year. The expansion of telemedicine services may have helped more members access their PCMP during the pandemic, though many still postponed or struggled to access primary care.

Women's Health

New metrics included in this evaluation for FY 2019-20 provide insight into how RMHP Prime is engaging and providing integral services to female members. Metrics include breast cancer screening, cervical cancer screening, and chlamydia screening (Table 3). These metrics are measured and reported on a calendar year basis. RMHP Prime saw improvement in one of the three included metrics between 2018 and 2019, though all metrics were below 2017 performance.

The breast cancer screening metric reflects the percentage of women ages 50 to 74 who had a mammogram screening for breast cancer during the measurement period. Between 2017 and 2019, performance in this metric has worsened from 50.4% to 48.0%. Increasing the percentage of women screened for breast cancer could help improve long-term health outcomes. In 2019, RMHP Prime performed slightly higher than the Colorado Medicaid average of 47.1%.

The cervical cancer screening metric reflects the percentage of women ages 21 to 64 who were screened using either of the following criteria: females ages 21 to 64 who had a cervical cytology performed every three years or females ages 30 to 64 who had a cervical cytology/HPV co-testing performed every five years. The number of women who were provided screening services for cervical cancer decreased from 43.2% in 2017 to 39.4% in 2019. This percentage is also lower than the Colorado Medicaid average of 42.5%.

RMHP Prime reached out to women with a breast cancer or cervical cancer screening gap in care. These women were sent educational material related to the importance of those services and were incentivized with a $25 gift card to complete their missing screening by the end of the year.

The chlamydia screening metric reflects the percentage of women ages 16 to 24 who were identified as being sexually active and who received one test for chlamydia during the

measurement year. RMPH Prime saw improvement between 2018 and 2019 in this metric, increasing from 46.5% to 47.8%. However, performance in 2019 was still below the percentage in 2017. Performance was also below the Colorado Medicaid average of 64.4%, which indicates room for improvement in this metric. RMHP Prime worked with both providers and Mesa County Public Health to determine underlying reasons for the lower screening rates. This analysis found that the way providers billed did not allow services they performed to be counted toward performance on the measure.

Table 3. RMHP Prime Performance on Women's Health Metrics, Calendar Years 2017-2019

Metric	2019	2018	2017
Breast Cancer Screening	48.0%	50.1%	50.4%
Cervical Cancer Screening	39.4%	41.9%	43.2%
Chlamydia Screening	47.8%	46.5%	49.3%

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Adult Access to Preventive Care

Connecting members with preventive health care services is important in reducing the risk of diseases and disabilities and can impact life expectancy.[21,22] This metric captures the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the year (Table 4).

Since calendar year 2017, RMHP Prime has increased the percentage of adults who get preventive or ambulatory care, from 70.9% to 72.1%. The Medicaid average in Colorado for this measure was 63.0% in 2019, which means RMHP Prime's performance is connecting a greater percentage of adults to preventive and/or ambulatory health services than the state average for the Medicaid program overall.

Table 4. RMHP Prime Performance on Adult Access to Preventive Care Metrics, Calendar Years 2017-2019

Metric	2019	2018	2017
Adult Access to Preventive/Ambulatory Health Services	72.1%	71.8%	70.9%

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Inpatient Length of Stay

This metric 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 FFS members and found associations between enrollment and preventable hospitalization rates and average length of inpatient hospital stays.[23, 24] These results point to an important relationship between managed care and prevention or reduction of unwanted or unnecessary utilization of services.

There has been an increase in the total inpatient average length of stay, from 3.6 days in calendar year 2017 to 4.3 days in 2019 (Table 5). The Colorado Medicaid average for this metric was 4.4 days in 2019, showing that RMHP Prime members are still spending slightly less time on average in the hospital, despite the gradual increase over the period. Continuing to track these changes over time could help to understand changes in patient health needs and efficiency of care delivery in inpatient settings. RMHP Prime points to decreased enrollment in Medicaid prior to the pandemic and an associated increase in average acuity in remaining membership as a partial driver of longer inpatient length of stay.

