# Medicaid Payment Reform and Innovation Pilot Program Report FY 2022-23

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

**April 2024**

**Submitted to:**

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

COLORADO
Department of Health Care Policy & Financing

## Contents





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## I. Introduction

The Department of Health Care Policy & Financing (HCPF) provides health coverage to low-income Coloradans and people with disabilities through safety net programs like Health First Colorado (Colorado's Medicaid program) and the Child Health Plan *Plus* (CHP+). In SFY22-23, its programs covered 1.7 million Coloradans, one in every four people in the state.

HCPF continues to pursue payment strategies to improve Medicaid equity, access, quality and affordability. Capitated managed care, in which managed care plans cover services for members in exchange for a fixed per-member-per month (PMPM) fee, is one of these strategies. (Information about HCPF's cost control initiatives, including cost transparency, prescription drug cost control, telemedicine and value-based hospital payments, may be found at https://hcpf.colorado.gov/affordability.)

Capitated managed care initiatives for both physical and behavioral health operate within the structure of the Accountable Care Collaborative (ACC), the primary delivery system for Health First Colorado. The ACC has Regional Accountable Entities (RAEs) that support Health First Colorado members and providers in each of the seven regions of the state. The RAEs administer the capitated managed care plan for **behavioral** health care and partner closely with providers of **physical** health care.

The focus of this report is the performance of the state's two fully capitated managed care plans for **physical** health in FY 2022-23: Denver Health Medical Plan and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Enrollees (RMHP PRIME). RMHP PRIME operates on the Western Slope, and Denver Health Medicaid Choice (DHMC) operates in the Denver metro area. This report is required by Section 25.5-5-415, C.R.S and does not include Health First Colorado's behavioral health managed care program, which is discussed in a separate report.

During FY 2022-23, RMHP PRIME had an average monthly enrollment of 55,768 members and Denver Health averaged 110,285 members per month. For context, enrollment in the Accountable Care Collaborative as a whole averaged 1,594,150 members per month. This report includes information about how the plans deliver their services and who they serve. It also includes information on program budget, program performance, and member experience.

## II. Managed Care and Medicaid

Many states rely on managed care to administer Medicaid benefits. In 2021, over 85% of Medicaid beneficiaries in the U.S. were enrolled in some form of managed care.[1] States use managed care because it allows them to meet health care needs while controlling the costs to the state. It is an alternative to fee-for-service payment models, in which health care providers are paid for every individual service with limited ways to connect services to quality, costs or outcomes. Managed care can increase accountability for outcomes while supporting statewide efforts to measure and monitor performance, access, and quality. Managed care programs can also provide opportunities for better care management and care coordination.

Managed care models differ in the type and extent of accountability used to achieve results. Some managed care models use payments to incentivize better health outcomes, equity, and access while constructing provider networks in a way that propels more effective service utilization and outcomes while recognizing higher performing providers.

Other managed care models, like the ones featured in this report, promote cost savings by using a PMPM capitation rate for some or all care, requiring plans to meet the member's needs for that amount. These plans are different from most other contracted agencies that provide services for Health First Colorado members; they are like small health insurance companies that bear the risk for the health outcomes of their members.

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

## III. Physical Health Managed Care Organizations in Colorado

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

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[1] U.S. Center for Medicare and Medicaid Services. (2023). Medicaid Managed Care Enrollment and Program Characteristics, 2021. https://www.medicaid.gov/sites/default/files/2023-07/2021-medicaid-managed-care-enrollment-report.pdf.

### A. Managed Care Organizations and the Accountable Care Collaborative

Capitated managed care initiatives for both physical and behavioral health operate within the structure of the Accountable Care Collaborative (ACC), which was launched in 2011 and is now the foundation of Health First Colorado. The ACC's seven RAEs support Health First Colorado members and providers in each of the seven regions of the state. The RAE contracts with primary care medical providers (PCMPs), who are paid a per-member-per-month payment by the RAEs for their medical home services in addition to fee-for-service payments they receive from the state for the medical care they provide.

