COLORADO

Department of Health Care Policy & Financing

2018–2019 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Background

Launched in 2011, the Accountable Care Collaborative (ACC) program is Colorado's primary vehicle for delivering healthcare to Colorado's Medicaid members. On July 1, 2018, Colorado's seven Regional Accountable Entities (RAEs) began operations to implement Phase II of Colorado's ACC program. ACC Phase II is designed to leverage the proven successes of the program and to enhance Colorado's Medicaid member and provider experiences. The core components of the ACC are:

- Regional organizations, each in a different part of the State, responsible for coordinating care and providing a comprehensive community-based system of mental health and substance use disorder services.
- Primary care medical providers (PCMPs) who serve as medical homes and provide the central point of members' care.
- Data and analytics that provide the Colorado Department of Health Care Policy and Financing (the Department), the RAEs, and the PCMPs actionable health information on individual members, the regional populations, and the Medicaid population as a whole.

The goals and objectives of ACC Phase II are as follows:

- Improve member health.
- Reduce costs.
- Join physical health (PH) and behavioral health (BH) under one accountable entity.
- Strengthen coordination of services by advancing team-based care and Health Neighborhoods.
- Promote member choice and engagement.
- Pay providers for any increased value they deliver.
- Ensure greater accountability and transparency.

Under 42 CFR §438, primary care case management (PCCM) entities, prepaid inpatient health plans (PIHPs), and managed care organizations (MCOs) are subject to external quality review (EQR). The RAEs operate under a 1915(b) waiver as both a PCCM entity and a PIHP; the PIHP is limited to the provision of behavioral health services. The RAEs in Regions 1 and 5 also have a Limited Managed Care Capitation Initiative, which operate under federal authority as MCOs. This report includes the results of EQR-related activities conducted in fiscal year (FY) 2018–2019, the first year of RAE operations.

Scope of External Quality Review Activities for the Regional Accountable Entities

The RAEs were subject to two of the federally mandated EQR activities, monitoring for compliance with federal healthcare regulations and validation of performance improvement projects (PIPs). Although performance measure validation (PMV) is a mandatory activity, the RAEs began new contracts in July 2018; therefore, Health Services Advisory Group, Inc. (HSAG) could not conduct this activity for the RAEs in 2018–2019. HSAG also conducted the following optional activities: Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Experience of Care & Health Outcomes (ECHO) surveys, encounter data validation (EDV) activities, and validation of network adequacy.

The mandatory activities conducted were:

- **Assessment of compliance with Medicaid managed care regulations (compliance with regulations).** Assessment of compliance with regulations was designed to determine the RAEs' compliance with contracts with the Department and with State and federal managed care regulations. HSAG assessed compliance through review of four standard areas approved by the Department.
- **HEDIS measure rates and validation—Limited Managed Care Capitation Initiative.** To assess the accuracy of the performance measures reported by or on behalf of the MCOs, each MCO's licensed HEDIS auditor validated each performance measure selected by the Department for review. The validation also determined the extent to which performance measures calculated by the MCOs followed specifications required by the Department.
- **Validation of PIPs.** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.

The optional activities conducted for the RAEs were:

- **Patient-centered medical home (PCMH) CAHPS surveys—RAEs.** HSAG administered and reported adult and child Medicaid results of the CAHPS PCMH surveys for Colorado Medicaid practices within each RAE. HSAG included adult and child practice results from the survey in this report.
- **CAHPS surveys—Limited Managed Care Capitation Initiative.** Each health plan was responsible for conducting a survey of its members and forwarding the results to HSAG for inclusion in this report.
- **ECHO surveys.** HSAG administered and reported the results of the adult and child/parent ECHO surveys. HSAG included the RAEs' results from the survey for both adult and child populations in this report.
- **EDV—information systems (IS) review.** HSAG reviewed the Department's current encounter data documentation and targeted IS questionnaires developed for the Department and the RAEs to determine the extent to which the Department and the RAEs have appropriate system documentation and infrastructure to produce, process, and monitor encounter data submissions.

- **EDV—MCO 412 audit over-read.** HSAG conducted this activity for Colorado's two MCOs providing services under the Limited Managed Care Capitation Initiative within the ACC program. HSAG conducted an independent over-read evaluation of the two MCOs' data quality audits of 412 encounters (the MCOs' internal 412 audits) and reviewed the MCOs' data validation reports to determine whether each MCO appropriately validated the accuracy and completeness of its encounter data submissions to the Department.
- **Validation of network adequacy.** HSAG reviewed Colorado's existing network adequacy standards and obtained network information from the managed care entities (MCEs) and the Department to analyze and assess the Department's network needs and establish standardized provider category definitions across the RAEs.

Scope of External Quality Review Activities for the Behavioral Health Organizations

The Department chose to work with the behavioral health organizations (BHOs) after the end of the BHO contracts to ensure that BH performance measure rates submitted in the last year of the BHO contracts (2017–2018) were validated in 2018–2019 and that the Department experienced no interruption in BH performance measure validated rates.

- **Validation of performance measures.** To evaluate accuracy of the performance measures reported by the BHOs, HSAG validated each performance measure selected by the Department for validation. The validation determined the extent to which performance measures reported by the BHOs were calculated following specifications established by the Department.

Summary of 2018–2019 Statewide Performance by External Quality Review Activity

Regional Accountable Entities Providing Services Under Colorado's Accountable Care Collaborative Program

Assessment of Compliance With Medicaid Managed Care Regulations

Results

In FY 2018–2019, HSAG reviewed four standards as directed by the Department (see Section 2—Reader's Guide, Methodology).

Table 1-1 displays the statewide average compliance results for the FY 2018–2019 assessment of compliance with regulations activity.

Table 1-1—Compliance With Regulations—Statewide Performance for the RAEs

Standard	Statewide Average—FY 2018–2019
Standard III—Coordination and Continuity of Care	95%
Standard IV—Member Rights and Protections	98%
Standard V—Member Information	92%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	88%

For the seven RAEs providing services under Colorado's ACC program, the health plans demonstrated high overall performance during this review year. The RAE statewide average performance demonstrated above 90 percent compliance on three of the four standards reviewed in FY 2018–2019—Coordination and Continuity of Care, Member Rights and Protections, and Member Information. As this is the first year that the seven RAEs have been scored on these four standards, the high average scores highlight the RAEs' ability to accurately understand the requirements and implement procedures to demonstrate compliance with the regulations within these standards.

For individual health plan scores and findings for the RAEs, see Section 3 of this report. For the health plan comparison of scores for FY 2018–2019 standards, see Section 5, Table 5-1.

Table 1-2 displays the statewide average compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard for Colorado's MCOs (now part of Colorado's Limited Managed Care Capitation Initiative under the ACC program).

Table 1-2—Compliance With Regulations—Statewide Trended Performance for the Two MCOs Included in the Limited Managed Care Capitation Initiative

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	88%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	85%	96%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)**	**96%**	**86%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)**	**90%**	**93%**
Standard V—Member Information (2017–2018, 2018–2019)**	**85%**	**83%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	77%	87%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	97%	86%
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	97%	99%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	50%
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	81%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019)**	**77%**	**93%**

**Changes in federal regulations, changes in State contract requirements, and design of the compliance monitoring tool may have impacted comparability of the compliance results.*

***Bold text indicates standards that HSAG reviewed during FY 2018–2019.*

The MCO average score demonstrated improved performance in the most recent year of review for seven out of the 10 standards as compared to the previous review year. During the most recent review year, there was a significant improvement (10 percentage points or more) as compared to the previous review year (FY 2016–2017) in four standards: Standard II—Access and Availability, Standard VI—Grievance and Appeal System, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services, with the most significant improvement (16 percentage points) being in Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. A slight increase (9 percentage points or fewer) was noted in three standards: Standard I—Coverage and Authorization of Services, Standard IV—Member Rights and Protections, and Standard VIII—Credentialing and Recredentialing. Statewide MCO average performance declined in four standards when comparing the most recent review year to the previous

review year: Standard III—Coordination and Continuity of Care, Standard IV—Member Information, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Changes in federal regulations, changes in State contract requirements, and design of the compliance monitoring tool may have impacted comparability of the compliance results.

Table 1-3 displays the RAE statewide average score for each standard within the Medicaid managed care regulations. Since the RAEs began operations in July 2018, only FY 2018–2019 scores are available for this report. For individual health plan scores and findings for the RAEs and MCOs, see Section 3 of this report. For the health plan comparison of scores for FY 2018–2019 standards, see Section 5, Table 5-1.

Table 1-3—Compliance With Regulations—Statewide Performance for the Seven RAEs Included in the ACC Program

Standard and Applicable Review Years	Statewide Average
Standard I—Coverage and Authorization of Services (not yet scored*)	NA*
Standard II—Access and Availability (not yet scored*)	NA*
Standard III—Coordination and Continuity of Care (2018–2019)*	**95%**
Standard IV—Member Rights and Protections (2018–2019)*	**98%**
Standard V—Member Information (2018–2019)*	**92%**
Standard VI—Grievance and Appeal System (not yet scored*)	NA*
Standard VII—Provider Participation and Program Integrity (not yet scored*)	NA*
Standard VIII—Credentialing and Recredentialing (not yet scored*)	NA*
Standard IX—Subcontracts and Delegation (not yet scored*)	NA*
Standard X—Quality Assessment and Performance Improvement (not yet scored*)	NA*
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)*	**88%**

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.

**Not yet scored as the RAE contract did not begin until July 1, 2018*

In the first year of RAE operations, HSAG reviewed four standard areas. The statewide average score in three of the four standard areas was over 90 percent compliant, indicating an understanding by the RAEs of most federal regulations related to these three standards. Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services demonstrated a statewide average of 88 percent, indicating an opportunity to improve RAE understanding of federal and State requirements related to this content area.

Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

In Standard III—Coordination and Continuity of Care, the required actions were related to the lack of implementing State-specified requirements related to the health plans' processes of delegating care coordination to its contracted providers and ongoing oversight of delegated tasks. In Standard IV—Member Rights and Protections and Standard V—Member Information, many of the required actions were related to not fully understanding the revisions to the Medicaid managed care regulations release in May 2016. For the EPSDT standard, required actions were primarily related to the need for the health plans to update policies, procedures, and provider and member materials related to federal and State EPSDT requirements. The most common required action was for the health plans to expedite completion of working with the Healthy Communities program to develop collaborative member onboarding plans.

HEDIS Measure Rates and Validation—Limited Managed Care Capitation Initiative

Information Systems Standards Review Results

HSAG reviewed the final audit reports produced by each MCO's licensed HEDIS auditor. For the current reporting period, both MCOs were fully compliant with all IS standards relevant to the scope of the PMV performed by the MCOs' licensed HEDIS auditors. During review of the IS standards, the MCOs' HEDIS auditors identified no notable issues with negative impact on HEDIS reporting. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology; and the rates and audit results were valid, reliable, and accurate.

Performance Measure Results

Table 1-4 and Table 1-5 display the Colorado Medicaid weighted averages for HEDIS 2017 through HEDIS 2019, along with the percentile ranking for each high- and low-performing HEDIS 2019 measure rate for the Limited Managed Care Capitation Initiative health plans (Denver Health Medical Plan [DHMP] and Rocky Mountain Health Plans Medicaid Prime [RMHP Prime]). Statewide performance measure results for HEDIS 2019 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018 (referred to throughout this report as percentiles), when available. Additionally, rates for HEDIS 2019 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for HEDIS 2019 shaded red with two carets (^^) indicate statistically significant decline in performance from the previous year.[1-1] Additional Medicaid weighted average measure rates are found in Section 5.

[1-1] Performance comparisons are based on the Chi-square test of significance. A change in performance is considered statistically significant in this report if the *p*-value from the Chi-square test was less than 0.05 and the rate difference was at least 3 percentage points.

Table 1-4—Limited Managed Care Capitation Initiative Statewide Weighted Averages—HEDIS 2019 High Performers

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Immunizations for Adolescents				
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	—	47.11%	48.70%	≥90th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	75.71%	83.67%	88.14%	75th–89th
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	92.16%	97.55%	97.17%	≥90th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	1.34%	0.34%	0.23%	≥90th
Living With Illness				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	37.16%	45.60%	49.79%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
— Indicates that NCQA recommended a break in trending for HEDIS 2018; therefore, the HEDIS 2017 rate is not displayed.

The HEDIS 2019 statewide weighted average for measures within the Pediatric Care and Preventive Screening domains are primarily representative of DHMP's performance, as RMHP Prime's child members include only children with disabilities in six counties in western Colorado. DHMP demonstrated strong performance with immunizations for adolescents, driven by the high inoculation rates of the HPV vaccine series. DHMP continued to avoid inappropriate antibiotic use to treat children and adolescents with respiratory infections. Additionally, none of DHMP's members were unnecessarily screened for cervical cancer. Conversely, RMHP Prime's rate for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure fell below the 25th percentile.

Both DHMP and RMHP Prime exceeded the 90th percentile for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in the Living With Illness domain, demonstrating a strength related to appropriate antibiotic use for acute respiratory conditions.

Table 1-5—Limited Managed Care Capitation Initiative Statewide Weighted Averages—HEDIS 2019 Low Performers

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	58.53%	68.25%	68.01%	10th–24th
Combination 3	56.00%	65.92%	64.77%	10th–24th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	4.25%	9.12%	7.08%	<10th
Six or More Visits	48.55%	4.39%	52.28%^	10th–24th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	57.64%	60.89%	63.57%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	33.94%	34.29%	39.36%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile Documentation—Total[1]	8.65%	16.52%	21.62%^	<10th
Counseling for Nutrition—Total	7.57%	6.14%	7.57%	<10th
Counseling for Physical Activity—Total	2.97%	1.35%	5.81%^	<10th
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	64.06%	43.75%	58.07%^	<10th
Postpartum Care	35.08%	38.18%	42.40%^	<10th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.33%	86.85%	88.52%	<10th
Ages 25 Months to 6 Years	79.07%	72.27%	75.14%	<10th
Ages 7 to 11 Years	83.05%	75.68%	80.16%^	<10th
Ages 12 to 19 Years	82.70%	75.68%	80.50%^	<10th
Adults' Access to Preventive/Ambulatory Health Services[1]				
Total	66.03%	62.88%	61.75%	<10th
Preventive Screening				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	50.53%	48.53%	10th–24th
Cervical Cancer Screening				
Cervical Cancer Screening	42.85%	43.12%	42.52%	<10th
Adult BMI Assessment[1]				
Adult BMI Assessment	18.39%	47.08%	52.30%^	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication				
Continuation and Maintenance Phase	35.55%	NA	41.94%	10th–24th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[*,1]				
Total	5.76%	1.49%	5.77%	<10th
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack[1]				
Persistence of Beta-Blocker Treatment After a Heart Attack	69.04%	66.18%	50.98%	<10th
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing	79.13%	83.03%	83.24%	10th–24th
*HbA1c Poor Control (>9.0%)**	93.82%	56.53%	56.98%	<10th
HbA1c Control (<8.0%)	4.88%	35.51%	34.71%	<10th
Eye Exam (Retinal) Performed	30.83%	27.40%	47.83%^	10th–24th
Medical Attention for Nephropathy	78.30%	82.72%	82.30%	<10th
Blood Pressure Control (<140/90 mm Hg)	5.05%	32.61%	37.14%^	<10th
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	56.05%	49.60%	52.77%^	<10th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	78.26%	73.19%	68.18%	<10th
Annual Monitoring for Patients on Persistent Medications				
Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	85.08%	84.90%	85.16%	10th–24th
Diuretics	84.45%	84.75%	85.98%	10th–24th
Total	—	84.84%	85.49%	10th–24th
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation				
Systemic Corticosteroid	69.02%	50.53%	47.02%	<10th
Bronchodilator	80.90%	61.10%	67.02%^	<10th
Asthma Medication Ratio[1]				
Total	61.23%	59.69%	**49.08%^^**	<10th
Use of Services				
Plan All-Cause Readmissions*[1]				
Index Total Stays—Observed Readmissions—Total	—	12.58%	**15.90%^^**	25th–49th

** For this indicator, a lower rate indicates better performance.*

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending for HEDIS 2018; therefore, the HEDIS 2017 rate is not displayed.

NA (Small Denominator) indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

For HEDIS 2019, DHMP and RMHP Prime continued to demonstrate low performance for measures related to comprehensive well-child/well-care visits and ensuring that children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' (AAP's) *Recommendations for Preventive Pediatric Health Care*.[1-2]

All of DHMP's rates and six of seven (85.7 percent) rates for RMHP Prime within the Access to Care domain were below the 25th percentile. The measures related to preventive screenings for women (*Breast Cancer Screening* and *Cervical Cancer Screening*) for both DHMP and RMHP Prime also fell below the 25th percentile. Additionally, despite a significant improvement in performance, the *Adult BMI Assessment* rates fell below the 25th percentile for both MCOs.

Ten of 15 (66.7 percent) measure rates within the Mental/Behavioral Health and Living With Illness domains that were determined to be low performers for HEDIS 2019 are related to the appropriate prescribing of and/or monitoring of members prescribed long-term medications.

Within the Use of Services domain, although both DHMP and RMHP Prime had fewer than expected readmissions (based on their observed/expected [O/E] ratio), both experienced an increase in the rate of observed readmissions from the prior measurement year (MY), demonstrating a potential opportunity for improvement.

Statewide Opportunities for Improvement and Recommendations Related to HEDIS Measure Rates and Validation

The MCOs' HEDIS compliance final audit reports indicated that both MCOs followed NCQA methodology, and that the rates submitted were valid, reliable, and accurate. Therefore, HSAG identified no opportunities for improvement or recommendations related to IS standards review.

Based on performance measure results, HSAG recommends that the Department and the MCOs conduct an analysis of barriers to achieving improved performance in child and adolescent well-care measures and the access to care measures. For example, are the low measure rates related to barriers to accessing care, the need for community outreach and education, provider billing issues, or administrative data source challenges? Once the causes are identified, the MCOs and the Department should work with providers and members to establish potential performance improvement strategies and solutions to increase the performance in these measure rates.

Related to substantially low performance in the Mental/Behavioral Health and Living With Illness domains, HSAG recommends that both DHMP and RMHP Prime work with the Department to identify the issues that contribute to the low rates for these measures (e.g., are the issues related to barriers to accessing outpatient care or pharmacies, the need for improved provider training and prescribing

[1-2] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: July 2, 2019.

patterns, or the need for community outreach and education) and implement strategies that focus on improving the care for members related to these measures.