Table 5. RMHP Prime Inpatient Length of Stay, Calendar Years 2017-2019

Metric	2019	2018	2017
Total Inpatient Average Length of Stay	4.3	3.7	3.6

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Member Experience

Overall, RMHP Prime performs higher on reported member experience metrics compared with the Medicaid average (Table 6). On the 2020 survey, RMHP Prime members rate their providers more favorably than the Medicaid average, and a high percentage have a favorable view of how their providers communicate with them. The percentage of RMHP Prime members who rated their health plan favorably was also higher than the percentage of all Medicaid members rating Health First Colorado favorably.

A greater percentage of RMHP Prime members gave their providers positive ratings in 2020 compared with 2019 or 2018 — 75.1% of members rated their provider favorably in 2020. There has been more variability in how members have rated their health plan over time: A similar number of RMHP Prime members rated their health plan favorably in 2020 (68.3%) compared with 2019 (69.1%), though both years show improvement over 2018 (56.5%).

RMHP Prime members reported similar rates of access to needed care and timeliness of care over the three years of data. In 2020, about 83% of members reported that they received care as soon as they needed it, while about 85% 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. RMHP Prime surveyed members from mid-February 2020 through the third week of May 2020, meaning members completed the survey during the COVID-19 pandemic.

Table 6. Patient Ratings of Their Care Experience, RMHP Prime and Colorado Medicaid Average, 2018-2020

Metric	2020 Performance	2019 Performance	2018 Performance	CO Medicaid Average Performance* (2020)
Percentage of respondents rating their provider favorably	75.1%	74.4%	68.7%	59.1%
Percentage of respondents rating their health plan favorably	68.3%	69.1%	56.5%	61.3%
Percentage of respondents pleased with how their provider communicates with them	93.4%	95.1%	92.2%	71.4%
Percentage of respondents reporting receiving care as soon as needed.	83.1%	82.6%	85.8%	N/A
Percentage of respondents reporting receiving the care they needed	84.5%	84.2%	82.5%	N/A

*Comparison group is all Medicaid members.
Source: 2020 Colorado Patient-Centered Medical Home Survey Adult Report

Program Performance – Denver Health Medicaid Choice

Evaluator Assessment

Denver Health Medicaid Choice met or exceeded the benchmark on two of four MLR metrics, and improved performance on a third. A fourth measure, providing a follow-up service to members who receive a positive screening for depression, was new in FY 2019-20, and DHMC did not meet the benchmark of 50% for this measure. One of the four metrics — also new in FY 2019-20 — ties DHMC's MLR to a pilot housing initiative that began in January 2020. DHMC met this metric by designing, implementing, and evaluating a supportive housing pilot program. Future reports should assess the progress of this new initiative in improving health outcomes for members participating in the program. The impact of the COVID-19 pandemic on these metrics and others is difficult to quantify, though it likely exacerbated challenges related to all aspects of care delivery, coordination, and management.

When utilization measures of health outcomes and provider performance were compared to past performance, DHMC showed improvement on two of four — hospital all-cause readmissions and emergency department visits. These are important measures of care management, keeping members from needing to return to an inpatient setting or from needing to use the emergency department, and for reducing potentially unnecessary utilization and thus reducing costs for the Medicaid program.

Neither the behavioral health engagement rate nor the percentage of members with one or more visits to a PCMP improved compared to the prior year, regardless of whether comparing full fiscal year or eight-month periods. These are key metrics for assessing whether members are accessing services fundamental to the Medicaid program; further attention should be paid to improving performance in future years.

New to this year's evaluation are HEDIS metrics measuring access to preventive care for women, children, adolescents, and adults. DHMC shows improvement since 2017 in all four measures related to preventive care for children and adolescents. DHMC also shows improvement in most metrics of preventive care for women and an access to care measure for adults.

On measures of patient experience assessed through a member survey, DHMC generally shows improvement compared with 2019. Around seven in 10 members rate their provider favorably and report receiving the care they need as soon as they need it. An even higher number (94.2%) report being pleased with how their provider communicates with them.

DHMC's strategies to improve performance include multiple mechanisms for marketing, outreach, and reminders for well-child and preventive care; increasing access and connection to primary care providers by streamlining appointment scheduling, increasing office hours and clinic locations, home care, and promotion of school-based care; case management and connection to housing; and analysis of data to improve workflows and outreach.