Under the ACC, RAEs also administer the capitated managed care plan for **behavioral** health care. Although the ACC is itself a type of managed care, it is not a capitated comprehensive risk model for **physical** health care. Two capitated managed care plans for physical health operate within the ACC: Denver Health Medical Plan (DHMP) and Rocky Mountain Health Plans (RMHP) PRIME. PRIME is operated as part of the Region 1 RAE contract with RMHP, whereas the state contracts directly with Denver Health, which works in partnership with the Region 5 RAE to meet the needs of members in the Denver metro area. For the populations they serve, these managed

care plans are held accountable for outcomes that usually fall to the RAEs, such as maternal health, complex care management and health equity.

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


## B. MCO: Rocky Mountain Health Plans PRIME

RMHP PRIME, operates on Colorado's Western Slope, covering approximately 16,000 square miles that include nine counties: Delta, Garfield, Gunnison, Mesa, Montrose, Ouray, Pitkin, Rio Blanco, San Miguel. RMHP PRIME's service area is primarily rural, though it includes the metropolitan area of Grand Junction. Much of its service area (all of Rio Blanco, Mesa and Gunnison counties and parts of Garfield and Montrose) is designated as a Health Professional Shortage Area (HPSA) for primary care, a federal

designation indicating unmet need provider capacity.[2] Like most of Colorado, its entire service area is HPSA-designated for mental health.[3]

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

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

Within RMHP PRIME, 66 practices are eligible to participate in Prime Global Pay, a model in which providers receive a capitation payment from RMHP to cover the cost of the practice's services for its PRIME members and provide additional care coordination services. The payments reflect a risk-adjusted cost of care for the practice. Shared savings that are based on quality and total cost performance are paid at the end of the year to these practices. Practices may be RMHP PRIME providers even if they do not opt to participate in PRIME Global Pay.

### C. MCO: Denver Health Medical Plan

Denver Health Medical Plan, per HB19-1285, operates in the Denver metro area in Adams, Arapahoe, Denver, and Jefferson counties. It has operated in this area since 2004. While its geographic area is relatively small, it serves a large population in a primarily urban environment with a population density of over 850 people per square

[2] Rural Health Information Hub. (2024). Health professional shortage areas: Primary care, by county, 2024 – Colorado. Retrieved from https://www.ruralhealthinfo.org/charts/5?state=CO. Accessed February 2024.

[3] Rural Health Information Hub. (2024). Health professional shortage areas: Mental health, by county, 2024 – Colorado. Retrieved from https://www.ruralhealthinfo.org/charts/7?state=CO. Accessed February 2024.

mile — much higher than Colorado's overall population density of just over 55 people per square mile. All four of its counties are designated as mental health HPSAs, and portions of these counties are designated as primary care HPSAs.[4]

Only newly Medicaid members residing in Denver County service area are automatically enrolled into the Denver Health Medical Plan. Adams, Arapahoe, and Jefferson County based Members have to choose/opt into DHMP. Members can opt out and choose for fee-for-service care instead, but they must take the initiative to do so.

Denver Health uses a staff model: its medical/health providers are employees rather than independent providers who contract with the health plan. Care is provided at Denver Health's main medical campus, 10 family health centers and 18 school-based health centers in the Denver metro area. In addition to its own network, Denver Health also contracts with community providers, such as STRIDE Community Health Center, InterMountain, University of Colorado Hospital and Children's Hospital Colorado, to provide services to members. Because Denver Health has its own contracts with these entities, its rates at these facilities can differ from HCPF's. For example, Denver Health pays a higher rate for services at Children's Hospital Colorado than HCPF does, although it has collaborated with HCPF to run a bill during the 2024 legislative session to prohibit providers from charging its Medicaid health plan more than Medicaid would have paid those providers directly. HCPF is exploring other ways to ensure that reimbursements by managed care organizations are consistent with HCPF's fee-for-service reimbursement rate.