Related to low statewide scores in breast and cervical cancer screening measures, HSAG recommends that the MCOs consider implementing or improving efforts to expand access to these screenings. This may include the MCOs following up with providers when members are overdue for a screening or working with providers to send reminders to members about scheduling an appointment. Best practices include sending reminders in the mail, calling members to schedule screenings, offering flexible or extended office hours, or offering mobile mammogram screenings.[1-3]

Low performance in *Adult BMI Assessment* may be related to the methodology of calculating this particular measure rate. HSAG recommends that the MCOs work with providers to ensure that screenings for BMI are documented within administrative data sources.

Validation of Performance Improvement Projects

Results

Table 1-6 displays the results of the FY 2018–2019 PIP validations and summarizes how far through the five modules of the rapid-cycle PIP process each RAE progressed. As noted in the "Validation Status" column in the table, no PIPs progressed to being evaluated on outcomes or receiving a final validation status.

Table 1-6—Statewide PIP Results

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 1—Rocky Mountain Health Plans				
	ACC	*Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18*	*Completed Module 1 and Module 2*	NA*
	BH	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	*Completed Module 1 and Module 2*	NA*
	MCO	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	*Completed Module 1 and Module 2*	NA*

[1-3] The Community Guide. *Cancer Screening: Evidenced-Based Interventions for Your Community*. Available at: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf. Accessed on: Aug 7, 2019.

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 2—Northeast Health Partners				
	ACC	*Increasing Well Checks for Members 21–64 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*
Region 3—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
Region 4—Health Colorado				
	ACC	*Increasing Well Checks for Members 21–64 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*
Region 5—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	MCO	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	*Completed Module 1 and Module 2*	NA*
Region 6—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years*	*Completed Module 1 and Module 2*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 7—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years*	*Completed Module 1 and Module 2*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*

**NA— No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.*

***The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

Table 1-6 summarizes PIP performance among the RAEs in FY 2018–2019. During this validation cycle, the RAEs initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs run on an 18-month schedule and will continue into the next FY. During FY 2018–2019, the primary PIP activities included the RAEs receiving training and technical assistance on the rapid-cycle PIP process and developing the foundation of the projects in the first two modules of the process.

During FY 2018–2019, the RAEs passed Module 1 and Module 2. The RAEs addressed all validation criteria for the first two modules in 12 of the 16 PIPs. The remaining four PIPs were BH PIPs submitted by the Region 2, Region 4, Region 6, and Region 7 RAEs; these four PIPs received a *Conditional Pass* for Module 1 and Module 2. These RAEs lacked historical data in their respective regions to completely address some validation criteria. The *Conditional Pass* assigned to the four PIPs allowed the RAEs to continue progressing through subsequent PIP modules while collecting data to fully address remaining validation criteria for Module 1 and Module 2. The RAEs will resubmit Module 1 and Module 2, once complete baseline data have been collected, and HSAG will conduct a final validation of these modules. The FY 2018–2019 validation findings for all 16 PIPs suggested that all RAEs designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. In the next FY, the RAEs will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1.

Statewide Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

As the Department explores potential topics for the next round of rapid-cycle PIPs, HSAG recommends that data access and availability for each RAE related to the potential topics be considered. For the RAEs to leverage the strengths of the rapid-cycle improvement process, each RAE needs ready access to both historical and prospective data. Data are used to determine RAE-level baseline performance, to set a goal for improvement in relation to baseline performance, and to monitor progress toward achieving the goal for improvement. If relevant RAE-level data are not readily available, the RAEs will spend

time, energy, and resources on developing data collection processes and tools that could otherwise be directed toward interventions that can directly lead to improvement.

PCMH CAHPS Surveys—RAEs

Results

Table 1-7 shows the FY 2018–2019 statewide average PCMH CAHPS survey results for PCMP practices serving adults within the seven RAEs.

Table 1-7—Adult Statewide PCMH CAHPS Results for RAEs*

Measure	FY 2018–2019 Statewide Average Rate
Rating of Provider	63.6%
Rating of Specialist Seen Most Often	62.3%
Rating of All Health Care	59.1%
Rating of Health Plan	60.3%
Getting Timely Appointments, Care, and Information	47.7%
How Well Providers Communicate with Patients	73.9%
Providers' Use of Information to Coordinate Patient Care	61.8%
Talking with You About Taking Care of Your Own Health	48.9%
Comprehensiveness	52.8%
Helpful, Courteous, and Respectful Office Staff	69.1%
Health First Colorado Customer Service	62.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	27.3%
Reminders about Care from Provider Office	71.6%
Saw Provider Within 15 Minutes of Appointment	38.4%
Received Health Care and Mental Health Care at Same Place	57.6%

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a member's experiences with a provider at a specific practice.*

Table 1-8 shows the FY 2018–2019 statewide average PCMH CAHPS survey results for practices serving children within the seven RAEs.

Table 1-8—Child Statewide PCMH CAHPS Results for RAEs*

Measure	FY 2018–2019 Statewide Average Rate
Rating of Provider	76.0%
Rating of Specialist Seen Most Often	74.0%
Rating of All Health Care	74.3%
How Well Providers Communicate with Child	80.6%
Getting Timely Appointments, Care, and Information	66.2%
How Well Providers Communicate with Parents or Caretakers	81.9%
Providers' Use of Information to Coordinate Patient Care	74.7%
Comprehensiveness: Child Development	65.7%
Comprehensiveness: Child Safety and Healthy Lifestyles	58.2%
Helpful, Courteous, and Respectful Office Staff	69.3%
Received Information on Evening, Weekend, or Holiday Care for Child	80.9%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	32.1%
Saw Provider Within 15 Minutes of Appointment	42.1%
Reminders about Child's Care from Provider Office	67.9%

** Results from the survey do not directly assess RAE performance, as the survey questions ask about a parent's/caretaker's experiences with the child's provider at a specific practice.*

Effective July 1, 2018, the Department implemented Phase II of its ACC program and entered into contracts with seven RAEs. Consequently, members attributed to the RAEs were surveyed for the first time during FY 2018–2019; therefore, the FY 2018–2019 PCMH results presented in this report represent a baseline assessment of members' experiences with the RAEs' providers. There are no previous year's results available for comparison.

Statewide Opportunities for Improvement and Recommendations Related to PCMH Surveys—RAEs

Adult

For the adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (27.3 percent)
- *Saw Provider Within 15 Minutes of Appointment* (38.4 percent)
- *Getting Timely Appointments, Care, and Information* (47.7 percent)

HSAG recommends that the Department work with the RAEs to develop statewide initiatives designed to improve access and timeliness of care for adult Medicaid members.

In addition, based on statewide comparisons, HSAG had the following observations related to adult PCMH CAHPS (see Section 5, Statewide Conclusions and Recommendations Related to PCMH CAHPS). For the adult PCMH CAHPS statewide results, for four measures (*Rating of Provider*; *Talking with You About Taking Care of Your Own Health*; *Health First Colorado Customer Service*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*), four RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve member perceptions related to these measures.

Of note, only one RAE region (RAE Region 7) experienced a single measure that was lower than the statewide average. In addition, the State's three most rural RAE regions (RAE Regions 1, 2, and 4) experienced a generally lesser number of measure rates that were lower than the statewide averages than the State's most urban RAE regions (RAE Regions 5 and 6). RAE Regions 5 and 6, which are within the Denver metropolitan area, experienced the greatest number of measure rates that were lower than the statewide averages (12 and 10 measure rates, respectively). RAE Region 3, which is considered within the Denver metropolitan area, had seven measure rates that were lower than the statewide averages. The Department may want to focus efforts on evaluating barriers to receiving quality and timely care for adults served by the RAEs in Colorado's most urban regions.

Child

For the child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (32.1 percent)
- *Saw Provider Within 15 Minutes of Appointment* (42.1 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (58.2 percent)

HSAG recommends that the Department work with the RAEs to develop statewide initiatives designed to improve access and timeliness of care and comprehensiveness of care for children enrolled in Medicaid.

In addition, based on statewide comparisons, HSAG had the following observations related to child PCMH CAHPS (see Section 5, Statewide Conclusions and Recommendations Related to PCMH CAHPS). For three measures (*Rating of Specialist Seen Most Often*; *Comprehensiveness: Child Safety and Healthy Lifestyles*; and *Child Received Care from Provider Office During Evenings, Weekends, or Holidays*), four RAE regions had rates that were lower than the statewide averages. In addition, there were two measure rates *(How Well Providers Communicate with Child* and *Providers' Use of Information to Coordinate Patient Care)* in which five RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions related to these measures.

Of note, there was one RAE region (RAE Region 5) that had only one child measure rate below the statewide average and two RAE regions (RAE Regions 1 and 4) that had the greatest number of measure rates that were lower than the statewide averages (13 and 14 measure rates, respectively). HSAG determined no particular trend or pattern related to this.

CAHPS Surveys—Limited Managed Care Capitation Initiative

Results

Table 1-9 shows the adult statewide results for FY 2016–2017, FY 2017–2018, and FY 2018–2019.

Table 1-9—Adult Statewide CAHPS Results for MCOs

Measure	FY 2016–2017 Statewide Average	FY 2017–2018 Statewide Average	FY 2018–2019 Statewide Average
Getting Needed Care	81.1%	79.6%	76.9%
Getting Care Quickly	80.1%	81.2%	77.9%
How Well Doctors Communicate	90.8%	92.3%	93.3%
Customer Service	87.4%	87.1%	91.6%
Shared Decision Making	83.0%	79.9%	85.0%
Rating of Personal Doctor	64.3%	70.0%	69.5%
Rating of Specialist Seen Most Often	65.4%	62.7%	70.2%
Rating of All Health Care	55.4%	56.0%	56.0%
Rating of Health Plan	54.7%	58.0%	61.6%

Overall, member experience rates for the MCOs' adult population have fluctuated, either increasing or decreasing slightly, across the years; however, there appears to be an upward trend (i.e., higher rates) for the *How Well Doctors Communicate* and *Rating of Health Plan* measures. Conversely, there appears to be a downward trend (i.e., lower rates) for the *Getting Needed Care* measure for the MCOs' adult population.

Table 1-10 shows the child statewide results for FY 2016–2017, FY 2017–2018, and FY 2018–2019.

Table 1-10—Child Statewide CAHPS Results for MCOs

Measure	FY 2016–2017 Statewide Average	FY 2017–2018 Statewide Average	FY 2018–2019 Statewide Average
Getting Needed Care	79.6%	84.8%	78.3%
Getting Care Quickly	84.1%	86.2%	87.2%
How Well Doctors Communicate	94.0%	94.7%	95.4%
Customer Service	85.5%	91.2%	86.1%
Shared Decision Making	74.5%+	78.2%+	78.0%+
Rating of Personal Doctor	79.2%	86.1%	85.8%
Rating of Specialist Seen Most Often	66.6%+	75.0%+	75.7%+
Rating of All Health Care	70.1%	76.7%	73.5%
Rating of Health Plan	68.1%	76.9%	73.2%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

For the MCOs' child population, there appears to be an upward trend (i.e., higher rates) for the *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often* measures. Member experience rates for the remaining measures have fluctuated, either increasing or decreasing slightly, across the years.

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys—Limited Managed Care Capitation Initiative

For the adult statewide Medicaid population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019 or between FY 2016–2017 and FY 2018–2019. However, the following three measure rates showed slight decreases between FY 2017–2018 and FY 2018–2019: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Personal Doctor*. HSAG recommends that the Department work with the MCOs to develop initiatives designed to improve access and timeliness of care. In addition, HSAG recommends that the Department explore with the MCOs what may be driving low experience scores for the *Rating of Personal Doctor* measure, such as communication skills.

For the child statewide Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019; however, the following measure rates showed substantial decreases between FY 2017–2018 and FY 2018–2019: *Getting Needed Care* (6.5 percentage points) and *Customer Service* (5.1 percentage points). HSAG recommends that the Department prioritize improving those measures that demonstrated substantial decreases in rates.

ECHO Surveys

Results

Table 1-11 presents the adult ECHO statewide results for FY 2018–2019.

Table 1-11—Adult ECHO Statewide Results for RAEs*

Measure	FY 2018–2019 Statewide Aggregate
Rating of All Counseling or Treatment	45.9%
Getting Treatment Quickly	66.3%
How Well Clinicians Communicate	88.0%
Perceived Improvement	58.0%
Information About Treatment Options	57.3%
Office Wait	81.5%
Told About Medication Side Effects	74.8%
Including Family	42.0%
Information to Manage Condition	76.3%
Patient Rights Information	88.8%
Patient Feels He or She Could Refuse Treatment	82.8%
Privacy	92.5%
Cultural Competency	66.5%+
Amount Helped	80.5%
Improved Functioning	54.9%
Social Connectedness	65.4%

**Members who received BH services from both the RAEs and the BHOs were included in the results. Caution should be exercised when interpreting these results as some results may not be attributable to the RAEs.*

Table 1-12 presents the child ECHO statewide results for FY 2018–2019.

Table 1-12—Child ECHO Statewide Results for the RAEs

Measure	FY 2018–2019 Statewide Aggregate
Rating of All Counseling or Treatment	46.5%
Getting Treatment Quickly	69.8%
How Well Clinicians Communicate	86.8%
Perceived Improvement	70.7%
Information About Treatment Options	72.1%
Office Wait	84.9%
Told About Medication Side Effects	85.2%
Information to Manage Condition	70.8%
Patient Rights Information	88.4%
Respondent Feels He or She Could Refuse Treatment for Their Child	85.3%
Privacy	94.0%
Cultural Competency	60.8%+
Amount Helped	78.1%
Improved Functioning	63.0%
Social Connectedness	83.4%

**Members who received BH services from both the RAEs and the BHOs were included in the results. Caution should be exercised when interpreting these results as some results may not be attributable to the RAEs.*

Effective July 1, 2018, the capitated BH contract was transitioned to the RAEs. Members in the RAEs were surveyed using the ECHO survey tool for the first time during FY 2018–2019; therefore, the FY 2018–2019 results presented in this report represent a baseline assessment of members' experiences with the RAEs. There are no previous year's results available for comparison.

Statewide Opportunities for Improvement and Recommendations Related to ECHO Surveys

For the adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (42.0 percent)
- *Rating of All Counseling or Treatment* (45.9 percent)
- *Improved Functioning* (54.9 percent)

HSAG recommends that the Department work with the RAEs to explore what may be driving low experience scores for these measures and to develop statewide initiatives for improvement where appropriate.

In addition, based on statewide comparisons, HSAG had the following observations related to adult ECHO results (see Section 5, Statewide Conclusions and Recommendations Related to ECHO Surveys). For five measures (*How Well Clinicians Communicate*, *Information About Treatment Options*, *Patient Feels He or She Could Refuse Treatment*, *Privacy*, and *Social Connectedness*), four RAE regions had rates lower than the statewide averages. In addition, for four measures (*Rating of All Counseling or Treatment*, *Patient Rights Information*, *Amount Helped*, and *Improved Functioning*), five RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve member perceptions related to these measures.

Of note, RAE Region 1 had the fewest amount of measure rates (four) that were lower than the statewide averages for adult measures, while RAE Region 7 had the greatest amount of measure rates (14) that were lower than the statewide averages. Most of the other RAE regions experienced seven or eight measure rates lower than the statewide averages, except for RAE Region 3, which had 11 measure rates that were lower than the statewide averages. HSAG determined no particular trend or pattern related to this.

For the child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (46.5 percent)
- *Cultural Competency* (60.8 percent)
- *Improved Functioning* (63.0 percent)

HSAG recommends that the Department work with the RAEs to explore what may be driving low experience scores for these measures and to develop statewide initiatives for improvement where appropriate.

In addition, based on statewide comparisons, HSAG had the following observations for the child ECHO results (see Section 5, Statewide Conclusions and Recommendations Related to ECHO Surveys). For three measures (*How Well Clinicians Communicate*, *Office Wait*, and *Told About Medication Side Effects*), four RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions related to these measures.

Of note, there were two RAE regions (RAE Regions 4 and 7) that had only three measure rates lower than the statewide averages for the child survey. The rest of the RAE regions had between five and nine measure rates that were lower than the statewide averages. HSAG determined no particular trend or pattern related to this.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

Results

The FY 2018–2019 RAE BH IS review analyzed self-reported qualitative information to evaluate the extent to which the Department and the RAEs maintain appropriate encounter data system documentation and infrastructure to produce, process, and monitor encounter data. The Department continues to transition from State-specific legacy flat file data submissions to Accredited Standards Committee (ASC) X12 transaction files (e.g., using the 837 I/P [institutional/professional] file layouts). As such, the IS review considered the RAEs' capacities to collect, process, and submit complete and accurate BH encounter data to the Department through each of these transmission processes.

While all RAEs provided X12 encounter data flow diagrams showing their data processes, detailed policy and procedures documentation was not submitted by all RAEs. In general, RAEs reported that inconsistent documentation from, and communication with, the Department impeded their transition from submitting flat files to submitting X12 transaction files. Both the Department and the RAEs reported their encounter data monitoring processes for legacy flat files and X12 transaction files; however, process differences between the flat files and the X12 transaction files support opportunities for the Department and the RAEs to implement additional monitoring opportunities for the X12 file submissions.

Statewide Opportunities for Improvement and Recommendations Related to RAE Behavioral Health Information Systems Review

As the RAEs' first comprehensive EDV activity, the IS review established a foundation from which to improve the quality of BH encounter data submitted by the RAEs to the Department, including the following recommendations:

- As of the March 2019 questionnaire responses, several RAEs indicated that their encounter data policies and procedures were being updated; the Department should verify that the policies and procedures were updated by requesting and reviewing copies of the RAEs' documents.
- Two RAEs reported that they do not include zero payment encounters from sub-capitated providers in their encounter data submissions to the Department. The same RAEs reported that they do not include denied encounters from community mental health centers (CMHCs) in their X12 transaction files; the Department should determine whether this practice is consistent with encounter data submission standards.
- Questionnaire responses from a single RAE indicated that the Department was developing a comprehensive, interChange-based provider file to facilitate the RAEs' provider data configuration efforts; the Department should develop a timeline for supplying these routine provider data files to the RAEs.
- While RAEs' responses noted participation in the biweekly Health Plan Systems meetings hosted by the Department, the Department was unable to provide meeting documentation for HSAG's review. As these meetings provide a routine forum for encounter data stakeholders to discuss concerns with

X12 transaction file submissions, the Department should publish meeting agendas, meeting minutes or notes, and supporting documents in a location accessible to all stakeholders.