Care Quality and Medical-Loss-Ratio Metrics

DHMC's MLR is adjusted based on its performance on four quality measures across care domains, including pediatric care, chronic disease, and access to care (see Table 7). The benchmarks are established based on the National Committee for Quality Assurance's 90th percentile (of national performance), with DHMC required to close the gap between its current performance and the 90th percentile performance by at least 10%.

DHMC met the performance benchmark on two of four MLR metrics: timeliness of prenatal care and a new requirement to report on a housing and health care initiative. DHMC fell short of meeting the childhood immunizations benchmark of 57.8%, scoring 57.6%, an increase from 56.6% in FY 2018-19. Only four in 10 members with a positive screening for clinical depression received a follow-up service, compared with the target of 50%.

The impact of the COVID-19 pandemic and associated complications for care delivery on these metrics likely suppressed performance in the last four months of the fiscal year.

Table 7. DHMC Performance on Care Quality and MLR Metrics Compared to Performance Benchmarks, FY 2019-20

Metric	FY 2019-20 Performance	FY 2019-20 Benchmark	FY 2018-19 Performance
Housing and Health Care Initiative	Complete	Report	N/A
Childhood immunizations (Combination 7)	57.6%	57.8%	56.6%
Depression screening and follow-up service	40.0%	50.0%	N/A
Timeliness of prenatal care	84.5%	73.8%	71.9%

Source: HCPF

Housing and Health Care Initiative

Access to stable housing is an important factor in health. In acknowledgement of this, DHMC and HCPF incorporated a new metric to DHMC's MLR in FY 2019-20 to implement a pilot program aimed at providing housing to eligible members and tracking the impacts these supports have on health and utilization. Beginning in January 2020, DHMC and the Colorado Coalition for the Homeless (CCH), in partnership with HCPF, launched the Home to Health (H2H) Supportive Housing Program. Eligible unhoused Denver Health Medicaid beneficiaries

who volunteer for the program receive permanent housing from federal housing subsidies and supportive services from CCH. DHMC contracted with CCH to provide these services for 10 members for a total of 12 months.

There are two primary goals of this pilot program: 1) to better understand the health and social needs of DHMC members who experience homelessness and who are at risk for poor health outcomes, leading to downstream healthcare utilization, and 2) to gather preliminary data to assess this model for broader Medicaid policy initiatives with HCPF and other key stakeholders.

The project's first evaluation report provided a snapshot of the initial six months of the program. Participation in the program, as well as implementation and evaluation efforts, were disrupted by the COVID-19 pandemic. Baseline data suggest that the 10 participants mostly rate their health fair or poor and are more likely to utilize CCH's care management, nursing, and therapy services than other services such as dental or peer support. Future evaluations will allow assessment of changes in health status, depression scores, housing stability, and many other metrics over time. The evaluation will also monitor for potential reductions in total cost of care or emergency department visits due to the intervention.[25]

Childhood Immunizations

This metric measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP (diphtheria, tetanus, pertussis), three IPV (inactivated polio vaccine), one MMR (measles, mumps, rubella), three Hib (Haemophilus influenzae type b), three Hepatitis B, one VZV (varicella-zoster virus), four PCV (pneumococcal conjugate vaccine), one Hepatitis A, and two or three rotavirus vaccines. These vaccines make up the Combination 7 metric for childhood immunizations.

Performance on the childhood immunization metric did not meet the benchmark for FY 2019-20, as only 57.8% of members 2 years of age received the relevant immunizations on the required schedule. However, there was improvement from the previous year's performance, increasing from 56.6% in FY 2018-19 to 57.6% in FY 2019-20. DHMC has implemented a few interventions to improve performance and data collection on this metric, including reminder calls to members who are due for a vaccination, a change from a three dose to a two dose version of the rotavirus vaccine, and an off-season review of immunizations administered without an applicable claim sent to DHMC.

DHMC staff noted that the pandemic had a significant impact on this metric, following a national trend of substantial reductions in childhood immunization between March and May 2020.[26] As COVID-19 spread in Colorado, some parents of small children were concerned about the safety of coming to health clinics to get vaccines. Many clinics that offered childhood immunizations were also closed during the initial months of the pandemic due to state

restrictions and safety concerns.[27] Keeping children's immunizations up to date during the COVID-19 pandemic continues to be a concern.