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

### D. Enrollment in MCOs

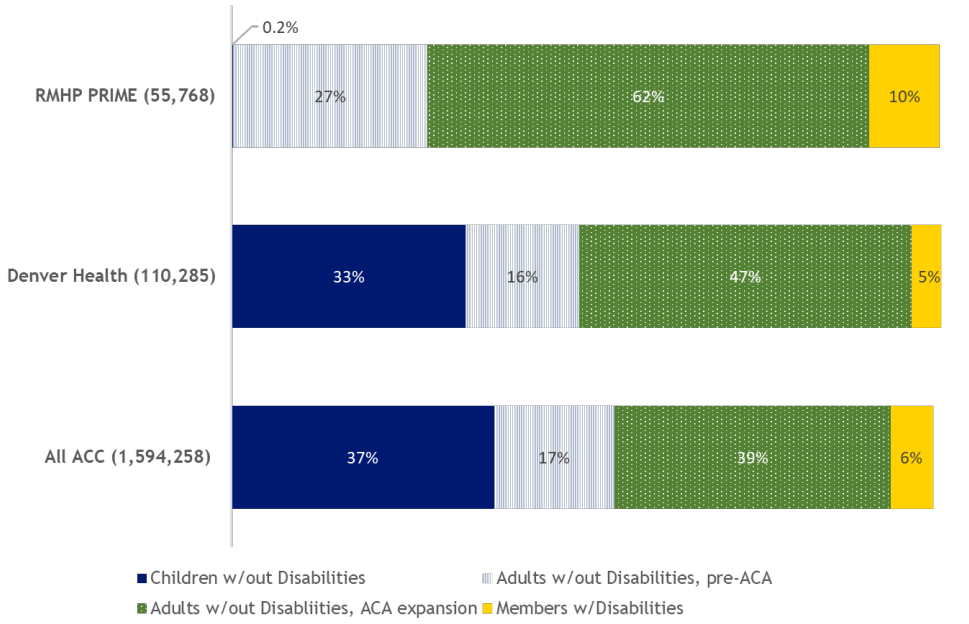
During FY 2022-23, RMHP PRIME had an average monthly enrollment of 55,768 members and Denver Health averaged 110,285 members per month. For context, enrollment in the Accountable Care Collaborative as a whole averaged 1,594,258 members per month.

Figure 2 reveals another way the two managed care plans differ: the enrollment mix. RMHP PRIME does not cover children, with the exception of children who are disabled. RMHP covers a small number of children *with* disabilities. It also serves a greater

[4] Rural Health Information Hub. (2024). Health professional shortage areas: Primary care, by county, 2024 – Colorado. Retrieved from https://www.ruralhealthinfo.org/charts/5?state=CO. Accessed February 2024.

percentage of adults with disabilities, including dually eligible Medicare-Medicaid members, than Denver Health or the ACC as a whole. This affects the priorities, strategies and PMPM costs of the two plans.

**Figure 2. Average Enrollment in ACC and MCOs by Eligibility, FY 2022-23**




## IV. Cost of Care

The cost of care for members in capitated managed care plans include all costs for members' care, regardless of whether it is covered under the physical health capitation, behavioral health capitation or fee-for-service. The cost is comprised of three elements: the physical health PMPM for members, the behavioral health PMPM for members and the cost of any services that are not covered by the PMPM (fee-for-service payments). The third category includes long-term services and supports, medical transportation, dental care, pharmacy and some Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children.

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

**Table 1. RMHP PRIME Cost of Care, FY 2022-23**

| Cost | Description | FY 2022-23 |
|---|---|---|
| Physical Health Capitation | Total per-member-per-month fees for medical care. | $299,437,480 |
| Behavioral Health Capitation | Total per-member-per-month fees for mental health care and substance use treatment. | $47,150,619 |
| Fee-for-Service Payments | Payments for services not covered under the capitation (e.g., long-term services and supports, dental care, medical transportation). | $67,988,306 |
| Total cost of care | The total cost of care (physical and behavioral health capitation payments and fee-for-service payments), while holding the MCO accountable for quality and population health outcomes. | $414,576,406 |
| Cost of care per member per month | The amount of money paid or received monthly for each individual enrolled in the managed care plan. | $621 per member per month |

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

**Table 2. Denver Health Medical Plan Cost of Care, FY 2022-23**

| Cost | Description | FY 2022-23 |
|---|---|---|
| Physical Health Capitation | Total per-member-per-month fee for medical care. | $298,289,918 |
| Behavioral Health Capitation | Total per-member-per-month fee for mental health care and substance use treatment. | $74,574,173 |
| Fee-for-Service Payments | Payments for services not covered under the capitation (e.g., dental care, medical transportation, long-term services and supports). | $75,981,807 |
| Delivery Paid Amounts | Payments made to clinics that charge an encounter fee for care (e.g., FQHCs). | $6,749,860 |
| Total cost of care | The total cost of care (physical and behavioral health capitation payments, fee-for-service payments and delivery paid amounts), while holding the MCO accountable for quality and population health outcomes. | $455,595,758 |
| Cost of care per member per month | The amount of money paid or received monthly for each individual enrolled in a managed care plan. | $345 per member per month |

## V. Program Performance

Program performance is also a critical part of the Medicaid MCO programs and is therefore closely assessed and tracked. Such tracking also ensures that cost savings are not achieved by reducing access, denying care to members, or providing a lower quality of care.