- Each RAE reported monitoring its encounter data quality; the Department should review examples of the RAEs' flat file and X12 encounter data quality monitoring reports. These reports may offer potential best practices or monitoring metrics by which other RAEs may enhance their encounter data oversight. Additionally, these reports will assist the Department in setting standards and expectations for the RAEs and further efforts to achieve consistency in processes across RAEs.
- To support the Department's overall encounter data quality and transition between the legacy flat files and the X12 transaction files, the Department should:
  - Conduct a thorough comparative analysis between the RAEs' flat file submissions and successfully submitted X12 transaction files to identify factors contributing to the Department's rejection of the RAEs' X12 transaction files.
    - Based on the comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.
  - Simplify the X12 transaction file submission specifications, updating all BH encounter data documentation to reflect the business rules specific to BH encounter data.
  - Following the RAEs' successful implementation of X12 transaction file submissions for a minimum of six months, conduct comprehensive EDV activities to assess the timeliness and accuracy of the RAEs' BH encounter data maintained in interChange. The EDV should include, at a minimum, a comparative analysis between the Department's electronic encounter data and data extracted from the RAEs' data systems.

Encounter Data Validation—MCO 412 Audit Over-Read

Results

HSAG conducted this EDV for Colorado's two MCOs (DHMP and RMHP Prime), providing services under the Limited Managed Care Capitation Initiative within the ACC program. HSAG's over-read results show a moderate level of confidence that RMHP Prime and DHMP's 412 audit findings accurately reflect their encounter data quality. Table 1-13 presents aggregated statewide over-read results with the percentage of over-read cases in which HSAG's auditor agreed with the health plans' auditors' results by encounter service category.

Table 1-13—Statewide Aggregated Encounter Over-Read Agreement Results for MCOs by Service Category*

Service Category	Case-Level Accuracy—Total Number of Cases	Case-Level Accuracy—Percent with Complete Agreement	Element-Level Accuracy—Total Number of Elements	Element-Level Accuracy—Percent with Complete Agreement
Inpatient	40	80.0%	240	93.3%
Outpatient	40	90.0%	200	96.0%
Professional	40	77.5%	200	93.5%
FQHC	40	67.5%	200	83.0%
Total	**160**	**78.8%**	**840**	**91.5%**

**Although over-read results represent the findings reported by HSAG to the Department, each MCO submitted feedback to the Department indicating disagreement with a number of findings in HSAG's MCO-specific EDV over-read reports.*

Statewide Opportunities for Improvement and Recommendations Related to MCO 412 Audit Over-Read

EDV results from the MCOs' 412 audits and HSAG's subsequent over-read demonstrate opportunities for improvement in the Department's encounter data submission guidelines and oversight, as well as the MCOs' oversight of data submissions from their providers. In nearly all cases in which HSAG's coders disagreed with the plan's audit results, HSAG's coders identified misalignment between medical record documentation and encounter data, rather than insufficient medical record documentation.

HSAG recommends that the Department continue to work with its encounter data system vendor to improve the encounter data documentation guiding the MCOs' data submissions. Additionally, HSAG recommends that the Department verify that each MCO is monitoring encounter data quality and ensuring its contracted providers are trained to submit encounters that accurately reflect the medical record documentation for services rendered.

Validation of Network Adequacy

Results

HSAG used a desk review approach to collect and review provider data from the MCEs, develop the provider crosswalks, and conduct a provider composition analysis (PCA) among all ordering, referring, and servicing providers contracted to provide care through the RAEs and limited initiative capitated plans (Medicaid MCOs).

Prior to requesting the MCEs' provider network data, HSAG distributed a Data Structure Questionnaire to the MCEs, and the MCEs' responses reflected a variety of methods for collecting and maintaining provider data. Each MCE reported conducting formal data validation to ensure that its data systems contain current contracting status, demographics, practice location(s), practice accommodation(s), and panel capacity for each contracted provider. Questionnaire findings also highlighted the MCEs' inconsistent data collection for provider classification attributes (e.g., provider type, specialty, taxonomy code, and degree/credential), affecting the development of standard provider categories. Though the MCEs reported that they verify providers' self-reported classification information, they did not supply documentation on the verification processes or specifications used to determine a provider's classification. Additionally, MCEs' questionnaire responses indicated that no standardized list of attribute options was offered to providers for use with the Colorado Health Care Professional (CHCP) application, resulting in a variety of similar provider type and specialty data values that may need to be incorporated into the MCEs' data cleaning efforts.

All MCEs submitted provider network data for the study, though the MCEs' data values did not consistently align with information on available provider attribute values reported in the Data Structure Questionnaires. Many MCEs' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., nurse practitioners [NPs] or physician assistants [PAs]). While these MCEs collect detailed subspecialty information for physicians, similar information was not reported for the non-physician providers. For example, an NP may have been listed in an MCE's data with a provider type of "Nurse Practitioner" and a provider specialty of "Nurse Practitioner." Without using taxonomy codes, HSAG was not able to assign these NPs to categories for primary care providers (PCPs) or women's health providers.

PCA results illustrated the need for standardized provider category definitions to ensure consistent network analysis results across MCEs. The PCA results also reinforced the need for the MCEs to evaluate the level of specificity available in their provider data systems. For example, MCEs may count any NP or clinical nurse specialist as a PCP, without regard to nursing subspecialties. Additionally, interChange provider data include hospitals, federally qualified health centers (FQHCs), rural health clinics (RHCs), and CMHCs; however, MCEs may not have had these providers counted in the PCA due to the way in which these providers were reflected in the MCEs' data.

Statewide Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

As the Department's first comprehensive investigation into the MCEs' provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing the MCEs' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the MCEs. The Department should also develop standardized quarterly network adequacy reporting templates for each MCE type. To ensure consistent reporting within each MCE type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps
    - Content should allow the MCE to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206[1-4] and reporting requirements under 42 CFR §438.207[1-5]
  - Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the MCE
  - Methodology information for any expected calculations (e.g., time/distance calculations should be based on driving distances between each member and the nearest applicable provider)
  - Templates for any expected data tables, including definitions for each cell that the MCE is expected to populate
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the MCEs and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the MCEs to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the MCEs' data values for provider type, specialty, and credentials. The MCEs should assess available data values in their provider data systems and standardize available data value options.

[1-4] Availability of Services, 42 CFR §438.206. Available at: https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8. Accessed on: May 20, 2019.

[1-5] Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at: https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207. Accessed on: May 20, 2019.

Behavioral Health Organizations

Validation of Performance Measures

Information Systems Standards Review Results

HSAG evaluated the BHOs' accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. For the current reporting period, HSAG determined that: the data collected and reported for the Department-selected measures by all five BHOs followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

Table 1-14 shows the MY 2016–2017 and 2017–2018 performance measure results for the statewide average and the corresponding incentive performance targets for the BHOs. Cells shaded green indicate the statewide average's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 1-14—Statewide Averages for BHOs

Performance Measures	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	41.76%	49.81%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	53.92%	60.54%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	25.24%	25.00%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	40.85%	46.49%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	59.67%	62.41%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	16.48	14.10	7.20

Performance Measures	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	23.41	25.97	19.71

** For this indicator, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).
Cells shaded green indicate the rate met or exceeded the MY 2017–2018 incentive performance target.

For MY 2017–2018, only one measure rate for the BHO statewide average (*Mental Health Engagement [All Members Excluding Foster Care]*) met or exceeded the incentive performance targets, indicating there are statewide opportunities to improve care.

FY 2018–2019 was the last year the BHOs were in operation; therefore, no recommendations are provided.

Statewide Conclusions and Recommendations

While the results of the EQR-related activities demonstrated strengths and opportunities for improvement across all three domains of care (quality, timeliness of, and access to care), when looking at trends across the activities, access to care and the quality and consistency of data reporting by the health plans appeared to be commonalities the Department may want to address across health plans and health plan types. The only compliance standard reviewed in FY 2018–2019 with a statewide score under 90 percent was Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (with a statewide score of 88 percent), which may indicate opportunities for improvement in the quality of and access to care for children's preventive and screening services. Colorado's low performing HEDIS measure rates[1-6] spanned all HEDIS domains of care. All HEDIS measures assess quality of care with a specific set of measures that also address access to care. All measures in the Access to Care domain demonstrated statewide weighted average rates below the 10th percentile compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018. Of note, several statewide rates, including four of the seven low performing Access to Care measure rates, were trending upward when compared to the previous year's results. PIP validation results indicated that, although the health plans were able to design valid and reliable projects, data access was an issue for most of the RAEs, which could impact the outcomes of these projects. PCMH CAHPS results for both the adult and child Medicaid populations indicated the lowest ratings related to access to care, with relatively high scores in measures that address quality of care. Statewide ECHO results indicated the lowest scores in measures that assessed quality of care received. Based on the encounter data and network adequacy activities conducted in FY 2018–2019, HSAG also found data quality issues related to the data submitted for these activities.

[1-6] HEDIS measure rates were calculated only for Colorado's two MCOs. HEDIS rates were not calculated for Colorado's FFS population in FY 2018–2019.

HSAG recommends that the Department prioritize evaluating its data system procedures and accuracy, health plan reporting requirements, and conduct robust oversight of encounter and provider data submissions, developing improvement initiatives as indicated. In addition, HSAG also recommends that the Department evaluate barriers to accessing care with particular attention to children's preventive and wellness care statewide and, for adults, the access and quality of care in the urban regions.

Quality Strategy

The Health First Colorado 2019 Quality Strategy (Quality Strategy) addresses the key elements recommended in the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, as well as in the guidance published on the Medicaid.gov website and in the State Medicaid Director letter guidance on designing and implementing State Quality Strategies. As recommended by CMS, the Department's Quality Strategy provides a blueprint for advancing the State's commitment to improving quality healthcare delivered through the RAEs and their contracted MCOs. Colorado's primary system of healthcare delivery and payment is designed to reward value and quality of care received by Health First Colorado and Child Health Plan *Plus* (CHP+) members. The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve quality of care based on the following Department Strategic Quality Improvement Goals:

- Decreasing healthcare costs and increasing affordability for individuals, families, employers, and the government
- Enhancing delivery system innovation to include:
  - Increasing and monitoring members' access to care and provider network adequacy
  - Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care
  - Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles
  - Implementing pay-for-performance to providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients
- Improving patient safety to include:
  - Ensuring members are connected to the right care, at the right time, every time
  - Promoting effective prevention and treatment of chronic disease
- Improving health outcomes, member experience, and patient safety through clinical analytics, evidence-based practices, and adoption

The Department's Quality Strategy includes a variety of performance measures designed for driving performance-based outcomes. Overall quantifiable objectives are related to closing performance gaps by 10 percent while identifying specific processes and policies that can become more person-centered.

In addition, Colorado's Quality Strategy addresses transparency, care coordination, and social determinants of health where possible based on community feedback as recommended by CMS. Health plan and State quality reporting is available at https://www.colorado.gov/hcpf. The Quality Strategy describes the interagency and community-based committees and collaborative teams that provide input and feedback in the ongoing design and revision of the Medicaid and CHP+ healthcare delivery system.

The Department further leverages its relationship with its EQRO, HSAG, to conduct all mandatory and several optional EQR-related activities. Over the 18-year relationship, HSAG and the Department have collaborated to design State-specific technical assistance and optional activities and projects developed to provide information needed to shape the iterative design of the Medicaid and CHP+ programs.

HSAG recommends that the Department further collaborate with CMS to identify when CMS will update the Quality Strategy Toolkit for States based on the revised Medicaid regulations released May 2016 to ensure the Quality Strategy reflects the latest Medicaid rules and the revised Code of Colorado Regulations at 10 CCR 2505-10, Section 8.209.[1-7] Although the Department is in compliance with identified regulations within the CMS Quality Strategy Toolkit for States, HSAG recommends that the Department revise the Quality Strategy for its next resubmission, via restatement of the current regulations or via a crosswalk to the CMS Quality Strategy Toolkit for States.

[1-7] Department of Health Care Policy and Financing. Code of Colorado Regulations. Available at: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8299&fileName=10 CCR 2505-10 8.200. Accessed on: May 20, 2019.

2. Reader's Guide

Report Purpose and Overview

States with Medicaid program delivery systems that include MCEs, referred to in this report collectively as health plans, are required to annually provide to the CMS an assessment of each MCE's performance related to the quality of, timeliness of, and access to care and services provided by each MCE (42 CFR §438.364). To meet this requirement, Colorado's Department of Health Care Policy and Financing (the Department), the State's Medicaid agency, has contracted with HSAG to perform the assessment and to produce this EQR annual technical report. The Department administers and oversees the Medicaid program for the State of Colorado. Colorado's Medicaid health plans evaluated by HSAG during FY 2018–2019 are listed in Table 2-1, Table 2-2, and Table 2-3.

Table 2-1—Colorado Medicaid RAEs

Medicaid RAEs	Services Provided
Region 1—Rocky Mountain Health Plans (RMHP)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 2—Northeast Health Partners (NHP)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 3—Colorado Access (COA)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 4—Health Colorado, Inc. (HCI)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 5—Colorado Access (COA)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 6—Colorado Community Health Alliance (CCHA)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.
Region 7—Colorado Community Health Alliance (CCHA)	Behavioral health inpatient and outpatient services. Coordination of both physical health and behavioral health services.

Table 2-2—Colorado Medicaid MCOs

Medicaid MCOs	Services Provided
Denver Health Medical Plan (DHMP)	Physical health primary inpatient, outpatient, specialty, and acute care for a subset of COA's Region 5 RAE members.
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	Physical health primary inpatient, outpatient, specialty, and acute care for a subset of RMHP's Region 1 RAE members.

Although the following BHOs did not provide services to Colorado's Medicaid members in FY 2018–2019, HSAG performed validation of performance measures for the BHOs during FY 2018–2019, based on FY 2017–2018 performance measure data and calculations.

Table 2-3—Colorado Medicaid BHOs

Medicaid BHOs	Services Provided
Access Behavioral Care—Denver (ABC-D)	Behavioral health inpatient and outpatient services.
Access Behavioral Care—Northeast (ABC-NE)	Behavioral health inpatient and outpatient services.
Behavioral Healthcare, Inc. (BHI)	Behavioral health outpatient and inpatient services
Colorado Health Partnerships, LLC (CHP)	Behavioral health inpatient and outpatient services.
Foothills Behavioral Health Partners, LLC (FBHP)	Behavioral health inpatient and outpatient services.

How This Report Is Organized

Section 1—Executive Summary includes a high-level, statewide summary of results and statewide comparative information derived from conducting mandatory and optional external quality review organization (EQRO) activities. This section also includes a summary description of relevant trends over a three-year period for each EQRO activity as applicable (given that the RAEs are in the first year of contracting with the State). The "Executive Summary" contains references to the section where the health plan-specific data can be found later in the report. In addition, the "Executive Summary" presents any conclusions drawn and recommendations made for statewide performance improvement, if applicable.

Section 2—Reader's Guide provides a brief overview of Colorado's Medicaid healthcare delivery system, Colorado's managed care health plans, the purpose and overview of this EQR annual technical report, the authority under which the technical report must be provided, and the EQR-related activities conducted during FY 2018–2019. The "Reader's Guide" also provides an overview of the methodology for each EQR-related activity performed and how HSAG used data and results obtained to draw conclusions about the quality of, timeliness of, and access to care and services provided by Colorado's Medicaid health plans.

Section 3—Evaluation of Colorado's Regional Accountable Entities provides summary-level results for each EQR-related activity performed for the RAEs. This information is presented by RAE and provides an EQR-related activity-specific assessment of the quality of, timeliness of, and access to care and services for each RAE as applicable to activities performed and results obtained.

Section 4—Evaluation of Colorado's Behavioral Health Organizations provides summary-level results for the validation of performance measures activity performed for Colorado's BHOs. This information is presented by BHO and provides an assessment of the quality of, timeliness of, and access to care and services for each BHO based on PMV activities performed and results obtained.

Section 5—Statewide Comparative Results, Assessment, Conclusions, and Recommendations includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results and statewide averages. This section also identifies, through presentation of results for each EQR activity, trends and commonalities used to derive statewide conclusions and recommendations.

Section 6—Assessment of Health Plans' Follow-Up on 2017–2018 Recommendations provides, by EQR activity, an MCO-specific assessment of the extent to which the MCOs were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activities. (This section is not applicable for the RAEs as FY 2018–2019 was the first contract year for the RAEs.)

Appendix A presents HEDIS results for measure rates with a hybrid option for MCOs that chose to submit using both administrative and hybrid methods. The MCOs were only required to report administrative rates for measures with a hybrid option.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the Medicaid health plans in each of the domains of quality of, timeliness of, and access to care and services.

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, prepaid ambulatory health plan (PAHP), or PCCM-entity (described in §438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through its structural and operational characteristics; the provision of services that are

consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[2-1]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or BHO—e.g., processing appeals and providing timely care.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2-3]

Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Assessment of Compliance With Medicaid Managed Care Regulations

For the FY 2018–2019 site review process to assess compliance with Medicaid managed care regulations, the Department requested a review of four areas of performance. The standard areas chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard. HSAG also reviewed the health plans' administrative records to provide the Department with information about the health plans' performance related to care coordination.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.
[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

- The health plans' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or corrective actions required to bring the health plans into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality of, timeliness of, and access to care and services furnished by the health plans, as addressed within the specific standard areas reviewed, with possible interventions recommended or corrective actions required to improve the quality of, timeliness of, or access to care.

Technical Methods of Data Collection

To assess for compliance with regulations for the health plans, HSAG performed the five activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-4] Table 2-4 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-4—Protocol Activities Performed for Assessment of Compliance With Regulations

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: July 17, 2018.