Depression Screening and Follow-up Service

Screening for clinical depression and follow-up is a new metric for the FY 2019-20 performance year. This metric captures the percentage of members obtaining a mental health service on or within 30 days of screening positive for depression within a primary care setting.

DHMC did not meet the benchmark for this performance measure. Four in 10 people were screened for clinical depression and received a follow-up service, short of the 50% benchmark.

Data challenges may have impacted performance on this metric. DHMC works with Colorado Access, the RAE for Region 5 (Denver), to track and report this data. Starting in January 2020 the contractual relationship of the two organizations flipped, with Colorado Access becoming a subcontractor to DHMC. New processes had to be constructed to facilitate the flow of data for this metric from Colorado Access to DHMC, which may have affected data accuracy. Efforts are underway to ensure the accuracy and completeness of behavioral health data exchanged between DHMC and Colorado Access. DHMC has begun to analyze clinical data from providers to assess potential gaps in reporting and data issues related to this metric. This metric is also a HCPF-assigned Performance Improvement Project (PIP) topic for DHMC for FY 2020-21. DHMC will implement and test a series of interventions to improve this rate in future years, such as a pilot program at a Denver-area clinic to include a depression screening as part of all pediatric appointments, and a behavioral health consultation during the appointment for any child who receives a positive screening.

Timeliness of Prenatal Care

Timeliness of prenatal care is defined as the percentage of live births that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the MCO. DHMC's performance of 84.5% exceeded the benchmark of 73.8%. DHMC also improved its performance from the previous year's evaluation, increasing from 71.9% of live births.

Timeliness of prenatal care is a strategic focus at DHMC, which has taken steps to increase engagement in OB-GYN intake, timing, and follow-up with pregnant members. There has been a push for collaborative alignment within the Denver Health system. DHMC has focused particularly on increasing initial intake visits as a gateway to greater engagement in prenatal care throughout pregnancy.

A data change also contributed to improved performance. For this year of data, the metric specification was changed to also account for visits occurring before the member's enrollment start date.

Health Outcomes and Provider Performance Metrics

Additional quality metrics provide further context about how DHMC members' care compares with the previous year's performance. Performance across FY 2019-20 and FY 2018-19, as well as the pre-COVID-19 period of FY 2019-20 compared with a baseline from the prior year, are provided in Table 8.

DHMC's scores improved on two of the four performance measures, for both the entire fiscal year and pre-COVID performance periods. Hospital all-cause readmissions and emergency department visits both decreased. The behavioral health engagement rate and percentage of members with at least one visit with their primary care provider did not improve from the previous year.

Table 8. DHMC Performance on Health Outcomes and Provider Performance Metrics, FY 2018-19 and FY 2019-20

Metric	FY 2019-20 Performance	FY 2018-19 Performance	July 2019 – Feb. 2020 (Pre-COVID) Performance*	July 2018 – Feb. 2019 Performance *
Hospital all-cause readmission rate	10.1%	10.5%	10.0%	10.3%
Emergency department visits	576 visits per 1,000 members	641 visits per 1,000 members	636 visits per 1,000 members	640 visits per 1,000 members
Behavioral health engagement rate	14.0%	14.6%	12.0%	12.1%
Percentage of members with one or more visits to a primary care medical provider	55.1%	64.0%	54.8%	56.5%

Source: HCPF

* Includes data from the eight-month pre-pandemic period of FY 2019-20, from July 2019 through February 2020, and the same period of months in FY 2018-19. These two columns can only be compared with each other and should not be compared with full performance year data.

Hospital All-Cause Readmission Rate

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

Readmissions were slightly lower in FY 2019-20 compared with FY 2018-19: 10.1% compared with 10.5%. Readmissions were also slightly lower in the most recent year when comparing pre-COVID-19 months: DHMC had a hospital all-cause readmission rate of 10.0% during the pre-COVID period of FY 2019-20 compared with 10.3% during the same time the previous fiscal year. DHMC care management teams collaborate with Denver Health inpatient care management teams to coordinate discharge planning with the goal of preventing avoidable readmissions.