To evaluate the performance of MCO initiatives, HCPF looks at four different types of performance metrics: medical loss ratio quality metrics, care utilization metrics, CMS Core Quality Measures and member experience data. Each is described below.

## A. Medical Loss Ratio Quality Metrics

The medical loss ratio (MLR) refers to how much money an MCO spends on providing medical services versus administrative services and profit. The higher the MLR requirement, the greater the percentage of revenue must be spent on care. For example, a health plan with an MLR of 89% spent 89% of its revenue on services; a health plan with an MLR of 83% is retaining more dollars for its administration and profit. Medicaid managed care plans are federally required to have an MLR of at least 85%.

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

The following MLR metrics were used to incentivize performance for RMHP PRIME in FY 2022-23:

1. **Initiation and Engagement of Alcohol and Other Drug Dependence**: **Engagement.** Percentage of members aged 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
    - Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
    - Engagement of AOD Treatment. Percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. (Note: This metric was not used for MLR calculations during FY 2022–23 but will be used starting in FY 2023–24.)
2. **Timeliness of Prenatal and Postpartum Care.**
    - Timeliness of Prenatal Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
    - Postpartum Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year

and October 7, 2022 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.

3. **Behavioral Health Engagement Rate for Members Experiencing Housing Instability.** The implementation and outcomes of a housing program and its strategies for Health First Colorado members enrolled in PRIME, based on a quarterly deliverable.
4. **Diabetes HbA1c Poor Control >9.0%.** Percentage of members ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) >9.0%.

RMHP PRIME's MLR floor began at 89%, 4% above the federally required standard of 85%. PRIME had the opportunity to lower its MLR floor by 1% for meeting the target for Metric 1, 2% for meeting the target for the Metric 2, and 1% for meeting Metric 3. RMHP PRIME has met 2 out of the 4 measures, with one measure still To Be Determined (TBD). TBD results come when the final report is due in June 2024. Table 3 shows RMHP PRIME's performance on MLR metrics for FY 2022–23.

**Table 3. RMHP PRIME MLR Metrics: Performance and Benchmarks, FY 2022-23**

| MLR Metric | Performance | Benchmark | Met? |
|---|---|---|---|
| Metric 1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Initiation: 59.6%<br>Engagement*: 16.8% | Initiation: 28.2%<br>Engagement: 9.1% | Yes |
| Metric 2: Prenatal and Postpartum Care: Prenatal Care (NQF1517)<br>Prenatal and Postpartum Care: Postpartum Care (NQF1517) | Prenatal Care: TBD%<br>Postpartum Care: TBD% | Prenatal Care: 91.2%<br>Postpartum Care: 80.3% | TBD |
| Metric 3: Behavioral Health Engagement Rate for Members Experiencing Housing Instability | 59.16% | 67.3% | No |

| MLR Metric | Performance | Benchmark | Met? |
|---|---|---|---|
| Metric 4: Diabetes HbA1c Poor Control <9.0% | 18.2% | 21.5% | Yes |

*AOD Engagement was not used for MLR calculations in FY 2022-23. It will be used starting FY 2023-24.

For Denver Health, the following MLR metrics were used to incentivize performance in FY 2022-23:

1. **Well-Child Care**
    - Percentage of children who had well-child visits with a primary care practitioner according to the following schedule:
        - Six or more well-child visits in the first 15 months of life.
        - Two or more well-child visits for children ages 15 to 30 months.
    - Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist during the measurement year.