For this step,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• Prior to the scheduled date of the on-site portion of the review, HSAG notified the health plans in writing, via e-mail, of the request for pre-on-site review documents. The document request included instructions for organizing and preparing the documents related to review of the four standards and on-site record reviews. Thirty days prior to each scheduled on-site review, the health plans provided documents for the pre-on-site document review. • Documents submitted for the pre-on-site document review and the on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted lists of members with complex needs who received care coordination activities during FY 2018–2019. HSAG used a random sampling technique to select records for review during the on-site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site review.
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plans' key staff members to obtain a complete understanding of the health plans' level of compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plans' organizational performance. • HSAG reviewed a sample of administrative records to provide the Department with information about the health plans' performance related to care coordination. • While on-site, HSAG collected and reviewed additional documents, as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents that were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the review, HSAG met with health plan staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved site review report templates to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined strengths, opportunities for improvement, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report templates. • HSAG submitted the site review reports to the health plans and the Department for review and comment. • HSAG incorporated the health plans' and Department's comments, as applicable, and finalized the reports. • HSAG distributed the final reports to the health plans and the Department.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (processing of grievances and appeals)
- Interviews with key health plan staff members conducted on-site

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the Medicaid health plans, HSAG assigned each of the components reviewed for assessment of compliance to one or more of those domains of care. Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table 2-5 depicts assignment of the standards to the domains of care.

Table 2-5—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓		✓
Standard IV—Member Rights and Protections	✓		
Standard V—Member Information	✓		
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	✓		✓

HEDIS Measure Rates and Validation—Limited Managed Care Capitation Initiative

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

DHMP and RMHP Prime had existing business relationships with NCQA Licensed Organizations (LOs) that conducted HEDIS audits for their other lines of business. The Department allowed the MCOs to use their existing NCQA LOs to conduct the audit in line with the HEDIS Compliance Audit policies and procedures. The HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the MCO's processes than do the requirements for validating performance measures as set forth by CMS. Therefore, using the HEDIS audit methodology complied with both NCQA and CMS specifications, allowing for a complete and reliable evaluation of the MCOs.

The following processes/activities constitute the standard practice for HEDIS audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[2-5]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS 2019 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The MCOs were responsible for obtaining and submitting their respective HEDIS Final Audit Reports (FARs) to HSAG. The HEDIS auditor's responsibility was to express an opinion on each MCO's

[2-5] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the MCOs, it did review the audit reports produced by the LOs.

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for FY 2018–2019 as part of the validation of performance measures:

- **FARs**: The FARs, produced by the health plans' licensed audit organizations, provided information on the health plans' compliance to information system standards and audit findings for each measure required to be reported.
- **Measure Certification Report:** The vendor's measure certification report was reviewed to confirm that all of the required measures for reporting had a "pass" status.
- **Rate Files from Previous Years and Current Year:** Final rates provided by health plans in IDSS format were reviewed to determine trending patterns and rate reasonability.

How Conclusions Were Drawn

IS Standards Review

Health plans must be able to demonstrate compliance with IS standards. Health plans' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCO compliance with the HEDIS Compliance Audit Standards. The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in Section 3, HEDIS 2017, HEDIS 2018, and HEDIS 2019 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA-licensed audit organization according to NCQA standards. With regard to the final measure rates for HEDIS 2017, HEDIS 2018, and HEDIS 2019, a measure result of *Small Denominator* (*NA*) indicates that the health plan followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is

not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the health plan chose not to report the measure.

HEDIS Measure Results

The MCOs' HEDIS measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate statistically significant improvement in performance from HEDIS 2018 to HEDIS 2019. Rates shaded red with two carets (^^) indicate statistically significant declines in performance from HEDIS 2018 to HEDIS 2019. Throughout the report, references to "significant" changes in performance are noted; these instances refer to statistically significant differences between performance from HEDIS 2018 to HEDIS 2019. Performance comparisons are based on the Chi-square test of proportions with results deemed significant with a *p*-value < 0.05. However, caution should be exercised when interpreting results of the significance testing, given that significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the IDSS for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the size of each plan is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for MCO 1
R_1 = the rate for MCO 1
P_2 = the eligible population for MCO 2
R_2 = the rate for MCO 2

Measure results, where available, for HEDIS 2019 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018 (referred to throughout this report as percentiles). Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* and *Plan All-Cause Readmissions* measure indicators were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018 since these indicators are not published in Quality Compass.

For some measures in the Use of Services domain (i.e., *Ambulatory Care*, *Inpatient Utilization—General Hospital/Acute Care*, and *Antibiotic Utilization*), HSAG did not perform significance testing because variances were not provided in the IDSS files; therefore, differences in rates are reported without

significance testing. In addition, higher or lower rates do not necessarily indicate better or worse performance for the measures in the Use of Services domain.

In the performance measure results tables, an em dash (—) indicates that the rate is not presented in this report as the Department did not require the MCOs to report this rate for the respective HEDIS submission or NCQA recommended a break in trending in HEDIS 2018 or HEDIS 2019. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2019 measure rate was not reportable or because the measure did not have an applicable benchmark.

Additionally, the following logic determined the high- and low-performing measure rates discussed within the results:

- High performers are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018.
  - Ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle compared to national percentiles but declining over time. These measures are those:
  - Below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018.

According to the Department's guidance, all measure rates presented in this report for the MCOs are based on administrative data only. The Department required that all HEDIS 2017, HEDIS 2018, and HEDIS 2019 measures be reported using the administrative methodology only. However, RMHP Prime still reported certain measures to NCQA using the hybrid methodology. The hybrid measures' results are found in Table A-1 in Appendix A. When reviewing HEDIS measure results, the following items should be considered:

- MCOs capable of obtaining supplemental data or capturing more complete data will generally report higher rates when using only the administrative methodology. As a result, the HEDIS measure rates presented in this report for measures with a hybrid option may be more representative of data completeness than of measure performance. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks or to prior years' results that were established using administrative and/or MRR data, as results likely underestimate actual performance. Table 2-6 presents the measures in this report that could be reported using the hybrid methodology.

Table 2-6—HEDIS Measures That Can Be Reported Using the Hybrid Methodology

HEDIS Measures
Pediatric Care Measures
Childhood Immunization Status
Immunizations for Adolescents
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
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Access to Care Measure
Prenatal and Postpartum Care
Preventive Screening Measures
Cervical Cancer Screening
Adult BMI Assessment
Living With Illness Measure
Comprehensive Diabetes Care

To draw conclusions about the quality and timeliness of, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains. This assignment to domains is depicted in Table 2-7.

Table 2-7—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for MCOs

Performance Measures	Quality	Timeliness	Access
Pediatric Care Measures			
Adolescent Well-Care Visits	✓		✓
Appropriate Testing for Children With Pharyngitis	✓		
Appropriate Testing for Children With Upper Respiratory Infection	✓		
Childhood Immunization Status	✓		
Immunizations for Adolescents	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 15 Months of Life	✓		✓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		✓

Performance Measures	Quality	Timeliness	Access
Access to Care Measures			
Adults' Access to Preventive/Ambulatory Health Services			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Prenatal and Postpartum Care	✓	✓	✓
Preventive Screening Measures			
Adult BMI Assessment	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Mental/Behavioral Health Measures			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
Living With Illness Measures			
Annual Monitoring for Patients on Persistent Medications	✓		
Asthma Medication Ratio	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Comprehensive Diabetes Care	✓		
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	✓		
Medication Management for People With Asthma	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	✓		
Pharmacotherapy Management of COPD Exacerbation	✓	✓	
Statin Therapy for Patients With Cardiovascular Disease	✓		
Statin Therapy for Patients With Diabetes	✓		
Use of Imaging Studies for Low Back Pain	✓		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	✓		

Performance Measures	Quality	Timeliness	Access
Use of Service Measures			
Ambulatory Care (Per 1,000 Member Months [MM])	NA	NA	NA
Antibiotic Utilization	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Plan All-Cause Readmissions	✓		
Use of Opioids at High Dosage	✓		
Use of Opioids From Multiple Providers	✓		

Validation of Performance Measures for Behavioral Health Organizations

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the BHO.
- Determine the extent to which the specific performance measures calculated by the BHO (or on behalf of the BHO) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

The Department selected the performance measures for calculation. Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. Calculation of the measures was accomplished by using a number of data sources, including claims/encounter data and enrollment/eligibility data.

HSAG conducted PMV for each of the BHOs' measure rates. The Department required that the MY 2018 (i.e., July 1, 2017–June 30, 2018) performance measures be validated during FY 2018–2019 based on the specifications outlined in the *BHO-HCPF Incentive Performance Measures Scope Document*, which was written collaboratively by the BHOs and the Department.[2-6] This document contained both detailed information related to data collection and rate calculation for each measure under the scope of the audit and reporting requirements, and all measure rates calculated using these specifications originated from claims/encounter data. For MY 2018, several measures were HEDIS-like measures, and several other measures were developed by the Department and the BHOs.

[2-6] Colorado Department of Health Care Policy and Financing. *BHO-HCPF Incentive Performance Measures Scope Document: Fiscal Year 2018 (FY18)*.

HSAG followed the same process for PMV for each BHO. The process included the following steps.

Pre-review Activities: Based on the measure definitions and reporting guidelines provided by the Department, HSAG:

- Developed measure-specific worksheets that were based on the CMS protocol and were used to improve the efficiency of validation work performed on-site.
- Developed an Information Systems Capabilities Assessment Tool (ISCAT) that was customized to Colorado's service delivery system and was used to collect the necessary background information on the BHOs' information systems, policies, processes, and data needed for the on-site performance of validation activities. HSAG added questions to address how encounter data were collected, validated, and submitted to the Department.
- Asked each BHO and the Department to complete the ISCAT prior to the on-site reviews. HSAG prepared two different versions of the ISCAT: one that was customized for completion by the BHOs and another that was customized for completion by the Department. The Department version addressed all data integration and performance measure calculation activities.
- Reviewed other documents in addition to the ISCAT, including source code for performance measure calculation, prior performance measure reports, and supporting documentation.
- Performed other pre-review activities including review of the ISCAT and supporting documentation, scheduling and preparing the agendas for the on-site visits, and conducting conference calls with the BHOs to discuss the on-site visit activities and to address any ISCAT-related questions.

On-Site Review Activities: HSAG conducted a site visit to each BHO to validate the processes used to collect and calculate performance measure data (using encounter data). HSAG also conducted a site visit to the Department to validate the processes used for calculating the penetration rate measures. The one-day on-site reviews included:

- An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- Evaluation of system compliance, including a review of the information systems assessment, focusing on the processing of claims, encounters, and member and provider data. HSAG performed primary source verification on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data system. Additionally, HSAG evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- Review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with key BHO and Department staff members, allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.

- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for reporting the selected performance measures. HSAG performed primary source verification to further validate the output files, and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- A closing conference to summarize preliminary findings from the review of the ISCAT and the on-site review, and to revisit the documentation requirements for any post-review activities.

Description of Data Obtained

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for MY 2018 as part of the validation of performance measures:

- **ISCAT**: This was received from each BHO and the Department. The completed ISCATs provided HSAG with background information on the Department's and BHOs' information systems, policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures**: This was obtained from the Department and the BHOs, and was used to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports**: These were obtained from the Department and each BHO and were reviewed to assess trending patterns and rate reasonability.
- **Supporting Documentation**: This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results**: HSAG obtained the results from the measures the Department calculated on behalf of each of the BHOs. HSAG also received performance measure results calculated by the BHOs.
- **On-Site Interviews and Demonstrations**: HSAG obtained information through interaction, discussion, and formal interviews with key BHO and Department staff members as well as through system demonstrations.

How Conclusions Were Drawn

IS Standards Review

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Report*, *Not Reported*, or *No Benefit* to each performance measure. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be noncompliant. Consequently, it was possible that an error for a single element resulted in a designation of *Not Reported* because the impact of the error biased the reported performance measure by more than 5 percentage

points. Conversely, it was also possible that errors for several elements had little impact on the reported rate and that the indicator was thereby given a designation of *Report*.

Performance Measure Results

The BHO's performance measure results for MY 2017–2018 were compared to the Department's established performance targets and are denoted in Table 2-8.

Table 2-8—Performance Targets

Performance Measures	Performance Targets*
Mental Health Engagement (All Members Excluding Foster Care)	48.48%
Mental Health Engagement (Only Foster Care)	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	72.94%
Emergency Department Utilization for Mental Health Condition	7.20
Emergency Department Utilization for Substance Use Condition	19.71

**Performance targets are specified in the BHO-HCPF Incentive Performance Measures Scope Document, FY 2018.*

To draw conclusions about the quality and timeliness of, and access to, care provided by the BHOs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains. This assignment to domains is depicted in Table 2-9.

Table 2-9—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for Behavioral Health Organizations

Performance Measures	Quality	Timeliness	Access
Mental Health Engagement (All Members Excluding Foster Care)	✓	✓	✓
Mental Health Engagement (Only Foster Care)	✓	✓	✓
Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	✓
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	✓	✓	✓
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	✓	✓	✓
Emergency Department Utilization for Mental Health Condition	NA	NA	NA
Emergency Department Utilization for Substance Use Condition	NA	NA	NA

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR §438.240(b) (1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-7]

Over time, HSAG identified that while the health plans had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few health plans had achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-8] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement.

PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),*

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 23, 2019.

[1-8] Langley GL, Moen R, Nolan KM, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Mar 26, 2019.

Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that, given the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed.

HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the health plans to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act**: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the health plan summarizes key findings and outcomes and presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission forms. In FY 2018–2019, these forms provided detailed information about the PIPs and the activities completed in Module 1 and Module 2.

Following HSAG's rapid-cycle PIP process, the health plans submit each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

How Conclusions Were Drawn

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

To draw conclusions about the quality and timeliness of, and access to, services provided by the Medicaid health plans, HSAG assigned each component reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, the Department required all health plans to choose a specific PIP topic related to the global topic of access to care; therefore, all PIP topics were also assigned to the access domain. The timeliness domain was assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table 2-10.

Table 2-10—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

RAE	Performance Improvement Project	Quality	Timeliness	Access
Region 1—RMHP (PH care)	*Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18*	✓		✓
Region 1—RMHP (BH care)	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	✓	✓	✓

RAE	Performance Improvement Project	Quality	Timeliness	Access
Region 2—NHP (PH care)	*Increasing Well Checks for Adult Members 21–64 Years of Age*	✓		✓
Region 2—NHP (BH care)	*Increasing Mental Healthcare Services After a Positive Depression Screening*	✓	✓	✓
Region 3—COA (PH care)	*Well-Child Visits for Members 10–14 Years of Age*	✓		✓
Region 3—COA (BH care)	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	✓	✓	✓
Region 4—HCI (PH care)	*Increasing Well Checks for Adult Members 21–64 Years of Age*	✓		✓
Region 4—HCI (BH care)	*Increasing Mental Healthcare Services After a Positive Depression Screening*	✓	✓	✓
Region 5—COA (PH care)	*Well-Child Visits for Members 10–14 Years of Age*	✓		✓
Region 5—COA (BH care)	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	✓	✓	✓
Region 6—CCHA (PH care)	*Well-Care Visits for Children Ages 15–18 Years*	✓		✓
Region 6—CCHA (BH care)	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	✓	✓	✓
Region 7—CCHA (PH care)	*Well-Care Visits for Children Ages 15–18 Years*	✓		✓
Region 7—CCHA (BH care)	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	✓	✓	✓
MCO	**Performance Improvement Projects**	**Quality**	**Timeliness**	**Access**
DHMP	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	✓		✓
RMHP Prime	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	✓		✓

PCMH CAHPS Surveys—RAEs

Objectives

The goal of the PCMH CAHPS surveys is to provide performance feedback that is actionable and aids in improving overall patient-centered experience at the practice level.

Technical Methods of Data Collection

The technical method of data collection for the RAE-contracted practices occurred through the administration of a modified CG-CAHPS 3.0 survey, featuring selected items from the PCMH Item Set 3.0 and CG-CAHPS 2.0 survey. HSAG administered the PCMH CAHPS surveys on behalf of the Department. The adult PCMH CAHPS survey included 37 items, and the child PCMH CAHPS survey included 49 items—all of which assess members' perspectives on healthcare services received from providers. HSAG administered the survey to RAE-contracted practices and collected the data attributed to the seven RAEs. HSAG aggregated data from survey respondents into a database for analysis. HSAG presents the 2019 adult and child PCMH CAHPS top-box scores for the RAEs in the tables in Section 3.

The survey questions were categorized into 15 measures of experience (adult survey) and 14 measures of experience (child survey). These measures included four global ratings, seven composite measures, and four individual item measures in the adult survey; and three global ratings, seven composite measures, and four individual item measures in the child survey. The global ratings reflect overall member experience with providers, specialists, healthcare, and the health plan (adult survey only). The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Timely Appointments, Care, and Information" or "How Well Providers Communicate with Patients"). The individual item measures are individual questions that look at a specific area of care (e.g., "Received Care During Evenings, Weekends, or Holidays" and "Saw Provider Within 15 Minutes of Appointment"). If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

For each global rating, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each composite and individual item measure, the percentage of respondents who chose a positive response was calculated. Response choices for the composite and individual item questions presented in the adult and child PCMH CAHPS surveys fell into one of two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response for the composites and the individual items was defined as a response of "Always" or "Yes."

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of and access to services provided by the RAE-contracted practices, HSAG assigned each component reviewed for the PCMH CAHPS surveys to one or more of these three domains. This assignment to domains is depicted in Table 2-11.

Table 2-11—Assignment of PCMH CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

PCMH CAHPS Topics	Quality	Timeliness	Access
Rating of Provider	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan (Adult Only)	✓		
Getting Timely Appointments, Care, and Information	✓	✓	✓
How Well Providers Communicate with Patients/Child	✓		
How Well Providers Communicate with Parents or Caretakers (Child Only)	✓		
Providers' Use of Information to Coordinate Patient Care	✓		
Talking with You About Taking Care of Your Own Health (Adult Only)	✓		
Comprehensiveness (Adult Only)	✓		
Comprehensiveness: Child Development (Child Only)	✓		
Comprehensiveness: Child Safety and Healthy Lifestyles (Child Only)	✓		
Helpful, Courteous, and Respectful Office Staff	✓		
Health First Colorado Customer Service (Adult Only)	✓		
Received Information on Evening, Weekend, or Holiday Care for Child (Child Only)	✓		
[Child] Received Care During Evenings, Weekends, or Holidays			✓
Reminders about Care/Child's Care from Provider Office	✓		
Saw Provider Within 15 Minutes of Appointment		✓	

CAHPS Surveys—Limited Managed Care Capitation Initiative

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about patients' experience with healthcare.