Emergency Department Visits

Like hospital readmissions, visits to a hospital emergency department can be costly and may indicate that improvements are needed in care management services and/or access to primary care services. As previously noted, the COVID-19 pandemic had a significant impact on care-seeking and utilization of services and changed many people's day-to-day behaviors. This may explain some of the decrease in the emergency department visits metric.

Emergency department utilization at DHMC was down slightly between the eight-month pre-COVID months in FY 2019-20 and the parallel timeframe in FY 2018-19. DHMC members visited the emergency department at a rate of 636 visits per 1,000 members during pre-COVID months of FY 2019-20, down from 640 visits per 1,000 members during the same period in FY 2018-19. The decline is much steeper when the pandemic months are considered. The rate for the entire year dropped from 641 visits per 1,000 members in FY 2018-19 to 576 visits per 1,000 members in FY 2019-20. This metric appears to have been directly impacted by the pandemic.

Behavioral Health Engagement Rate

The behavioral health engagement rate metric measures the percentage of members who had at least one behavioral health visit during the measurement period. The behavioral health engagement rate for FY 2019-20 went down slightly, to 14.0% from 14.6% during FY 2018-19. Some of this decrease may be attributed to the COVID-19 pandemic, which restricted access to and desire for in-person care during the last several months of FY 2019-20. Evidence suggests this decrease may have been even more significant if not for transitioning many behavioral health visits to telemedicine. CHI's analysis of electronic medical record data from

Front Range providers found that use of behavioral health services for conditions such as anxiety, depression, and substance use decreased overall during the COVID-19 pandemic. The transition of many behavioral health services to telemedicine mitigated a more precipitous drop.[28] It is likely the decrease in behavioral health care use would have been larger without the relaxing of regulations around use and reimbursement of care delivered via telemedicine.

The behavioral health engagement rate during the pre-COVID period of FY 2019-20 and the same months from FY 2018-19 were roughly the same (12.0% and 12.1%, respectively). This indicates that access to behavioral health care pre-pandemic was similar to the prior year, but that the pandemic curtailed access.

Members With at Least One Visit to a Primary Care Medical Provider

Access to a primary care provider is a proxy for effective utilization of the medical home model, which is a key tenet of the ACC. The percentage of members with one or more visits to a PCMP in FY 2019-20 decreased (55.1%) compared with the prior year (64.0%). This may be an impact of the COVID-19 pandemic, although the percentage of members with a PCMP visit in the pre-pandemic period (54.8%) was also lower than the percentage for the same months in the prior year (56.5%).

In FY 2019-20, DHMC employed multiple strategies to increase primary care engagement:

- DHMC partnered with STRIDE Community Health Centers, adding 16 facilities at which DMHC members may receive services.
- DHMC has contracted with DispatchHealth, allowing members to receive primary care services at home.
- Denver Health has maintained Saturday office hours at three of its community health centers.
- DHMC has attempted to reduce wait lists by improving administrative workflow in scheduling appointments, hiring additional providers, adjusting panel sizes, fostering collaboration between the appointment center and clinics to fill open appointment slots.
- Members also have access to EPIC My Chart, which allows them to message their PCMP, schedule primary care visits, request prescription refills, and review lab results.[29]

DHMC has been making efforts to connect with members who experienced delays in receiving primary care due to the COVID-19 pandemic. Much of this work has been done at the provider level, trying to connect people to needed services as well as finding ways to meet some patients' needs at home during the pandemic. DHMC found that providers for the most part did not have the technical equipment to meet the demand for audio and video visits. DHMC has since launched initiatives to help bridge this gap, such as distributing iPads to providers. DHMC has also created a virtual urgent care, which can serve as an alternative for in-person care.

Child and Adolescent Preventive Care

Children have distinct health care needs from adults as well as different needs during distinct life stages of development. Delivering preventive care to children at these different stages is integral in preventing the onset or progression of physical or behavioral health issues.[30]

For this reason, CHI incorporated four additional measures into the evaluation to understand care delivery and performance on preventive care for the child and adolescent populations served by DHMC (Table 9). These measures include: well-child visits in the first 15 months of life; well-child visits in the third, fourth, fifth, and sixth years of life; adolescent well-child visits; and child and adolescent counseling for nutrition. DHMC improved across three of the four child and adolescent preventive care measures from 2018 to 2019 and improved across all four metrics compared with 2017.