5. **Timeliness of Prenatal and Postpartum Care.**
    - Timeliness of Prenatal Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
    - Postpartum Care. Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
6. **Initiation and Engagement of Alcohol and Other Drug Dependence: Initiation and Engagement**. This measures the percentage of members age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
    - Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
    - Engagement of AOD Treatment. Percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

7. **Housing and Health.** This metric has two parts. 1) Denver Health must submit the results of quarterly surveys and measure the behavioral health engagement rate for members who receive services from the Colorado Coalition for the Homeless. 2) Health and Housing evaluation deliverable.

Denver Health's MLR began at 89%, 4 percentage points above the federally required standard of 85%. They had the opportunity to lower its MLR by 1 percentage point for meeting each metric's target shown in Table 4, and it is still To Be Determined (TBD) on if the metrics were met. TBD results come when the final report is due in June 2024.

**Table 4. Denver Health Performance on MLR Metrics Compared to Benchmarks, FY 2022-23**

| Denver Health MLR Metric | Performance | Benchmark | Met? |
|---|---|---|---|
| Metric 1: Well-Child Care<br><br>First 15 Months<br>15-30 Months<br>3-21 Years | <br><br>54.3%<br>54.4%<br>41.9% | <br><br>55.7%<br>57.3%<br>43.5% | TBD |
| Metric 2: Prenatal Care (NQF1517) and Postpartum Care (NQF1517) | Postpartum: 69.2%<br><br>Prenatal: 83.4% | Postpartum: 69.7%<br><br>Prenatal: 84.1% | TBD |
| Metric 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | 42.7% | 43.5% | TBD |
| Metric 4: Housing & Health<br><br>1) BH Engagement rate for MCO/CCH Members<br><br>2) Housing and Health Deliverable | 27.96% | 33.66% | Yes |

### B. Care Utilization Metrics

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

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

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

**Table 5. Care Utilization for RMHP PRIME, FY 2019-20 to FY 2022-23**

| Care Utilization Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|
| Hospital All-Cause Readmission (goal is to decrease utilization) | 10.1% | 10.2% | 9.3% | 10.1% |
| Behavioral Health Engagement Rate (goal is to increase utilization) | 22.3% | 21.5% | 20.5% | 20.3% |
| Percentage of members with 1+ visits to a PCMP (goal is to increase utilization) | 68.0% | 65.4% | 65.1% | 64.5% |

| | | | | |
|---|---|---|---|---|
| Emergency department visits per 1,000 members per year (goal is to decrease utilization)* | 777 | 683 | 686 | 594 |

*MCO ED rates are not risk adjusted and therefore not comparable to RAEs.

Table 6 shows Denver Health's care utilization measures for the current and past three fiscal years.

**Table 6. Care Utilization for Denver Health, FY 2019-20 to FY 2022-23**

| Care Utilization Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|
| Hospital All-Cause Readmission (goal is to decrease utilization) | 10.1% | 11.9% | 11.4% | 11.9% |
| Behavioral Health Engagement Rate (goal is to increase utilization) | 14.0% | 13.3% | 15.4% | 14.4% |
| Percentage of members with 1+ visits to a PCMP (goal is to increase utilization) | 55.1% | 55.3% | 54.9% | 53.6% |
| Emergency department visits per 1,000 members per year (goal is to decrease utilization)* | 576 | 482 | 537 | 489 |

* MCO ED rates are not risk adjusted and therefore not comparable to RAEs.

### C. CMS Core Quality Measures

MCO evaluation includes some of the Core Quality Measures from the Centers for Medicare and Medicaid Services (CMS). These measures align with the measures from Healthcare Effectiveness Data and Information Set (HEDIS), a set of care access and utilization measures widely used for managed care that HCPF has used in the past to assess the quality of its managed care programs.[5] These measures are reported on a calendar year rather than the fiscal year. Therefore, the clinical quality data in this report is based on dates reflected in the 2023 CMS Adult and Child Core Measure Sets and is not based on the state fiscal year (July 2022 to June 2023).

[5] "Major Health Plan Quality Measurement Sets" (2022). Agency for Healthcare Quality and Research. https://www.ahrq.gov/talkingquality/measures/index.html. Accessed February 23, 2024.

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

Below are the clinical measures used this year.