Technical Methods of Data Collection

DHMP and RMHP Prime were required to arrange for conducting CAHPS surveys for Medicaid members enrolled in their specific organizations. The technical method of data collection for the MCOs was through the *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the HEDIS supplemental item set for the adult population and through the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the child population. Each health plan used a certified vendor to conduct the CAHPS surveys on behalf of the health plan. The surveys included a set of standardized items (58 items for the *CAHPS 5.0 Adult Medicaid Health Plan Survey* and 48 items for the *CAHPS 5.0 Child Medicaid Health Plan Survey*) that assess member perspectives on care. To support the reliability and validity of the findings, NCQA requires standardized sampling and data collection procedures related to selection of members and distribution of surveys to those members. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. HSAG aggregated data from survey respondents into a database for analysis.

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics important to members, such as communication skills of providers and accessibility of services. The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall experience with their personal doctors, specialists, health plans, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+). Results of the CAHPS surveys for each Medicaid MCO are found in Section 3.

Description of Data Obtained

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response for the composite measures was defined as a response of "Usually/Always" or "Yes."

DHMP and RMHP Prime provided HSAG with the data presented in this report. Morpace Inc. and Center for the Study of Services (CSS) administered the *CAHPS 5.0 Adult Medicaid Health Plan Survey*

and *CAHPS 5.0 Child Medicaid Health Plan Survey* for DHMP and RMHP Prime, respectively. The health plans reported that NCQA methodology was followed in calculating these results.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to, services provided by the MCOs, HSAG assigned each of the components reviewed for CAHPS to one or more of these three domains. This assignment to domains is depicted in Table 2-12.

Table 2-12—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

CAHPS Topics	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

ECHO Surveys

Objectives

The overarching objectives of administering the ECHO surveys were to effectively and efficiently obtain information and to gain understanding about patients' experiences with behavioral healthcare and services provided. Members who received behavioral health services from the BHOs were included in the results. Caution should be exercised when interpreting these results as some results may not be attributable to the RAEs.

Technical Methods of Data Collection

The technical method of data collection occurred through the administration of a modified version of the *Adult ECHO Survey, Managed Behavioral Healthcare Organization (MBHO), Version 3.0* (adult ECHO survey), which incorporates items from the Mental Health Statistics Improvement Program (MHSIP) survey, and a modified version of the *Child/Parent ECHO Survey, MBHO, Version 3.0* (child/parent ECHO survey), which incorporates items from the Youth Services Survey for Families (YSS-F) survey and the YSS. HSAG administered the ECHO surveys on behalf of the Department. The surveys included 59 items in the adult ECHO survey and 69 items in the child/parent ECHO survey, all of which assess member perspectives on the behavioral healthcare services received. HSAG administered the survey and

collected the data for the seven RAEs. HSAG presents the 2019 adult and child ECHO top-box scores for the RAEs in the tables in Section 3.

The survey questions were categorized into 16 measures of satisfaction (adult survey) and 15 measures of satisfaction (child survey). These measures included one global rating, four composite scores, nine individual item measures in the adult survey and eight individual item measures in the child survey, and two MHSIP/YSS-F domain agreement measures. A series of questions from the MHSIP, YSS-F, and YSS surveys were added to the standard ECHO survey in order to meet the reporting needs of Colorado's Office of Behavioral Health (OBH). The global rating reflects a respondent's overall experience with counseling or treatment. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Treatment Quickly* and *How Well Clinicians Communicate*). The individual item measures are individual questions that consider a specific area of care (e.g., *Office Wait Times* and *Told About Medication Side Effects*). The MHSIP/YSS-F domains are a series of questions from the surveys that evaluate improved functioning and social connectedness. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

For the global rating, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. A positive or top-box response for the composites was defined as a response of "Usually/Always," "Yes," or "Much better/A little better." For each individual item measure (nine in the adult survey and eight in the child survey), the percentage of respondents who chose a positive response was calculated. A positive or top-box response for the individual item measures was defined as a response of "Usually/Always," "Yes," or "Somewhat/A lot."[2-9]

Response choices for the ECHO MHSIP/YSS-F domain questions fell into one category. Options were: "Strongly agree," "Agree," "Neutral," "Disagree," "Strongly Disagree," and "Not Applicable." For purposes of calculating the results for the MHSIP/YSS-F domain agreement rates, global proportions were calculated for each domain. Questions comprising each domain are based on a 5-point Likert scale, with each response coded to score values as follows:

1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree

After applying this scoring methodology, the average score for each respondent is calculated for all questions that comprise the domain. Respondents with an average score less than or equal to 2.5 are considered "agreements" and assigned an agreement score of 1, whereas those respondents with an

[2-9] For the individual item measure, "Privacy," a positive response is defined as "No."

average score greater than 2.5 are considered "disagreements" and assigned an agreement score of zero. Respondent answers with fewer than 33 percent of responses within each MHSIP/YSS-F domain are excluded from the analysis.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of and access to services provided, HSAG assigned each of the components reviewed for the ECHO surveys to one or more of these three domains. This assignment to domains is depicted in Table 2-13.

Table 2-13—Assignment of ECHO Measures to the Quality, Timeliness, and Access to Care Domains

ECHO Topics	Quality	Timeliness	Access
Rating of All Counseling or Treatment	✓		
Getting Treatment Quickly	✓	✓	
How Well Clinicians Communicate	✓		
Perceived Improvement	✓		
Information About Treatment Options	✓		✓
Office Wait		✓	✓
Told About Medication Side Effects	✓		
Including Family (Adult Only)	✓		
Information to Manage Condition	✓		✓
Patient Rights Information	✓		
Patient Feels He or She Could Refuse Treatment	✓		
Privacy	✓		
Cultural Competency	✓		
Amount Helped	✓		
Improved Functioning	✓		✓
Social Connectedness	✓		

Encounter Data Validation—RAE Behavioral Health Information Systems (IS) Review

Objectives

RAEs began operational activities on July 1, 2018; consequently, HSAG and the Department determined that an EDV IS review aligned most closely with the Department's encounter data oversight needs. The goal of the IS review was to examine the extent to which the Department and the RAEs maintain appropriate system documentation and the infrastructure to produce, process, and monitor BH encounter data. Additionally, the IS review sought to assess the capacity of the Department and RAEs to collect, process, and transmit encounter data in Electronic Data Interchange (EDI) X12 format.

Technical Methods of Data Collection

The IS review seeks to define how each participant in the encounter data submission process collects and processes encounter data, to understand the flow of data from the RAEs' vendors to the RAEs and from the RAEs to the Department. HSAG used a three-stage IS review process that included document review, development and fielding of a customized encounter data questionnaire, and follow-up with key Department and RAE staff members. RAEs serving more than one region were permitted to submit a single set of desk review materials to HSAG if the same systems, policies and procedures, and data handling processes applied to all regions. A detailed description of the EDV activity, methods, and results are contained in the *CO2018–19 BH EDV IS Report* submitted by HSAG to the Department in June 2019.[2-10]

Description of Data Obtained

HSAG conducted a thorough desk review of documents related to current encounter data initiatives/validation activities. Documents supplied by the Department included data dictionaries, process flow charts, data system diagrams, encounter system edits, and encounter data submission requirements for legacy flat file and X12 transaction files. Results from this review helped HSAG to develop a targeted questionnaire that addressed specific topics of interest for the Department.

During the second study phase, HSAG, in collaboration with the Department, developed a targeted IS questionnaire to gather both general and specific information regarding data processing, personnel, and data acquisition capabilities for the RAEs and the Department to complete. Questionnaire items were designed to separately collect information related to legacy encounter data systems and encounter data systems supporting X12 transaction files. The questionnaire included assessment items grouped into the following topic areas:

- Transition from Legacy Flat Files to X12 Transaction Files
- Encounter Data Sources and Systems

[2-10] Health Services Advisory Group. Colorado Department of Health Care Policy and Financing: *CO2018-19 Behavioral Health Encounter Data Validation: Information Systems Review Report*; June 2019.

- Data Exchange Policies and Procedures
- Encounter Data Management, Monitoring, and Reporting

Upon completion of the customized encounter data assessment, HSAG followed up with key personnel at the Department and each RAE to clarify any information provided through questionnaire responses.

Of note, information obtained from the Department's and the RAEs' questionnaire responses was self-reported and HSAG did not validate the responses for accuracy.

How Conclusions Were Drawn

HSAG reviewed information obtained in March 2019 from the Department's and RAEs' self-reported questionnaire responses to assess the degree to which the documented encounter data policies, procedures, and activities support the RAEs' submission and the Department's receipt of accurate and complete encounter data. Conclusions and recommendations address the extent to which reported policies and procedures promote or impede the quality of encounter data submissions.

Encounter Data Validation—MCO 412 Audit Over-Read

Objectives

The MCO 412 audit over-read evaluated each MCO's compliance with the Department's encounter data submission standards, as well as the consistency and accuracy with which the MCOs audit encounter data through the use of MRR.

Technical Methods of Data Collection

The Department developed and implemented the MCO Encounter Data Quality Review Guidelines to guide the MCOs in conducting an internal audit (EDV) of 412 encounters randomly selected by the Department. For each MCO, the Department then selected 103 final, adjudicated PH encounter lines from four distinct service categories (i.e., a total of 412 encounters) to be audited. Each MCO procured supporting medical record documentation for each sampled case and conducted the internal audit, submitting the internal audit results and an encounter data quality report to HSAG and the Department.

In addition to reviewing the MCOs' internal audit documentation, HSAG conducted an over-read of medical records for a sample of randomly selected 412 internal audit cases to evaluate whether the MCOs' internal audit was accurate and consistent with standard coding manuals. HSAG used a two-stage sampling approach among the Department's 412 sample lists to generate MCO-specific over-read samples, resulting in a list of 20 randomly selected encounter lines per service category and 80 cases overall for each MCO.

Description of Data Obtained

The Department used encounter data submitted by each MCO to generate the 412 sample lists. The Department evenly divided each MCO's 412 EDV samples among the following four service categories: encounters with services rendered in FQHCs, as well as in inpatient, outpatient, and professional settings. HSAG then used the Department's sample case lists to generate MCO-specific over-read samples evenly divided among the four service categories.

Each MCO was responsible for procuring supporting medical record documentation for each sampled case, and the MCOs used these medical records to conduct their internal audits as well as to provide the selected cases to support HSAG's over-read.

How Conclusions Were Drawn

During the over-read process, HSAG evaluated the extent to which each MCO's audit responses were accurate based on the review of the encounter data and corresponding medical record documentation. HSAG entered all over-read results into a standardized audit tool that aligned with the Department's MCO Encounter Data Quality Review Guidelines.

Following completion of the over-read, HSAG tabulated the over-read results by service category to determine the percentage of over-read cases and encounter data elements in which HSAG agreed with the MCOs' internal audit responses.

Validation of Network Adequacy

Objectives

Federal regulations for managed care that were released in May 2016 stated that validation of network adequacy shall commence no later than one year from the issuance of the associated EQR protocol (42 CFR §438.358(b)(1)(iv)). In preparation of the release of the validation of network adequacy protocol, the Department collaborated with HSAG to support a review of current network adequacy documentation and processes; prepare a provider crosswalk for use in future network adequacy validation tasks; and conduct a baseline PCA of the Medicaid provider networks for all MCEs.

The provider crosswalk was designed to use provider types, specialties, credentials, and/or taxonomy codes from the Department's and the MCEs' existing provider data to establish standard definitions for identifying categories of managed care providers (e.g., physician and non-physician PCPs). The primary focus of the PCA was to assess the distribution of providers affiliated with each MCE for the Department's selected provider categories.

Technical Methods of Data Collection

HSAG used a desk review approach to collect documentation and provider data from the Department and participating MCEs (i.e., the RAEs and Medicaid MCOs). The Department supplied HSAG with provider network documentation and standards, including the MCEs' network adequacy contract requirements and quarterly network adequacy reports. In addition, the Department supplied data for all ordering, referring, servicing, and billing providers active with the Department (i.e., registered in interChange). Concurrent with the Department's data extract, each MCE completed a brief Data Structure Questionnaire with targeted information regarding its provider data structure(s) and methods for classifying providers. Finally, each MCE submitted provider network data using a standardized data requirements document approved by the Department.

Description of Data Obtained

Qualitative data for the study included the Department's provider network documentation and the MCEs' self-reported Data Structure Questionnaire responses.

Quantitative data for the study included provider-level network data from the Department and each MCE, including data values with provider attributes for type (e.g., NP), specialty (e.g., family medicine), credentials (e.g., licensed marriage and family therapist), and/or taxonomy code. However, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the MCEs and a lack of consistent use of taxonomy codes by the Department.

Of note, the Department has not directed the MCEs to use standard categorization criteria when producing quarterly network adequacy reports, and the Department is unable to identify the MCE and/or FFS affiliation(s) for each provider, resulting in a reliance on the MCEs' provider data for this study.

How Conclusions Were Drawn

Following development of the study methodology, the Department approved the following high-level provider categories applicable to each MCE type and aligned with the minimum provider categories identified in Section 42 438.68 of the federal network adequacy standard requirement:

- Facility-Level Providers (Medicaid MCOs)
  - Hospitals, pharmacies, imaging services, and laboratories
- Prenatal Care and Women's Health Services (RAEs and Medicaid MCOs)
  - Individual providers, FQHCs, RHCs, CMHCs, and birthing centers
- PCPs (RAEs and Medicaid MCOs)
  - Individual general and pediatric providers, FQHCs, RHCs, CMHCs, and school-based health clinics (SBHCs)
- Physical Health Specialists (Medicaid MCOs)
  - Individual general and pediatric providers, FQHCs, and RHCs

- Ancillary Physical Health Services (Medicaid MCOs)
  - Audiology, optometry, podiatry, and occupational/physical/speech therapy
- Behavioral Health Specialists (RAEs)
  - Individual physician and non-physician providers, FQHCs, RHCs, and CMHCs
  - Mental hospitals and psychiatric residential treatment facilities
  - Substance abuse facilities and licensed addiction counselors

Detailed provider categories within these high-level groups guided subsequent data review and provider crosswalk development, and HSAG mapped the MCEs' provider data attributes into preliminary provider crosswalks (i.e., documents describing the logic and data values that would identify providers attributed to each Department-approved category).

HSAG then reconciled the preliminary crosswalk results within each MCE type and collaborated with the Department to review the resulting provider category definitions and finalize the crosswalks. HSAG applied the results of the provider crosswalk to the MCEs' provider data to conduct the PCA, generating MCE-specific frequency counts of total and unique providers for each provider category.

As the study was designed to provide a baseline for future network adequacy validation tasks using existing provider network data and documentation, the MCEs were not given the opportunity to submit additional information on their providers following the PCA.

Aggregating and Analyzing Statewide Data

For each MCO and RAE (collectively health plans), HSAG analyzed the results obtained from each EQR mandatory and optional activity conducted for that organization. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

3. Evaluation of Colorado's Regional Accountable Entities

Region 1—Rocky Mountain Health Plans (RMHP)

Assessment of Compliance With Medicaid Managed Care Regulations

RMHP RAE Overall Evaluation

Table 3-1 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-1—Summary of RMHP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	12	12	12	0	0	0	100%
Standard IV—Member Rights and Protections	7	7	6	1	0	0	86%
Standard V—Member Information	19	18	15	3	0	1	83%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	8	0	0	0	100%
Totals	**46**	**45**	**41**	**4**	**0**	**1**	**91%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

RMHP: Strengths

RMHP demonstrated a well-defined and comprehensive care coordination program, not only through the *Care Coordination* policy and procedure, but also through its staff operations evaluated by HSAG during the on-site review. The *Care Coordination* policy and procedure outlined requirements for assisting members with access to needed services, and defined specific populations targeted for care coordination. Through the utilization of Essette care management software, RMHP was able to share care coordination files and member-specific care management information with community mental health centers, partner integrated care coordination teams, public health departments, and large primary care clinics in a secure manner. RMHP's staff operations included integrated care coordination teams

that were dispersed region-wide to provide care coordination to members at the local level. RMHP's processes included customer service teams initiating outreach to communicate with all newly enrolled members within 30–45 days of enrollment for conducting an intake assessment of member needs, while continuing to be available to assist members and providers through the "One-Call Center."

RMHP members and staff members were informed about member rights, advance directives, and privacy laws through various mechanisms. RMHP staff members were trained on member rights, advance directives, and federal and State laws pertaining to privacy through written policies. The *Health First Colorado Member Handbook* defined member rights and responsibilities, and advance directives, while the RMHP member newsletter reminded members how to access a list of member rights and responsibilities on the RMHP website. RMHP ensured—primarily through review of RMHP's customer service interactions—that employees and providers afforded members their rights. This review process included monitoring calls received, determining whether the issues raised by the member were related to member rights, and responding as appropriate.

RMHP members received additional required member information in different formats; via the RMHP website, the *Getting Started Guide*, and the *Health First Colorado Member Handbook*. The *Getting Started Guide*—a supplement to the member handbook—provided a clear pathway for members to navigate the RMHP healthcare system. Prior to publication, member-facing materials were reviewed by the Member Advisory Council for providing feedback to RMHP. Furthermore, members received information via telephonic outreach and quarterly newsletters. RMHP demonstrated that its written member communications were written in easily understood language, with appropriate font size, and available in various alternative formats. All critical member communications recapped how members could obtain interpretive services, auxiliary aids, communications in a different language, and how to reach customer service for additional assistance. RMHP maintained a website that housed information about healthcare services available and how to access them. The website contained a searchable provider directory, drug formulary, community resources, covered benefits, RMHP contact information, and a link to the *Health First Colorado Member Handbook*.

RMHP's *Early and Periodic Screening, Diagnostic, and Treatment Services* (*EPSDT)* policy and procedure described a comprehensive program for managing and providing EPSDT services for members under 21 years of age. Members were notified about EPSDT benefits through several methods, including new member welcome calls, the new member *Getting Started Guide*, and the *Health First Colorado Member Handbook*. RMHP members could utilize the RMHP website to obtain detailed information on the types and frequency of screenings available, types of diagnostic and treatment services available, age-specific immunizations, and services available through the Healthy Communities program. RMHP educated providers on EPSDT benefits through RMHP provider manuals for both primary care and BH providers, an annual EPSDT provider letter, and provider webinars. RMHP provided support for providers with resolving any barriers related to EPSDT benefits. Care coordinators were also available to assist members with referrals for services not covered by the plan and to out-of-network providers, and with additional system navigation needs. In addition, RMHP had established memorandums of understanding (MOUs) with each of 10 county Healthy Communities programs in the region and maintained both a regional-level relationship with Healthy Communities partners to facilitate

inter-agency education, and local-level relationships with providers and agencies to define referral processes applicable to each individual community.

RMHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care or Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Standard IV—Member Rights and Protections

While RMHP provided an education session to providers concerning advance directives, HSAG found that RMHP did not have provisions for community education regarding advance directives. RMHP was required to:

- Develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard V—Member Information

While RMHP maintained a website that housed detailed information about healthcare services available and how to access them, and included a searchable provider directory, HSAG found that the website and the provider directory had significant contrast errors and were not readily accessible as defined by guidelines set forth in Section 508 of Section 504 of the Rehabilitation Act. In addition, RMHP's provider directory did not include information pertaining to whether the provider had completed cultural competency training and whether the provider's office has accommodations for people with physical disabilities. RMHP was required to:

- Ensure that its website is fully machine-readable and readily accessible per Section 508 guidelines.
- Ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.
- Update its provider directories to include whether the provider has completed cultural competency training and whether the provider's office has accommodations for people with physical disabilities (including offices, exam rooms, and equipment).

Limited Managed Care Capitation Initiative—RMHP Prime Evaluation

Table 3-2 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

Table 3-2—Summary of RMHP Prime Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	11	11	0	0	0	100%
Standard IV—Member Rights and Protections	7	7	6	1	0	0	86%
Standard V—Member Information	19	18	15	3	0	1	83%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**44**	**43**	**39**	**4**	**0**	**1**	**91%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

RMHP Prime: Strengths

RMHP policies, procedures, and processes related to its Region 1 RAE apply to the RMHP Prime MCO line of business as well. RMHP Prime providers within a six-county sub-region of the RAE administered capitated PH benefits to RMHP Prime MCO members, while the RMHP Prime members received BH benefits through the RAE's PIHP program. RMHP Prime's member handbook informed members of the 90-day time frame for opting out of the MCO. RMHP actively monitored Prime provider attribution reports received from the Department and continually worked with Prime providers to confirm and correct inaccurate provider attribution, when discovered. RMHP had implemented the calculation of a key performance indicator (KPI) to measure the use of care compacts between providers to include between primary care and at least one BH entity. RMHP further incentivized providers through the RMHP practice transformation program to increase the degree of complexity of care coordination processes offered in its practices. RMHP demonstrated a well-defined and comprehensive care coordination program, not only through the *Care Coordination* policy and procedure, but also through its staff operations evaluated during the on-site review. The *Care Coordination* policy and procedure outlined requirements for assisting members with access to needed services and defined specific populations targeted for care coordination. Through the utilization of Essette care management software, RMHP was able to share care coordination files and member-specific care management information among care coordination teams located within the RMHP Prime service area. Customer service teams

had a process to initiate outreach to all newly enrolled members within 30–45 days of enrollment to conduct an intake assessment of member needs, while continuing to be available to assist members and providers through the "One-Call Center."

RMHP Prime members and staff members were informed about members rights, advance directives, and privacy laws through several different mechanisms, which included the distribution of written policies and procedures to staff members. RMHP Prime members were informed about member rights and responsibilities, as well as advance directives, through the Prime member handbook, and the RMHP member newsletter reminded members how to access a list of member rights and responsibilities on the RMHP website. RMHP ensured—primarily through review of RMHP's customer service interactions—that employees and providers afforded members their rights. This review process included monitoring calls received, determining whether the issues raised by the member were related to member rights, and responding as appropriate.

RMHP Prime members received additional required member information in different formats; via the RMHP website, the *Getting Started Guide*, and the Prime member handbook. The *Getting Started Guide*—a supplement to the member handbook—provided a clear pathway for members to navigate the RMHP healthcare system. Prior to publication, member-facing materials were reviewed by the Member Advisory Council for providing feedback to RMHP. Furthermore, members received information via telephonic outreach and quarterly newsletters. RMHP's written member communications were written in easily understood language, with appropriate font size, and available in various alternative formats. All critical member communications recapped how members could obtain interpretive services, auxiliary aids, communications in a different language, and how to reach customer service for additional assistance. RMHP maintained a website that housed information about healthcare services available and how to access them. The website contained a searchable provider directory, a drug formulary, community resources, covered benefits, RMHP contact information, and a link to the Health First Colorado Member Handbook.

RMHP's *EPSDT* policy and procedure described a comprehensive program for managing and providing EPSDT services for Prime members under 21 years of age. Prime members were notified about EPSDT benefits through different methods, including new member welcome calls, the new member *Getting Started Guide*, and the Prime member handbook. Prime members also received an annual notification letter informing them of EPSDT benefits available to them, and various well-child care reminders were sent to applicable members throughout the year. RMHP members could utilize the RMHP website to obtain additional detailed information on the types and frequency of screening services available and types of diagnostic and treatment services, age-specific immunizations, and services available through the Healthy Communities program. RMHP providers received education on EPSDT benefits through the RMHP provider manual, an annual EPSDT provider letter, and provider webinars. The provider manual informed providers that RMHP had adopted the AAP Bright Futures periodicity schedule and listed all components and requirements of periodic health screenings. In an effort to ensure EPSDT screenings and examinations were being documented in the medical record, RMHP conducted annual audits of a small sample of Prime provider medical records.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care or Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Standard IV—Member Rights and Protections

While RMHP provided an education session to Prime providers concerning advance directives, HSAG found that RMHP did not have provisions for community education regarding advance directives. RMHP Prime was required to:

- Develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard V—Member Information

While RMHP maintained a website that housed detailed information about healthcare services available and how to access them, and included a searchable provider directory, HSAG found that the website and the provider directory had significant contrast errors and were not readily accessible per Section 508 guidelines. In addition, RMHP Prime's provider directory did not include information pertaining to whether the provider had completed cultural competency training and whether the provider's office has accommodations for people with physical disabilities. RMHP Prime was required to:

- Ensure that its website is fully machine-readable and readily accessible per Section 508 guidelines.
- Ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.
- Update its provider directories to include whether the provider has completed cultural competency training and whether the provider's office has accommodations for people with physical disabilities (including offices, exam rooms, and equipment).

RMHP Prime: Trended Performance for Compliance With Regulations

Table 3-3—Compliance With Regulations—Trended Performance for RMHP Prime

Standard and Applicable Review Years	RMHP Prime Average—Previous Review	RMHP Prime Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	90%	100%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**100%**	**100%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**80%**	**86%**
Standard V—Member Information (2017–2018, 2018–2019)*	**100%**	**83%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	88%	89%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	93%	93%
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	100%	100%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	100%
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	77%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019)*	**92%**	**100%**

**Bold text indicates standards that HSAG reviewed during FY 2018–2019.*

RMHP Prime's most recent year of review for two of 11 standards demonstrated significant performance improvement (10 percentage points or more): Standard II—Access and Availability and Standard X—Quality Assessment and Performance Improvement, with the most significant improvement being in Standard X—Quality Assessment and Performance Improvement (23 percentage points). RMHP Prime's performance improved slightly in four additional standards during the most recent year of review: Standard I—Coverage and Authorization of Services; Standard IV—Member Rights and Protections; Standard VI—Grievance and Appeal System; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. When compared to previous review years, four of the standards remained unchanged, with three of those standards remaining stable at 100 percent. Only one standard demonstrated a decline when compared to previous review year, Standard V—Member Information. Changes in federal regulations, changes in State contract requirements, and the design of the compliance monitoring tool may have impacted comparability of the compliance results between review cycles, particularly in Standard V—Member Information, where a significant number of additional requirements were added with the release of the 2016 revisions to the federal regulations.

HEDIS Measure Rates and Validation—RMHP Prime

RMHP Prime: Information Systems Standards Review Results

According to the 2019 HEDIS Compliance Audit Report, RMHP Prime was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted RMHP Prime's HEDIS performance measure reporting.

RMHP Prime: Performance Measure Results

Table 3-4 shows the performance measure results for RMHP Prime for HEDIS 2017 through HEDIS 2019, along with the percentile ranking for each HEDIS 2019 rate.

Table 3-4—Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	NA	NA	NA	—
Combination 3	NA	NA	NA	—
Combination 4	NA	NA	NA	—
Combination 5	NA	NA	NA	—
Combination 6	NA	NA	NA	—
Combination 7	NA	NA	NA	—
Combination 8	NA	NA	NA	—
Combination 9	NA	NA	NA	—
Combination 10	NA	NA	NA	—
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	NA	NA	54.29%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	—	NA	14.29%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	NA	NR	—
Six or More Visits	NA	NA	NR	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.35%	58.21%	61.90%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	15.57%	15.68%	17.66%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	2.40%	3.18%	4.37%	<10th
Counseling for Nutrition—Total	14.00%	15.55%	15.53%	<10th
Counseling for Physical Activity—Total	0.80%	0.71%	0.00%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	NA	NA	NA	—
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	94.74%	NA	NA	—
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	51.22%	22.65%	44.69%^	<10th
Postpartum Care	28.22%	27.15%	28.58%	<10th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	NA	NA	NA	—
Ages 25 Months to 6 Years	90.57%	87.84%	81.82%	10th–24th
Ages 7 to 11 Years	90.11%	90.36%	86.21%	10th–24th
Ages 12 to 19 Years	86.06%	91.12%	89.13%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services[1]				
Total	72.23%	70.93%	71.84%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Total	45.23%	49.26%	46.46%	10th–24th
Breast Cancer Screening[1]				
Breast Cancer Screening	—	50.44%	50.10%	10th–24th
Cervical Cancer Screening				
Cervical Cancer Screening	40.88%	43.21%	41.93%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	3.07%	2.12%	2.86%	10th–24th
Adult BMI Assessment[1]				
Adult BMI Assessment	16.21%	17.25%	27.74%^	<10th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	56.03%	52.34%	52.20%	50th–74th
Effective Continuation Phase Treatment	36.21%	34.46%	33.85%	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	21.95%	20.00%	<10th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	2.70%	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack[1]				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	—
Comprehensive Diabetes Care[1]				
HbA1c Testing	86.05%	83.94%	84.59%	10th–24th
*HbA1c Poor Control (>9.0%)**	74.00%	70.68%	**76.08%^^**	<10th
HbA1c Control (<8.0%)	21.71%	25.19%	**19.55%^^**	<10th
Eye Exam (Retinal) Performed	38.23%	7.47%	50.14%^	10th–24th
Medical Attention for Nephropathy	83.54%	82.98%	83.21%	<10th
Blood Pressure Control (<140/90 mm Hg)	0.00%	0.00%	8.91%^	<10th
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	43.48%	43.37%	46.70%	<10th
Statin Adherence 80%	62.75%	57.33%	60.05%	50th–74th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	71.08%	71.96%	64.86%	<10th
Statin Adherence 80%—Total	66.10%	68.38%	60.83%	25th–49th
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.67%	84.52%	83.59%	<10th
Diuretics	85.51%	85.80%	85.88%	10th–24th
Total	—	85.03%	84.48%	10th–24th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	74.17%	72.70%	71.67%	25th–49th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	37.87%	40.89%	47.50%	≥90th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	53.09%	44.50%	40.28%	<10th
Bronchodilator	62.89%	54.13%	56.48%	<10th
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	63.41%	63.25%	64.91%	50th–74th
Medication Compliance 75%—Total	34.63%	38.89%	38.60%	50th–74th
Asthma Medication Ratio[1]				
Total	56.35%	52.07%	53.74%	10th–24th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.19%	34.87%	30.09%	25th–49th
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis[1]				
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	75.25%	74.77%	71.00%	25th–49th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	66.27	62.98	61.52	25th–49th
Outpatient Visits—Total[1]	320.65	317.25	326.38	25th–49th
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Discharges per 1,000 Member Months (Total Inpatient)—Total	9.66	9.01	9.42	75th–89th
Average Length of Stay (Total Inpatient)—Total	3.66	3.62	3.68	10th–24th
Discharges per 1,000 Member Months (Medicine)—Total	4.47	4.20	4.39	75th–89th
Average Length of Stay (Medicine)—Total	3.66	3.70	3.74	10th–24th
Discharges per 1,000 Member Months (Surgery)—Total	2.36	2.12	2.23	75th–89th
Average Length of Stay (Surgery)—Total	5.39	5.39	5.26	<10th
Discharges per 1,000 Member Months (Maternity)—Total	2.96	2.83	2.96	50th–74th
Average Length of Stay (Maternity)—Total	2.20	2.10	2.33	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.75	0.70	0.64	75th–89th
Average Days Supplied per Antibiotic Script—Total	9.27	9.32	9.11	50th–74th
Average Scripts PMPY for Antibiotics of Concern—Total	0.32	0.28	0.25	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	42.10%	39.55%	39.52%	50th–74th
Plan All-Cause Readmissions**[1]				
Index Total Stays—Observed Readmissions—Total	—	9.33%	11.71%	75th–89th
Index Total Stays—O/E Ratio—Total	—	0.56	0.64	≥90th
Use of Opioids at High Dosage**[2]				
Use of Opioids at High Dosage	—	—	4.19%	—
Use of Opioids From Multiple Providers**[2]				
Multiple Prescribers	—	—	25.73%	—
Multiple Pharmacies	—	—	4.22%	—
Multiple Prescribers and Multiple Pharmacies	—	—	2.79%	—

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
— Indicates that the rate is not presented as the measure was not required to be reported during HEDIS 2017. This symbol may also indicate that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR indicates that the MCO did not report the measure.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a significant decline in performance from the previous year.

RMHP Prime: Strengths

The following HEDIS 2019 measure rate was determined to be a high performer for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018):

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

RMHP Prime continued to demonstrate strength with the appropriate treatment of members with acute bronchitis, with the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate above the 90th percentile.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2019 measure rates were determined to be low performers for RMHP Prime (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018):

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Chlamydia Screening in Women—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Adult BMI Assessment*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*

- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*
- *Pharmacotherapy Management of COPD Exacerbation—System Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*

For HEDIS 2019, RMHP Prime demonstrated opportunities to improve access to the appropriate providers and services for child and adult members, as evidenced by all measure rates within the Access to Care and Preventive Screening domains falling below the 25th percentile. The MCO should work with the Department and providers to identify the causes for the low access to care and preventive screening rates (e.g., barriers to care, lack of family planning services, provider training, community outreach and education) and implement strategies to improve the care for members.

Additionally, RMHP Prime's performance related to appropriately prescribing medications and monitoring members with chronic conditions (e.g., diabetes, cardiovascular disease, COPD, asthma) indicated opportunities for improvement, with several measure rates falling below the 25th percentile. RMHP Prime should focus efforts on identifying the factors contributing to the low rates for these measures (e.g., barriers to outpatient care and pharmacies, provider training and prescribing patterns, member education) and implement strategies to improve the care for members with chronic conditions.

Validation of Performance Improvement Projects

RMHP: Accountable Care PIP

Table 3-5 displays the FY 2018–2019 validation findings for RMHP's *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP.

Table 3-5—Validation Findings for *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Mountain Family Health Center.
SMART Aim Statement	By 6/30/2020, increase the percentage of well-child visits among RAE Members at Mountain Family Health Center 15–18 years of age, from 36.74% to 40.67%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 15 through 18 years of age attributed to Mountain Family Health Center during the rolling 12-month measurement period who received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

RMHP: Strengths

RMHP selected an accountable care PIP topic focused on increasing the rate of well-child visits among members 15 to 18 years of age. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that RMHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. RMHP has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, RMHP will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As RMHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on

impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

RMHP: Behavioral Health PIP

Table 3-6 displays the FY 2018–2019 validation findings for RMHP's *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP.

Table 3-6—Validation Findings for *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 11 years of age or older attributed to Colorado Mountain Medical.
SMART Aim Statement	By 6/30/2020, increase the percentage of depression screenings among RAE Members attributed to Colorado Mountain Medical age 11 years and older from 0.00% to 20.00%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 11 years of age or older attributed to Colorado Mountain Medical who received a depression screening during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

RMHP: Strengths

RMHP selected a BH PIP topic focused on increasing the depression screening rate among members 11 years of age and older. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that RMHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. RMHP has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

In the next phase of the BH PIP, RMHP will have the opportunity to analyze existing processes related to improving the *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As RMHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

RMHP Prime PIP

Table 3-7 displays the FY 2018–2019 validation findings for RMHP Prime's *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP.

Table 3-7—Validation Findings for *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 18 years of age and older attributed to Foresight Family Practice.
SMART Aim Statement	By June 30, 2020, increase from 1.45% to 11.94% the percentage of Prime members aged 18 and greater at Foresight Family Practice who receive effective pharmacotherapy for opioid use disorder (OUD) or alcohol use disorder (AUD) within 60 days of an initial diagnosis.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 18 years of age and older attributed to Foresight Family Practice who were diagnosed with OUD or AUD and filled a prescription for a medication known as an effective pharmaceutical treatment of the disorder within 60 days of initial diagnosis.

Module 1—PIP Initiation	
SMART Aim Data Collection Plan	• **Data Source:** RMHP's claims database. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

RMHP Prime: Strengths

RMHP Prime selected a PIP topic focused on increasing the percentage of members 18 years and older diagnosed with an OUD or AUD and who received effective pharmaceutical treatment within 60 days of initial diagnosis. The MCO has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that RMHP Prime designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. RMHP Prime has progressed to Module 3, where the MCO will determine potential interventions to test for the PIP.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to the RMHP Prime PIP

In the next phase of the PIP, RMHP Prime will have the opportunity to analyze existing processes related to improving treatment for members diagnosed with an OUD or AUD at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The MCO will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As RMHP Prime continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the MCO progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey—RMHP RAE

Table 3-8 shows the adult PCMH CAHPS results for RMHP for FY 2018–2019.