The first new metric, zero well-child visits in the first 15 months of life, measures the percentage of members who turned 15 months of age during the measurement year who did not have a well-child visit with a primary care provider. Since 2017, DHMC has improved on this metric by decreasing the percentage of children 15 months and younger with zero visits from 9.1% in 2017 to 4.8% in 2019. This performance is comparable to the Colorado Medicaid average, measured at 4.8% in 2019.

The percentage of children with well-child visits in the third, fourth, fifth, and sixth years of life with a primary care provider has also improved over time, increasing from 60.9% in 2017 to 64.5% in 2019. Again, DHMC's performance is comparable to the Colorado Medicaid average on this metric in 2019, at 64.5%.

The percentage of adolescents (those ages 12 to 21) who received a comprehensive well-care visit with a primary care physician or OB-GYN has varied, increasing between 2017 and 2018 but decreasing from 2018 to 2019. DHMC performed slightly higher than the Colorado Medicaid average in this metric in 2019. In 2019, around four in ten (40.1%) adolescents enrolled in DHMC received a comprehensive well-care visit compared to 38.2% of adolescent members across the state.

The child and adolescent counseling for nutrition measures the percentage of members ages 3 to 17 who had an outpatient visit with a PCMP or OB/GYN and received counseling for nutrition during the measurement year. DHMC also improved the percentage of adolescent members receiving this preventive screen over time, increasing from 6.0% in 2017 to 9.2% in 2019. DHMC's performance is comparable to the Colorado Medicaid average in this metric as well – 9.4% of Medicaid members received this screening in 2019.

DHMC noted that adolescent populations are harder to reach than younger children. It has been even more difficult to reach this group during the COVID-19 pandemic, as the closure of schools impacted DHMC's ability to reach them through its SBHC network. The system is

attempting to improve its reach; for instance, DHMC has created online consent forms that make it easier for adolescents to be enrolled in school-based health services.

Efforts focusing on access to care for pediatric members may have contributed to improvement in these metrics. DHMC employs a variety of outreach strategies to connect children and adolescents to primary and preventive care. In FY 2019-2020, DHMC mailed an average of 2,663 birthday cards each month to children ages 2-19 with information on nutrition, physical activity, vaccines, upcoming well-child visits, and information on scheduling an appointment. DHMC also views Denver Health's network of SBHCs as a key component of pediatric care. DHMC has continued to inform eligible members of services available at SBHCs. In early 2020, Denver Health commenced a pilot project in which Healthy Communities navigators — an outreach program for families with children enrolled in Medicaid and the Child Health Plan *Plus* — and SBHC program administrators collaborated to identify and reach out to eligible DHMC members when annual wellness exams are due. The program showed promising results prior to the pandemic, and DHMC hopes to expand the program in the future and when schools and SBHCs reopen safely.[31]

Table 9. DHMC Performance on Child and Adolescent Preventive Care Metrics, Calendar Years 2017-2019

Metric	2019	2018	2017
Zero Well-Child Visits in the First 15 Months of Life**	4.8%	7.1%	9.1%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.5%	63.6%	60.9%
Adolescent Well-Care Visits	40.1%	41.3%	36.3%
Counseling for Nutrition	9.2%	7.5%	6.0%

Source: 2020 HEDIS Aggregate Report for Health First Colorado
**For this metric, a lower rate indicates better performance.

Women's Health

Women's health metrics included in this analysis include breast cancer screening, cervical cancer screening, and chlamydia screening (Table 10). DHMC improved across two of the three women's health performance measures from 2018 to 2019.

The breast cancer screening metric measures the percentage of female members ages 50 to 74 who had a mammogram exam for breast cancer during the measurement period. Between 2017 and 2019, there was a small decline in the number of women who received a screening

for breast cancer. In 2019, DHMC also performed lower than the Colorado Medicaid average (47.1%). To improve performance on this measure, DHMC sends mailers to members due for mammography. Mailer distribution was paused during the early stages of the pandemic, when limits on nonemergent procedures were in place but have since resumed on a monthly basis. To improve response rates, the mailer has been edited to include a contact name and phone number and information on transportation assistance.