1. **Timeliness of Prenatal Care.** Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
2. **Postpartum Care.** Percentage of deliveries of live births on or between October 8, 2021 of the year prior to the measurement year and October 7, 2022 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
3. **Chlamydia Screening.** Percentage of female members aged 16 to 24 who were identified as sexually active and received at least one test for chlamydia.
4. **Breast Cancer Screening**. Percentage of female members aged 50 to 74 who had a mammogram.
5. **Cervical Cancer Screening**. Percentage of female members aged 21 to 64 who were screened for cervical cancer according to clinical guidelines.
6. **Antidepressant Medication Management, Acute and Continuation Phases.** Percentage of members aged 18 years+ who were treated with antidepressant medication, were diagnosed with major depression, and remained on the medication for at least 84 days (acute phase) and 180 days (continuation phase).
7. **Asthma Medication Ratio.** Percentage of members aged 5 to 64 with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater.
8. **Preventive care for children and adolescents** (Denver Health only)
    - **Well-child visits in the first 30 months of life**. Percentage of members who received six or more well-child visits before turning 15 months of age, and the percentage of members who received two or more well-child visits before turning 30 months of age.
    - **Child and adolescent well-care visits**. Percentage of members aged 3 to 21 who had at least one well-care visit.

- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.** Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year:
  - Body mass index (BMI) percentile documentation
  - Counseling for nutrition
  - Counseling for physical activity

Tables 7 and 8 show the results for RMHP PRIME and Denver Health on clinical measures for calendar years 2019–2022. These clinical measures are based on administrative claims data only, without chart review. This can lead to artificially low utilization rates for some services such as prenatal and postpartum care, which use global billing and do not have a claim submitted individually for each service.

**Note:** The state Medicaid average has been included for context, but this number should be interpreted with caution. The MCO numbers are not weighted (adjusted), but statewide Medicaid averages are weighted to reflect the larger impact that large MCOs have on the overall statewide average rate.

**Table 7. Clinical Quality Measures for RMHP PRIME, Calendar Years 2019-2022**

| Clinical Measure | 2019 | 2020 | 2021 | 2022 | Medicaid Average 2022 |
|---|---|---|---|---|---|
| Timeliness of Prenatal Care | 42.0% | 56.7% | 56.5% | 49.8% | 65.2% |
| Postpartum Care | 35.9% | 32.9% | 37.0% | 36.3% | 54.9% |
| Breast Cancer Screening | 48.0% | 44.8% | 40.9% ages 50-64<br>39.0% ages 65-74 | 44.3% ages 50-64<br>41.2% ages 65-74 | 45.7% ages 50-64<br>37.9% ages 65-74 |
| Cervical Cancer Screening | 39.4% | 40.3% | 42.3% | 42.4% | 37.7% |

| Clinical Measure | 2019 | 2020 | 2021 | 2022 | Medicaid Average 2022 |
|---|---|---|---|---|---|
| Chlamydia Screening (ages 16-20 and 21-24 years) | 47.8% | 45.0% | 41.7% ages 16-20<br>45.1% ages 21-24 | 39.3% ages 16-20<br>49.6% ages 21-24 | 76.1% ages 16-20<br>62.1% ages 21-24 |
| Antidepressant Medication Management: Acute (ages 18-64 and 65+ years) | 73.7% | 55.5% | 57.4% | 63.0% ages 18-64<br>78.8% ages 65+ | 64.5% ages 18-64<br>77.7% ages 65+ |
| Antidepressant Medication Management: Continuation (ages 18-64 and 65+ years) | 64.9% | 42.5% | 36.7% | 43.8% ages 18-64<br>42.4% ages 65+ | 45.1% ages 18-64<br>49.4% ages 65+ |
| Asthma Medication Ratio (ages 19-64 years) | 48.4% | 51.8% | 57.2% | 59.1% | 55.7% |

**Table 8. Clinical Quality Measures for Denver Health, Calendar Years 2019-2022**

| Clinical Measure | 2019 | 2020 | 2021 | 2022 | Medicaid Average 2022 |
|---|---|---|---|---|---|
| Well Child Visits in First 30 Months of Life: Members who received 6 or more visits on or before 15 months of age | N/A: Measure started in 2020 | 54.7% | 54.3% | 58.3% | 58.3% |
| Well Child Visits in First 30 Months of Life: Members who received 2 or more visits between 15 | N/A: Measure started in 2020 | 57.1% | 54.4% | 59.3% | 59.3% |