Table 3-8—Adult PCMH CAHPS Question Summary Rates and Global Proportions for RMHP

Measure	FY 2018–2019 Rate
Rating of Provider	66.8%
Rating of Specialist Seen Most Often	63.9%
Rating of All Health Care	60.2%
Rating of Health Plan	58.2%
Getting Timely Appointments, Care, and Information	48.3%
How Well Providers Communicate with Patients	76.7%
Providers' Use of Information to Coordinate Patient Care	66.4%
Talking with You About Taking Care of Your Own Health	47.5%
Comprehensiveness	55.7%
Helpful, Courteous, and Respectful Office Staff	71.8%
Health First Colorado Customer Service	65.5%
Received Care from Provider Office During Evenings, Weekends, or Holidays	34.8%
Reminders about Care from Provider Office	73.4%
Saw Provider Within 15 Minutes of Appointment	43.5%
Received Health Care and Mental Health Care at Same Place	52.9%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

RMHP: Strengths

For the RMHP adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (76.7 percent)
- *Reminders about Care from Provider Office* (73.4 percent)
- *Helpful, Courteous, and Respectful Office Staff* (71.8 percent)

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the RMHP adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (34.8 percent)
- *Saw Provider Within 15 Minutes of Appointment* (43.5 percent)
- *Talking with You About Taking Care of Your Own Health* (47.5 percent)

HSAG recommends that RMHP develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that RMHP explore areas that may be contributing to low experience scores for the *Talking with You About Taking Care of Your Own Health* measure and develop initiatives designed to improve the score for this measure.

Table 3-9 shows the child PCMH CAHPS results for RMHP for FY 2018–2019.

Table 3-9—Child PCMH CAHPS Question Summary Rates and Global Proportions for RMHP

Measure	FY 2018–2019 Rate
Rating of Provider	75.1%
Rating of Specialist Seen Most Often	67.0%+
Rating of All Health Care	67.9%
How Well Providers Communicate with Child	77.7%
Getting Timely Appointments, Care, and Information	61.7%
How Well Providers Communicate with Parents or Caretakers	81.0%
Providers' Use of Information to Coordinate Patient Care	71.1%
Comprehensiveness: Child Development	61.7%
Comprehensiveness: Child Safety and Healthy Lifestyles	54.5%
Helpful, Courteous, and Respectful Office Staff	67.1%
Received Information on Evening, Weekend, or Holiday Care for Child	80.3%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	40.4%+
Saw Provider Within 15 Minutes of Appointment	39.6%
Reminders about Child's Care from Provider Office	58.7%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

RMHP: Strengths

For the RMHP child population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Parents or Caretakers* (81.0 percent)
- *Received Information on Evening, Weekend, or Holiday Care for Child* (80.3 percent)
- *How Well Providers Communicate with Child* (77.7 percent)

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the RMHP child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Saw Provider Within 15 Minutes of Appointment* (39.6 percent)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (40.4 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (54.5 percent)

HSAG recommends that RMHP develop initiatives designed to improve access to care, and timeliness and comprehensiveness of care for children.

CAHPS Survey—RMHP Prime

Table 3-10 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2016–2017 through FY 2018–2019.

Table 3-10—Adult Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2016–2017 Rate	FY 2017–2018 Rate	FY 2018–2019 Rate
Getting Needed Care	86.7%	82.5%	84.2%
Getting Care Quickly	84.6%	85.8%	82.6%
How Well Doctors Communicate	88.8%	92.2%	95.1%
Customer Service	88.2%+	88.9%+	93.8%+
Shared Decision Making	83.4%	82.7%	85.8%
Rating of Personal Doctor	55.6%	68.7%	74.4%
Rating of Specialist Seen Most Often	61.4%	64.5%	69.6%
Rating of All Health Care	48.2%	61.4%	64.3%
Rating of Health Plan	51.6%	56.5%	69.1%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

RMHP Prime: Adult Medicaid Strengths

For the RMHP Prime adult Medicaid population, three measure rates increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

For the RMHP Prime adult Medicaid population, six measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Nine measures were higher than the 2018 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, five measure rates were considered substantially higher, being more than 5 percentage points greater than the 2018 national averages:

- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of All Health Care*
- *Rating of Health Plan*

RMHP Prime: Adult Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For the RMHP Prime adult Medicaid population, no measure rates decreased substantially and no measure rates were lower than the 2018 national averages. While the *Rating of All Health Care* measure rate increased more than 5 percentage points, this measure remained RMHP Prime's lowest performing measure for the adult Medicaid population. RMHP Prime may want to explore areas that may be contributing to low experience scores for this measure and continue to develop initiatives designed to improve performance related to the *Rating of All Health Care* measure.

Table 3-11 shows the child Medicaid CAHPS results achieved by RMHP Prime for FY 2016–2017 through FY 2018–2019.

Table 3-11—Child Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2016–2017 Rate	FY 2017–2018 Rate	FY 2018–2019 Rate
Getting Needed Care	88.5%$^{+}$	89.8%$^{+}$	91.5%$^{+}$
Getting Care Quickly	95.5%$^{+}$	95.3%$^{+}$	88.4%$^{+}$
How Well Doctors Communicate	97.0%$^{+}$	96.9%$^{+}$	89.6%$^{+}$

Measure	FY 2016–2017 Rate	FY 2017–2018 Rate	FY 2018–2019 Rate
Customer Service	84.1%+	89.3%+	85.7%+
Shared Decision Making	91.7%+	92.1%+	93.2%+
Rating of Personal Doctor	80.3%+	87.5%+	71.7%+
Rating of Specialist Seen Most Often	57.5%+	74.1%+	75.0%+
Rating of All Health Care	56.1%+	63.0%+	68.8%+
Rating of Health Plan	64.7%+	68.5%+	71.4%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

RMHP Prime: Child Medicaid Strengths

For the RMHP Prime child Medicaid population, one measure rate increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of All Health Care*

For the RMHP Prime child Medicaid population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Four measures were higher than the 2017 national averages:

- *Getting Needed Care*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Of these, two measure rates were considered substantially higher, being more than 5 percentage points greater than the 2017 national averages:

- *Getting Needed Care*
- *Shared Decision Making*

RMHP Prime: Child Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For the RMHP Prime child Medicaid population, three measure rates decreased substantially between FY 2017–2018 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*

For the RMHP Prime child Medicaid population, three measure rates decreased substantially between FY 2016–2017 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*

Five measure rates were lower than the 2018 national averages:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

Of these, no measures were considered substantially lower than the 2018 national averages.

For the RMHP Prime child Medicaid population, four measure rates decreased between FY 2017–2018 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Personal Doctor*

For the RMHP Prime's child Medicaid population, three measure rates decreased substantially between FY 2017–2018 and FY 2018–2019, and five measures were lower than the 2018 national averages, with four of those rates having decreased when compared to the previous measure year. HSAG recommends that RMHP Prime focus barrier analyses on determining what may be driving decreases in these rates and develop improvement efforts to minimize further decline in rates.

ECHO Survey

Table 3-12 shows the adult ECHO survey results achieved by RMHP for FY 2018–2019.

Table 3-12—Adult ECHO Question Summary Rates and Global Proportions for RMHP

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	38.5%
Getting Treatment Quickly	65.5%+
How Well Clinicians Communicate	89.3%
Perceived Improvement	63.5%
Information About Treatment Options	63.3%
Office Wait	84.1%
Told About Medication Side Effects	73.6%+
Including Family	45.9%
Information to Manage Condition	75.9%
Patient Rights Information	92.5%
Patient Feels He or She Could Refuse Treatment	86.1%
Privacy	94.1%
Cultural Competency	NA
Amount Helped	80.5%
Improved Functioning	59.2%
Social Connectedness	72.9%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

RMHP: Strengths

For the RMHP adult population, the following three measures had the highest rates compared to the other measures' rates:

- *Patient Rights Information* (92.5 percent)
- *How Well Clinicians Communicate* (89.3 percent)
- *Patient Feels He or She Could Refuse Treatment* (86.1 percent)

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the RMHP adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (38.5 percent)
- *Including Family* (45.9 percent)
- *Improved Functioning* (59.2 percent)

HSAG recommends that RMHP explore areas that may be contributing to low experience scores for these measures and develop initiatives for improvement where appropriate.

Table 3-13 shows the child ECHO survey results achieved by RMHP for FY 2018–2019.

Table 3-13—Child ECHO Question Summary Rates and Global Proportions for RMHP

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	47.4%
Getting Treatment Quickly	71.6%+
How Well Clinicians Communicate	85.7%
Perceived Improvement	70.9%
Information About Treatment Options	69.2%
Office Wait	84.1%
Told About Medication Side Effects	83.3%+
Information to Manage Condition	68.8%
Patient Rights Information	87.1%
Respondent Feels He or She Could Refuse Treatment for Their Child	87.1%
Privacy	95.2%
Cultural Competency	NA
Amount Helped	75.3%
Improved Functioning	64.6%
Social Connectedness	85.3%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

RMHP: Strengths

For the RMHP child population, the following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (95.2 percent)
- *Patient Rights Information* (87.1 percent)
- *Respondent Feels He or She Could Refuse Treatment for Their Child* (87.1 percent)

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the RMHP child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (47.4 percent)
- *Improved Functioning* (64.6 percent)
- *Information to Manage Condition* (68.8 percent)

HSAG recommends that RMHP explore areas that may be contributing to low experience scores for these measures and develop initiatives for improvement where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

RMHP: Strengths

RMHP's questionnaire responses, documentation, and follow-up responses suggest that RMHP maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. Of note, RMHP reported using existing EDI infrastructure, and data management policies and procedures from other lines of business (e.g., RMHP Prime and CHP+).

RMHP reported configuring data management and adjudication software and systems to assess the completeness, accuracy, and timeliness of BH claims and subsequent encounter data submissions to the Department. Additionally, RMHP uses a care coordination platform to monitor members' clinical and financial outcomes. Monitoring information is shared with key internal staff members and contracted CMHCs to monitor BH programs and for rate-setting purposes.

RMHP's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. RMHP reported a 100 percent flat file acceptance rate for institutional and professional BH encounters.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

RMHP reported relatively high rejection rates for X12 837 I/P transaction files (42.5 percent and 42.4 percent for professional and institutional encounters, respectively), which did not align with the Department's reported rejection rates for these file types (59.0 percent and 35.0 percent for professional and institutional encounters, respectively). However, RMHP developed an internal system to capture rejection information (e.g., error code categories associated with rejected or denied encounters). RMHP reported regularly monitoring and reviewing rejections and discussing data rejections at biweekly meetings between the Department, the RAEs, and the CMHCs.

Based on the IS review findings, HSAG offers the following recommendations to improve RMHP's BH encounter data quality:

- RMHP reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which RMHP may enhance its encounter data oversight.
- RMHP should conduct a thorough comparative analysis between its flat file submissions and successfully submitted X12 transaction files to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on RMHP's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Encounter Data Validation—MCO 412 Audit Over-Read

FY 2018–2019 was RMHP Prime's first year participating in the independent MCO audit and subsequent over-read. HSAG's over-read results indicated complete agreement with RMHP Prime's internal audit results for 58 of the 80 sampled encounters, resulting in a 72.5 percent agreement rate. Table 3-14 shows case-level and element-level accuracy rates by service category.

Table 3-14—Percent of Cases in Total Agreement and Percent of Element Accuracy by Service Category

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	85.0	120	97.5
Outpatient	20	85.0	100	93.0
Professional	20	70.0	100	91.0
FQHC	20	50.0	100	70.0
Total	**80**	**72.5**	**420**	**88.3**

Cases in which HSAG's reviewers disagreed with RMHP Prime's audit results are divided into the following general categories:

- Cases in which HSAG's reviewers and RMHP Prime's reviewers disagreed about whether the encounter data elements were supported by the medical record.
- Cases that contained the RMHP Prime reviewer's comments stating that the medical record was insufficiently authenticated, though HSAG's reviewers disagreed. Most of these instances involved FQHC cases and RMHP Prime acknowledged that individual data elements often aligned with the encounter data but were scored negatively due to missing member identifiers throughout the medical records.

RMHP Prime provided medical record documentation for 73 of the 80 sampled over-read cases, and HSAG's over-read results were not impacted by RMHP Prime's medical record procurement.

RMHP: Strengths

Overall results from HSAG's FY 2018–2019 MCO over-read showed that HSAG's reviewers agreed with RMHP Prime's reviewers for 88.3 percent of individual audited data elements, with the highest agreement rate (97.5 percent) among inpatient cases. Additionally, RMHP Prime's 412 internal audit results show a higher level of service coding accuracy among inpatient encounter data compared to the other service categories assessed, with 90.3 percent of sampled inpatient encounters having diagnosis code documentation that supported the encounter data.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to MCO 412 Audit Over-Read

Results from HSAG's FY 2018–2019 MCO over-read suggest opportunities for RMHP Prime to improve its audit processes and encounter data quality. RMHP Prime's internal audit response file submission did not align with the file layout specified in the guidelines, and its service coding accuracy documentation regarding its audit tool was limited. Additionally, RMHP Prime's 412 internal audit results showed service coding accuracy less than 80.0 percent for all encounter data elements audited for the outpatient, professional, and FQHC service categories (i.e., the medical record documentation did not support the encounter data values).

RMHP Prime's service coding accuracy results showed a significant number of cases with procedure code data values not supported by medical record documentation, as well as variation in disagreement rates between service categories. To address encounter data deficiencies, HSAG recommends that RMHP Prime thoroughly document its encounter data processes, including implementing robust encounter data quality monitoring procedures, and ensuring contracted providers are trained to submit encounters that accurately reflect medical record documentation and services rendered.

Validation of Network Adequacy[3-1]

RMHP: Strengths

RMHP's Provider Data Structure Questionnaire responses noted that RMHP validated providers' type and specialty information against the following public data verification resources: the National Plan & Provider Enumeration System (NPPES) Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. RMHP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the RMHP data system, these individual providers were not listed on network provider rosters. RMHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contracted provider.

RMHP reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or obstetrics/gynecology (OB/GYN) specialties. RMHP also reported using a status confirmation process to identify and verify provider directory notations for providers with a PCP-like specialty who did not wish to serve as a PCP. RMHP reported conducting monthly outreach to PCPs to verify demographic, location, and panel capacity information.

[3-1] Findings in this section are applicable to both RMHP Region 1 and RMHP Prime, as the health plan's provider data systems and structure are used for both lines of business.

RMHP identified prenatal care (PNC) providers as individuals with an OB/GYN or nurse midwifery specialty, but also included selected family medicine practitioners who offer OB/GYN services.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although RMHP consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, RMHP did not restrict these data indicators by degree or credential. Additionally, RMHP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map RMHP's provider data to the Department's provider categories. RMHP's data submission reflected physician-level taxonomy codes for NPs' provider records; since these NPs had no NP taxonomy codes, HSAG was unable to assign these providers to applicable PCA categories. Finally, provider data submitted by RMHP included no records for substance abuse treatment facilities.

As the first comprehensive review of RMHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing RMHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, RMHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 2—Northeast Health Partners (NHP)

Assessment of Compliance With Medicaid Managed Care Regulations

NHP Overall Evaluation

Table 3-15 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-15—Summary of NHP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	11	10	1	0	0	91%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	14	14	0	0	5	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	8	0	0	0	100%
Totals	**45**	**40**	**39**	**1**	**0**	**5**	**98%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

NHP: Strengths

NHP's *Care Coordination* policy described a comprehensive care coordination program, including principles, processes, and overall organization. The policy described processes for member care coordination and addressed all care coordination requirements within the RAE contract. NHP's stratification methodology identified members with high-risk, high-cost, and complex care coordination needs. NHP provides care coordination activities for all members through five delegated entities known as Accountable Care Coordination Entities (Accountable CC entities), which include all FQHCs in the region and North Colorado Health Alliance. NHP's call center and Accountable CC entity care coordinators assisted members individually with choosing a BH provider and/or changing their designated PCMP, while also providing the contact information for those providers, and with a designated care coordinator's phone number. NHP had processes to ensure that care coordinators performed member needs assessments for each member and developed individual care plans, as

appropriate, based on each member's needs and goals and to ensure that the care coordinator's assessments were shared with other providers involved in the member's care, including BH providers. Interventions for members with more complex needs included a face-to-face visit between the care coordinator and member. A unique collaborative care coordination environment existed throughout Region 2 between the health neighborhood agencies and community organizations, which played a significant role in care coordination. NHP used Beacon Health Options' (Beacon's) Connect 4 Care care coordination system to collect and communicate some of the required components of the care coordination tool to the delegated Accountable CC entities; however, each Accountable CC entity maintained its own electronic care coordination system to complete care coordination documentation for each member. Accountable CC entities enabled seamless care coordination of PH and BH services through a variety of mechanisms, including embedding BH care coordinators in PCMP locations; providing BH providers with direct access to the PCMP's electronic health record (EHR); and maintaining communication with BH providers involved in the member's care.

Beacon, NHP's administrative services organization (ASO), maintained policies and procedures related to member rights and protections. The Beacon *Member Rights and Responsibilities* policy clearly outlined the intent to protect member rights afforded under 42 CFR §438.100. Beacon maintained additional polices to address anti-discrimination, advance directives, and privacy and confidentiality guaranteed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NHP had numerous processes designed to ensure members and providers are aware of members' rights and that members are allowed to exercise those rights without fear of retaliation. Staff, members, and providers received training and communication about these rights via in-person and webinar trainings, town hall meetings, Member Experience Advisory Council (MEAC) meetings, and the NHP website.

NHP created multiple mechanisms to assist members with understanding the benefits and services available to them. NHP had processes for testing member materials for sixth grade readability and to ensure that specific documents available electronically on NHP's website comply with Section 508 guidelines. NHP also used a texting campaign to send welcome messages and care reminders to members. NHP offered language line assistance for translation and provided materials in other formats when needed. NHP's provider directory included most required information about providers, including information about providers' cultural competency training and accommodations for members with physical disabilities, as available.

The *EPSDT* policy and procedures addressed the provision of EPSDT services for members 20 years old and younger, including requirements for providers to ensure that members receive well-child screening services through the PCMP and that BH practitioners provided mental health diagnostic and treatment services for EPSDT-eligible members when deemed appropriate. The NHP provider handbook outlined detailed information on EPSDT benefits and services, described assistance available through the Healthy Communities (HC) program, and referred providers to the Health First Colorado website to obtain additional information. NHP's clinical record audit tools included documentation of EPSDT-related services and requirements for members ages 20 and under. Members were informed of EPSDT benefits through the NHP website and various member "touchpoints" such as Department of Human Services (DHS) child welfare staff members; care coordinators; Healthy Communities (HC) family health coordinators; PCMPs; CMHCs; and the Weld County Women, Infants, and Children's (WIC) program.