The cervical cancer screening metric tracks the percentage of female members ages 21 to 64 who were screened for cervical cancer using either of the following criteria: females ages 21 to 64 who had a cervical cytology performed every three years or females ages 30 to 64 who had a cervical cytology/HPV co-testing performed every five years. Since 2017, there has been improvement in this measure, increasing from 43.0% to 45.6% in 2019. In 2019, DHMC outperformed the Colorado Medicaid average of 42.5% of female members screened for cervical cancer.

Due to the COVID-19 pandemic, the Denver Health Women's Mobile Clinic, which performs both mammograms and cervical cancer screenings, paused service in March 2020. The impact of this temporary pause in service may be noted in future evaluations. In addition, the delivery of a new Women's Mobile Clinic, slated for early 2020, was delayed until the third quarter of 2021. DHMC anticipates that technological innovations — such as text message screening reminders and the ability for members to schedule breast and cervical cancer screenings themselves — will coincide with the new clinic providing services.[32]

The chlamydia screening metric tracks the percentage of female members ages 16 to 24 who were identified as being sexually active and received one test for chlamydia during the measurement year. DHMC has increased the number of female members with a screening from 66.7% in 2017 to 72.9% in 2019. In 2019, DHMC also outperformed the Colorado Medicaid average of 64.4% on this metric as well. In 2020, universal chlamydia screening for adolescents was implemented based on a need identified by a workgroup analysis of chlamydia screening positivity data.

Table 10. DHMC Performance on Women's Health Metrics, Calendar Years 2017-2019

Metric	2019	2018	2017
Breast Cancer Screening	46.0%	46.5%	50.7%
Cervical Cancer Screening	45.6%	43.1%	43.0%
Chlamydia Screening	72.9%	69.6%	66.7%

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Adult Access to Preventive Care

Connecting members with preventive health care services is important in identifying potential diseases or conditions early and promoting health. This metric gauges the percentage of members ages 20 and older who had an ambulatory or preventive care visit (Table 11).

DHMC has improved its score in this measure from 53.9% in 2018 to 55.3% in 2019. The 2019 performance recovered after a drop in performance between 2017 and 2018 measurement years. For context, DHMC's score of 55.3% was lower than the Colorado Medicaid average of 63.0% in 2019.

DHMC's action plan for FY 2019-20 includes activities for continuing to improve on this metric, including further transportation support, additional analysis on access barriers members are experiencing, and opportunities for case management and patient navigation services. See the PCMP and preventive care discussion on pages 30 and 31 for a description of DHMC's strategy for engaging members with primary care and preventive care.

Table 11. DHMC Performance on Adult Access to Preventive Care Metrics, Calendar Years 2017-2019

Metric	2019	2018	2017
Adult Access to Preventive/Ambulatory Health Services	55.3%	53.9%	55.2%

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Inpatient Length of Stay

Total inpatient average length of stay measures the average number of days members spent in inpatient care across members of all ages (Table 12). Between 2017 and 2019, DHMC has seen a decrease in the average length of stay in inpatient care from 4.7 days in 2017 to 4.4 days in 2019. For comparison, DHMC performed comparably to the Colorado Medicaid average of 4.4 days in 2019. Despite this decrease in average length of stay, the hospital readmission rate for members did not increase between FY 2018-19 and FY 2019-20.

DHMC focused on analyzing a subset of common reasons for delays in care by diagnosis-related groups (DRGs) as well as work around discharge planning and follow-up care after hospital discharge. DHMC also communicated with providers, nurses, and other staff about goals for the average length of stay metric to help with coordination. DHMC credits these initiatives for improvement on this metric over time and is expanding the DRGs it is including in its analysis of inpatient length of stay.[33]

Table 12. DHMC Inpatient Length of Stay, Calendar Years 2017-2019

Metric	2019	2018	2017
Total Inpatient Average Length of Stay (Days)	4.4	4.6	4.7

Source: 2020 HEDIS Aggregate Report for Health First Colorado

Member Experience

Based on 2020 survey results, DHMC outperformed the Medicaid average on two of the three metrics with an available comparison (Table 13). About seven in ten (69.6%) of members rated their provider favorably compared with 59.1% of the Medicaid average. DHMC also outperformed in provider communication, with 94.2% of members reporting that they were pleased with how their provider communicated with them. DHMC did not outperform the Medicaid average for percentage of members with a favorable rating of their health plan, with 60.3% reporting a favorable rating compared with 61.3% of the Medicaid average. However, a higher percentage of members rated DHMC favorably in 2020 than in previous years. The percentage of members rating their provider favorably and pleased with how their provider communicates with them also improved in 2020 compared with 2019.