| Clinical Measure | 2019 | 2020 | 2021 | 2022 | Medicaid Average 2022 |
|---|---|---|---|---|---|
| and 30 months of age | | | | | |
| Child and Adolescent Well Care Visits (members ages 3–21 years who received one well visit) | N/A: Measure started in 2020 | 39.3% | 41.9% | 42.9% | 42.6% |
| Counseling for Nutrition (members ages 3–17 years who received nutrition counseling) | 9.2% | 69.9% | 74.4% | 73.1% | 72.4% |
| Timeliness of Prenatal Care | 84.5% | 83.4% | 79.5% | 77.3% | 65.2% |
| Postpartum Care | 66.5% | 69.2% | 70.7% | 69.5% | 54.9% |
| Breast Cancer Screening (ages 50-64 and 65-74 years) | 46.0% | 42.6% | 41.7% ages 50-64<br>31.0% ages 65-74 | 46.9% ages 50-64<br>35.8% ages 65-74 | 45.7% ages 50-64<br>37.9% ages 65-74 |
| Cervical Cancer Screening | 45.6% | 41.1% | 39.4% | 34.2% | 37.7 |
| Chlamydia Screening | 72.9% | 67.4% | 76.8% ages 16-20<br>68.5% ages 21-24 | 77.0% ages 16-20<br>70.3% ages 21-24 | 76.1% ages 16-20<br>62.1% ages 21-24 |
| Antidepressant Medication Management: Acute (ages 18-64 and 65+ years) | 57.2% | 61.1% | 64.5% ages 18-64<br>78.0% ages 65+ | 66.4% ages 18-64<br>76.9% ages 65+ | 64.5% ages 18 -64<br>77.7% ages 65+ |

| Clinical Measure | 2019 | 2020 | 2021 | 2022 | Medicaid Average 2022 |
|---|---|---|---|---|---|
| Antidepressant Medication Management: Continuation (ages 18-64 and 65+years) | 37.7% | 40.7% | 42.6% ages 18-64<br>72.0% ages 65+ | 46.5% ages 18-64<br>53.9% ages 65+ | 45.1% ages 18-64<br>49.4% ages 65+ |
| Asthma Medication Ratio (ages 19-64 years) | 46.6% | 51.4% | 47.4% | 51.9% | 55.7% |

### D. Member Experience

A member's experience of care is another important measure of how well MCOs are meeting member needs. HCPF contracts with the Health Services Advisory Group, Inc. (HSAG) to administer an annual standardized survey to Health First Colorado members to understand different aspects of members' experience of care. The Health Plan Survey was administered to members from December 2022 to May 2023.

Tables 9 and 10 summarize RMHP's and Denver Health's survey results for adult members, respectively.[6]

**Table 9. Care Experience for Adults, RMHP PRIME, 2019-20 to 2022-23**

| Experience of Care Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 | Colorado RAE Aggregate 2022-23* |
|---|---|---|---|---|---|
| Percentage of respondents rating their provider favorably | 75.1% | 67.9% | 61.2% | 73.2% | 62.2% |

[6] 2023 Colorado Adult Regional Accountable Entity (RAE) Member Experience Report. Access the report at https://hcpf.colorado.gov/client-satisfaction-surveys-cahps.

| Experience of Care Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 | Colorado RAE Aggregate 2022-23* |
|---|---|---|---|---|---|
| Percentage of respondents rating their health plan favorably | 68.3% | 55.1% | 58.5% | 70.5% | 53.8% |
| Percentage of respondents pleased with how their provider communicates with them | 93.4% | 92.1% | 87.4% | 94.7% | 92.7% |
| Percentage of respondents reporting receiving care as soon as needed | 83.1% | 80.2% | 80.2% | 88.7% | 78.9% |
| Percentage of respondents reporting receiving the care they needed | 84.5% | 83.5% | 83.6% | 86.1% | 78.3% |

*Comparison group is all Health First Colorado members.