The percentage of members who received needed care improved between the 2019 and 2020, but performance was still below the 77.5% reported in 2018. The percentage of respondents who reported receiving care as soon as needed has decreased since 2018, falling from 78.0% to 73.5% in 2020. As noted above, no analysis has been conducted to assess statistical significance of any changes in percentages from year to year.

To increase members' access to care, Denver Health is expanding capacity at various clinics and offering more evening and weekend hours. DHMC is also promoting patient communication with its care teams through messaging functionality in the Epic MyChart application. Denver Health operates a 24-hour Nurse Advice phone line to offer members after hours support. DHMC's contract with DispatchHealth, signed in October 2019, is an option for members to receive services in their home when appropriate.

Table 13. Patient Ratings of Their Care Experience, DHMC and Colorado Medicaid Average, 2018-2020

Metric	2020 Performance	2019 Performance	2018 Performance	Medicaid Average Performance (2020)*
Percentage of respondents rating their provider favorably	69.6%	66.0%	70.9%	59.1%
Percentage of respondents rating their health plan favorably	60.3%	56.4%	59.1%	61.3%
Percentage of respondents pleased with how their provider communicates with them	94.2%	92.0%	92.5%	71.4%
Percentage of respondents reporting receiving care as soon as needed	73.5%	74.7%	78.0%	N/A
Percentage of respondents reporting receiving the care they needed	74.5%	71.8%	77.5%	N/A

*Comparison group is all Medicaid members.
Source: 2020 Colorado Patient-Centered Medical Home Survey Adult Report

Challenges and Limitations

The COVID-19 pandemic significantly impacted access to care, patient behavior, and provider resources in the last four months of the evaluation period (March through June 2020), making it difficult to compare performance with prior years.

CHI attempted to account for the impacts of COVID-19 in various ways, including providing additional context on how the impact of the pandemic may have affected various metrics. Where possible, CHI also analyzed performance using a pre-pandemic time compared with the same period from the prior fiscal year.

These specific time periods can only be compared against each other, not against full fiscal year performance, because they have not been annualized. They have also not been adjusted for any potential seasonality. Shortening the performance period to eight months also may introduce more variation in performance due to a shorter time period with fewer observations.

The short timeline to conduct the evaluation limited qualitative data collection from patients and providers.

Analysis of the health outcomes and provider performance metrics included in the FY 2019-20 evaluation is limited to comparing the MCO's performance over time rather than against any benchmark or comparison group. This is a change from prior year analyses, which attempted to identify a population of members enrolled in FFS Medicaid plans to use as a comparison group. In the FY 2018-19 report, CHI noted challenges with identifying an appropriate comparison group. For example, patient health needs in either the MCO population or the comparison group could be higher on average, which impacts performance. Because of those challenges, comparison groups were not used for the health outcomes and provider performance metrics for the FY 2019-20 report.

Looking Ahead

CHI is working with HCPF to introduce risk-adjusted comparison groups for the purpose of evaluating MCO performance on certain metrics. These risk-adjusted data were not available at the time of this report but are expected to be available in 2021. Once those data are available and an analysis can be completed, CHI and HCPF intend to create and release a separate, stand-alone report including the findings from that risk-adjusted analysis. The process for developing that report will be similar to this report; HCPF and the MCOs will be given the opportunity to review and provide feedback which CHI will assess as the independent evaluator. The metrics expected to be included in that analysis are: hospital all-cause readmission rate, emergency department visits, behavioral health engagement rate, and percentage of members with one or more visits to a primary care medical provider. These comparison groups would allow the evaluation to assess MCO performance not just for improvement over time, but also for whether the MCOs are able to improve health outcomes performance against the FFS population.

In future evaluations, CHI recommends including a survey of providers associated with each of the MCOs. The lack of available data on provider satisfaction is a limitation of this report and previous evaluations. The provider survey should assess the satisfaction of a broad, representative set of providers, allowing a more robust set of findings than a key informant interview or even multiple key informant interviews.

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