**Table 10. Care Experience for Adults, Denver Health, 2019-20 to 2022-23**

| Experience of Care Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 | Colorado RAE Aggregate 2022-23* |
|---|---|---|---|---|---|
| Percentage of respondents rating their provider favorably | 69.6% | 77.7% | 68.9% | 68.2% | 62.2% |
| Percentage of respondents rating their health plan favorably | 60.3% | 58.0% | 58.6% | 58.9% | 53.8% |

| Experience of Care Metric | 2019-20 | 2020-21 | 2021-22 | 2022-23 | Colorado RAE Aggregate 2022-23* |
|---|---|---|---|---|---|
| Percentage of respondents pleased with how their provider communicates with them | 94.2% | 94.2% | 92.1% | 91.7% | 92.7% |
| Percentage of respondents reporting receiving care as soon as needed | 73.5% | 79.9% | 71.3% | 71.3% | 78.9% |
| Percentage of respondents reporting receiving the care they needed | 74.5% | 84.1% | 71.7% | 72.0% | 78.3% |

*Comparison group is all Health First Colorado members.

One aspect of member experience is the MCO's responsiveness to the member, which can be assessed through call center metrics. During this fiscal year, data was collected on speed of answer, or how long it took for the member to speak to someone. In FY 2022–23, the average speed of answer for RMPH (RAE 1 and PRIME) was 8 seconds. The average speed of answer for Denver Health was 63 seconds.

| MCO | Average member monthly call volume | Member response times (avg speed of answer) | Member call abandonment rate |
|---|---|---|---|
| Denver Health | 1,605 | 63 seconds | 1.43% |
| RAE1(RMHP)/RMHP PRIME | 4,127 | 8 seconds | 0.30% |

Due to staffing shortages, Denver Health experienced longer response times. However, they expanded the call center capacity in August 2023 and experienced only a 3.8% call abandonment rate.

## VI. Future Plans for Managed Care Initiatives

This section describes the planned growth, changes and focus areas for MCOs in the coming year, which is separate from the re-procurement process for ACC Phase III, effective July 1, 2025. As part of its ongoing work in payment reform and affordability, HCPF plans to continue with the two MCOs described in this report dependent on the re-procurement process for Region 1 RMHP. Whoever wins the bid for Region 1, will get to choose continuing with the PRIME contract. Based on statute HB 24-1086 Denver Health's contract will be continued for Phase III. (The MCO contracts are separate from the RAE contracts, which will be awarded based on responses to a request for proposals that will be issued in Spring 2024. The new RAE contracts for ACC Phase III will take effect on July 1, 2025.)

### A. Continued Innovation in Value-Based Payments

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

HCPF will also continue to explore trends in value-based payments and ways MCOs can implement payment models that increase provider investment in, and accountability for, health outcomes and health equity. For example, HCPF's FY 2023–24 approved budget includes funding for a 16% rate increase for providers that select the option to receive at least a quarter of their revenue upfront, so they are invested in the cost and quality of care for members.

HCPF is also advancing innovative tools to assist physicians in better controlling costs and improving outcomes, in alignment with value-based tools. HCPF provides tools that assist providers in achieving shared goals, which are then rewarded through value-based payments. MCOs are required to implement these tools to leverage HCPF advances and maintain consistency across providers. These tools include the Phase I of the Prescriber Tool, which was implemented in January 2021 (OpiSafe module) and June 2021 (affordability module), the eConsult specialty support tool rolled out in the first quarter of calendar year 2024, Phase II of the Prescriber Tool (SHIE – see below) which will begin rolling out in stages starting in late 2024, and forthcoming cost and quality indicator insights (Providers of Distinction).

### B. Social Health Information Exchange (SHIE)

HCPF is working with the Office of eHealth Information (OeHI) and the Office of Information Technology (OIT), finance and build the Social Health Information Exchange (SHIE). The Social Health Information Exchange (SHIE) is a next phase of evolving prescriber tools. It will enable providers, Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs) and community workers to better support individuals by connecting them to available payer programs, state programs, and community supports. Specifically, the tool will help connect individuals to payer health improvement programs like prenatal and related maternity programs, diabetes management, cardiac, asthma programs or case management supports; it will help connect individuals to state health related social needs program such as Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or Housing Vouchers; it will also aid providers, their care teams and community workers in connecting individuals to community food banks, homeless shelters and other related social supports. The contract with Resultant, the state's vendor partner, helping to build the SHIE, was executed in November of 2023. All of these programs are intended to improve whole-person care, access, equity, quality and affordability. MCOs and RAEs will collaborate with HCPF and the Office of eHealth Innovation to create and implement this important tool.