Policies and procedures outlined the complete and accurate listing of EPSDT medical necessity criteria, and utilization management (UM) staff members arranged for provision of vocational services, clubhouse and drop-in centers, intensive case management, residential care, respite services, and other capitated or waiver-paid BH benefits as needed. Numerous NHP staff members assisted members and providers with overcoming barriers to accessing EPSDT-related benefits. NHP care coordinator teams had established alliances with State and county agencies and community organizations in local areas of the region to enable EPSDT-related referrals for individual members. NHP had executed one unified written agreement with the three Healthy Communities programs in the region. NHP demonstrated overall vigilance by providers, care coordinators, support staff members, and local agencies and organizations for the provision of EPSDT benefits and services for members.

NHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Standard III—Coordination and Continuity of Care

NHP demonstrated having adequate policies and procedures, monitoring tools, and communications to providers regarding requirements for maintaining member health records and for maintaining confidentiality and security of members' health records, as well as processes for sharing members' needs assessments among providers. NHP, however, provided no documents that clearly communicated expectations that all providers share member medical records with other providers or organizations directly involved with the member's care. NHP was required to:

- Enhance provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.

Validation of Performance Improvement Projects

NHP: Accountable Care PIP

Table 3-16 displays the FY 2018–2019 validation findings for NHP's *Increasing Well Checks for Members 21–64 Years of Age* PIP.

Table 3-16—Validation Findings for *Increasing Well-Checks for Members 21–64 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Male members, 21–64 years of age who are attributed to Weld County Public Health and Environment.
SMART Aim Statement	By 6/30/2020, increase the percentage of well checks that are received among males ages 21–64, from 31.26 percent to 34.36 percent at Weld County Public Health and Environment.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	Percentage of adult males ages 21–64 at Weld County Public Health and Environment who have received an annual well check during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly, based on a rolling 12-month measurement period.

NHP: Strengths

NHP selected an accountable care PIP topic focused on increasing the rate of well-care visits among male members 21 to 64 years of age. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that NHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. NHP has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, NHP will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As NHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on

impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results. The intended effect of the intervention should be determined before testing begins to ensure a sound data collection plan for the intervention evaluation.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

NHP: Behavioral Health PIP

Table 3-17 displays the FY 2018–2019 validation findings for NHP's *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP.

Table 3-17—Validation Findings for *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Module 1—PIP Initiation	
Narrowed Focus Population*	*Not yet determined.* The health plan will provide the narrowed focus in October 2019 when 12 months of baseline data have been collected and analyzed for narrowed focus selection.
SMART Aim Statement*	By 6/30/2020 increase the percentage of members AGE Group TBD who receive a mental health services in a physical or mental health care setting within 30 days of a positive depression screening at TBD PROVIDER (from TBD% to TBD%).
Module 2—SMART Aim Data Collection	
SMART Aim Measure*	Percentage of members AGE GROUP TBD who received a positive depression screening at PROVIDER TBD and then received a mental health service in a primary care or mental health care setting within 30 days of the positive depression screen during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly, based on a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

**The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

NHP: Strengths

NHP selected a BH PIP topic focused on increasing the percentage of members who received follow-up mental health services within 30 days of screening positive for depression. The RAE designed a methodologically sound project and achieved a *Conditional Pass* on Module 1 and Module 2, achieving all validation criteria that did not require 12 months of historical data.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

NHP will have the opportunity to update Module 1 and Module 2 after 12 months of baseline data have been collected for the PIP. At that time, the RAE will set a goal for improvement in relation to the baseline rate. Additionally, in the next phase of the BH PIP, NHP will have the opportunity to analyze existing processes related to its *Increasing Mental Healthcare Services After a Positive Depression Screening* rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As NHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Set a SMART Aim goal that represents real improvement over the baseline rate and is attainable within the time frame defined by the SMART Aim end date.
- Design a SMART Aim data collection methodology that is comparable to the baseline data collection methodology and supports the rapid-cycle process.
- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey

Table 3-18 shows the adult PCMH CAHPS results achieved by NHP for FY 2018–2019.

Table 3-18—Adult PCMH CAHPS Question Summary Rates and Global Proportions for NHP

Measure	FY 2018–2019 Rate
Rating of Provider	72.1%
Rating of Specialist Seen Most Often	69.7%
Rating of All Health Care	64.3%
Rating of Health Plan	64.4%
Getting Timely Appointments, Care, and Information	58.8%
How Well Providers Communicate with Patients	79.2%
Providers' Use of Information to Coordinate Patient Care	67.0%
Talking with You About Taking Care of Your Own Health	47.1%
Comprehensiveness	54.9%
Helpful, Courteous, and Respectful Office Staff	74.3%
Health First Colorado Customer Service	59.7%+
Received Care from Provider Office During Evenings, Weekends, or Holidays	24.7%+
Reminders about Care from Provider Office	63.1%
Saw Provider Within 15 Minutes of Appointment	52.7%
Received Health Care and Mental Health Care at Same Place	54.5%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

NHP: Strengths

For the NHP adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (79.2 percent)
- *Helpful, Courteous, and Respectful Office Staff* (74.3 percent)
- *Rating of Provider* (72.1 percent)

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the NHP adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (24.7 percent)
- *Talking with You About Taking Care of Your Own Health* (47.1 percent)
- *Saw Provider Within 15 Minutes of Appointment* (52.7 percent)

HSAG recommends that NHP develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that NHP explore areas that may be contributing to low experience scores for the *Talking with You About Taking Care of Your Own Health* measure and develop initiatives designed to improve the score for this measure.

Table 3-19 shows the child PCMH CAHPS results achieved by NHP for FY 2018–2019.

Table 3-19—Child PCMH CAHPS Question Summary Rates and Global Proportions for NHP

Measure	FY 2018–2019 Rate
Rating of Provider	83.3%
Rating of Specialist Seen Most Often	76.4%+
Rating of All Health Care	75.8%
How Well Providers Communicate with Child	79.0%+
Getting Timely Appointments, Care, and Information	73.7%+
How Well Providers Communicate with Parents or Caretakers	84.1%
Providers' Use of Information to Coordinate Patient Care	80.0%+
Comprehensiveness: Child Development	68.3%
Comprehensiveness: Child Safety and Healthy Lifestyles	59.3%
Helpful, Courteous, and Respectful Office Staff	70.3%
Received Information on Evening, Weekend, or Holiday Care for Child	70.1%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	20.9%+
Saw Provider Within 15 Minutes of Appointment	48.1%
Reminders about Child's Care from Provider Office	54.7%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

NHP: Strengths

For the NHP child population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Parents or Caretakers* (84.1 percent)
- *Rating of Provider* (83.3 percent)
- *Providers' Use of Information to Coordinate Patient Care* (80.0 percent)

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the NHP child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (20.9 percent)
- *Saw Provider Within 15 Minutes of Appointment* (48.1 percent)
- *Reminders about Child's Care from Provider Office* (54.7 percent)

HSAG recommends that NHP develop initiatives designed to improve access and timeliness of services provided.

ECHO Survey

Table 3-20 shows the adult ECHO survey results achieved by NHP for FY 2018–2019.

Table 3-20—Adult ECHO Question Summary Rates and Global Proportions for NHP

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	56.1%
Getting Treatment Quickly	70.9%+
How Well Clinicians Communicate	87.6%
Perceived Improvement	59.4%
Information About Treatment Options	59.6%
Office Wait	80.7%
Told About Medication Side Effects	78.9%+
Including Family	44.4%
Information to Manage Condition	76.9%
Patient Rights Information	86.8%

Measure	FY 2018–2019 Rate
Patient Feels He or She Could Refuse Treatment	83.7%
Privacy	87.9%
Cultural Competency	NA
Amount Helped	78.7%
Improved Functioning	52.5%
Social Connectedness	60.0%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

NHP: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (87.9 percent)
- *How Well Clinicians Communicate* (87.6 percent)
- *Patient Rights Information* (86.8 percent)

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the NHP adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (44.4 percent)
- *Improved Functioning* (52.5 percent)
- *Rating of All Counseling or Treatment* (56.1 percent)

HSAG recommends that NHP work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-21 shows the child ECHO survey results achieved by NHP for FY 2018–2019.

Table 3-21—Child ECHO Question Summary Rates and Global Proportions for NHP

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	51.0%
Getting Treatment Quickly	68.6%+
How Well Clinicians Communicate	87.9%
Perceived Improvement	67.3%
Information About Treatment Options	70.7%
Office Wait	83.8%
Told About Medication Side Effects	88.9%+
Information to Manage Condition	70.9%
Patient Rights Information	89.5%
Respondent Feels He or She Could Refuse Treatment for Their Child	85.3%
Privacy	96.9%
Cultural Competency	NA
Amount Helped	75.7%
Improved Functioning	62.5%
Social Connectedness	81.0%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

NHP: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (96.9 percent)
- *Patient Rights Information* (89.5 percent)
- *Told About Medication Side Effects* (88.9 percent)

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the NHP child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (51.0 percent)
- *Improved Functioning* (62.5 percent)
- *Perceived Improvement* (67.3 percent)

HSAG recommends that NHP work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

NHP: Strengths

NHP's questionnaire responses, documentation, and follow-up responses suggest that NHP maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. NHP delegates network management responsibilities to Beacon; though Beacon submitted X12 transaction files for BH encounters during ACC Phase I, Beacon initiated a 30 percent reconfiguration of the software historically used to produce X12 transaction files in response to the Department's Medicaid Management Information System (MMIS) business edits for X12 transaction files. NHP reported that, as of March 2019, Beacon created an extract, transform, load (ETL) program to identify and document encounter response file rejection information received from the Department's EDI vendor, DXC; rejection information review is ongoing, and Beacon's final development of BH encounter data policies and procedures is contingent on its resolution.

NHP reported that Beacon uses Edifecs to assess providers' claims and encounter submissions for completeness, accuracy, and timeliness, and produces error logs to facilitate the CMHCs' record corrections and file resubmission. Monthly report cards are generated and submitted for review of data quality issues by key internal staff members, as well as contracted CMHCs' information technology (IT) divisions. NHP provided an example of a monthly report card to supplement its IS review questionnaire responses.

NHP's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Consequently, NHP reported no issues with BH encounter flat file submission, though it did not provide an exact flat file rejection rate.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

NHP's ASO, Beacon, required contracted CMHCs to modify their EHR systems to produce flat files to meet the Department's specifications, though independent providers are allowed to submit claims in 837 I/P transaction files. As the X12 transaction file format is the Department's defined format for BH encounter record submission, NHP indicated that it is working to develop a data infrastructure that will permit submission of 837 I/P transaction files for claims from all providers, allowing data review and adjudication processes to be streamlined regardless of data source. NHP's survey responses indicated that Beacon employs separate processes to create X12 transaction files for claims data from individual providers and encounter data from CMHCs. Though encounters of all statuses (e.g., paid and denied) are produced from independent providers' claims, CMHC encounters are limited to paid encounters; denied encounters from CMHCs are not included in X12 transaction file submissions to the Department.

NHP reported moderate rejection rates for X12 837 I/P transaction files (30.0 percent each for professional and institutional encounters), though the Department reported higher rejection rates for NHP's encounter files (95.0 percent and 56.0 percent for professional and institutional encounters, respectively). In addition to compliance issues with FFS-based business rules and provider information discrepancies, NHP indicated that the rejection of split encounters contributed to X12 transaction file rejection.

As of the March 2019 questionnaire responses, NHP indicated that Beacon was not submitting X12 transaction files to the Department due to issues occurring during two test submissions. Though NHP participates in regular meetings with the Department and its EDI vendor, NHP reported an ongoing process through which adjudication and processing software is being reconfigured to meet the Department's encounter submission specifications. NHP also indicated that it has notified the Department and DXC of X12 file rejections based on submission specifications that conflict with other compliance documentation.

Based on the IS review findings, HSAG offers the following recommendations to improve NHP's BH encounter data quality:

- NHP reported that it includes no zero payment encounters from sub-capitated providers or denied encounters from CMHCs in its encounter data submissions to the Department. NHP should work with the Department to determine whether these practices are consistent with encounter data submission standards.
- NHP reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which NHP may enhance its encounter data oversight.
- NHP should conduct a thorough comparative analysis between its flat file submissions and successfully submitted X12 transaction files to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on NHP's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Validation of Network Adequacy

NHP: Strengths

NHP's Provider Data Structure Questionnaire responses noted that NHP validated providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. NHP reported permitting single case agreements only for BH providers. NHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contracted provider.

NHP reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties. NHP also reported limiting EPSDT providers to BH professionals. NHP reported conducting monthly outreach to PCPs to verify demographic, location, and panel capacity information.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although NHP consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, NHP did not restrict these data indicators by degree or credential.

NHP's provider data extract for the study contained several limitations, suggesting the data did not accurately reflect NHP's provider network. For example, data included similar, but not identical, data values for the provider type field, complicating HSAG's efforts to map NHP's provider data to the Department's provider categories. Further, NHP classified PH and BH providers using a "Practitioner" type value, while other health plans offered separate provider type values for physicians, osteopaths, and NPs. NHP also listed no attribute values for providers groups or practices, indicating that group-level provider records, if available, may be identified using other database elements. Finally, NHP submitted data with only provider type values of "Primary Care," "Physician Assistants/Nurse Practitioners," or "Pediatrics," and did not include data values for providers' specialty, degree, or taxonomy code(s). Based on the Department's approved provider category definitions, HSAG was unable to assign these providers to any provider categories for the PCA.

As the first comprehensive review of NHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing NHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, NHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 3—Colorado Access (COA)

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 3 Overall Evaluation

Table 3-22 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-22—Summary of COA Region 3 Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	12	11	11	0	0	1	100%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	17	16	1	0	2	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**46**	**43**	**41**	**2**	**0**	**3**	**95%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

COA Region 3: Strengths

COA's *Care Coordination* policy addressed all care coordination program requirements applicable to members with high-risk or complex needs. Care coordination teams were organized according to areas of expertise—behavioral health, physical health, criminal justice, long-term care, community-based (social support), pediatric care, and adolescent care. COA care coordinators were also embedded in select facilities within the region and transition of care teams were aligned with specific hospital facilities. The COA provider manual described that the PCMP was responsible for coordinating care and making referrals for each member. PCMPs could refer members with higher-level coordination of care needs to COA's care management program. In addition, COA had designated 15 PCMP entities as enhanced clinical partners (ECPs) that were responsible for providing a more intensive level of care coordination for members within its practice. COA adopted the four-quadrant model for stratifying members into care coordination intervention categories and was developing data-driven stratification to

assign each member to a risk quadrant. COA care navigators telephonically outreached to members assigned to lower risk categories, while members identified as high risk received an individualized comprehensive needs assessment and care plan. Facility-based care managers conducted face-to-face meetings with members transitioning from acute-care facilities. All care coordination activities—e.g., assessments, care plans, and interventions—were documented in COA's Altruista Guiding Care system, which met all required elements of an electronic care coordination tool. Care coordinators shared the results of assessments and planned interventions with other entities involved with the members' care and facilitated exchange of information among providers.

COA maintained policies and procedures that addressed member rights and responsibilities articulated in 42 CFR §438.100 as well as other applicable laws and regulations pertaining to member rights including anti-discrimination, equal access for members with disabilities, advance directives, and privacy and confidentiality assured under HIPAA. COA's policies and procedures described processes to ensure that member materials were easily understood and readily accessible. Members, providers, and staff members were informed about these policies through staff and provider training, member newsletters, topic-specific mailings, and the Member Advisory Council. COA conducted ongoing auditing and monitoring to identify any compliance issues that may have an impact on member rights and to address and mitigate issues, if needed.

COA maintained a robust process for testing and ensuring member materials available in paper and electronic format were easy to understand and complied with Section 508 guidelines. COA's Member Advisory Council reviewed member materials prior to publication. COA's new member packet, annual member mailings, and information available on COA's website were clear and designed to help members understand the requirements and benefits offered under the State plan. Topic-specific written communications and interactive voice response (IVR) calls also assisted members in understanding preventive and routine services available. COA demonstrated an effective process for providing members with language line assistance for translation, while also providing materials in other languages and formats when needed, which included Braille and audio formats. COA's website included all required information either through direct description or through links to pages within the website or links to the State's website. The RAE provider directory included the required information about providers, including cultural competency training and disability access. COA has plans to enhance the provider directory with more robust details related to the type of disability access offered.

COA provided information about EPSDT benefits and services, including specific BH services to members via the member website and provided links to the *Health First Colorado Member Handbook*, the Department's EPSDT fact sheet, a training video for parents, and a list of COA care management contact numbers. The *EPSDT* policy stated that providers were informed of the EPSDT program through the provider manual, in which the "Behavioral Health Policies and Standards" listed the services available through EPSDT. Providers were also informed about EPSDT updates via newsletters and quarterly forums. The *EPSDT* policy and the provider manual stated that COA care coordination services were available to assist providers in resolving barriers related to EPSDT benefits and also referred providers to the Healthy Communities program. COA care coordination staff members included EPSDT subject-matter experts. COA and the Tri-County Health Department (TCHD) had created an MOU and scope of work (SOW) to document the commitment of both organizations to work together in

developing an onboarding plan for newly enrolled Medicaid members. Prior to completion of the onboarding plan, COA continued to refer members and providers to the Healthy Communities program for assistance in accessing EPSDT-related services.

COA *Region 3: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations*

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections.

Standard V—Member Information

While COA's website included clear and concise information about required website elements, the section of the website that addressed filing and processing appeals contained outdated information. COA Region 3 was required to:

- Ensure that information on its website includes updated and correct information regarding appeals procedures.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

The MOU between the TCHD Healthy Communities program and COA and the associated SOW outlined an agreement for COA and the Tri-County Healthy Communities contractor to participate in an up to two-year formal planning process that would result in a collaborative onboarding plan for children and families receiving Medicaid. COA had not yet completed the onboarding plan in partnership with Healthy Communities. COA Region 3 was required to:

- Expedite the planning and implementation process with the Tri-County Healthy Communities contractor to create an annual plan for onboarding children and families.

Validation of Performance Improvement Projects

COA Region 3: Accountable Care PIP

Table 3-23 displays the FY 2018–2019 validation findings for COA's *Well-Child Visits for Members 10–14 Years of Age* PIP.

Table 3-23—Validation Findings for *Well-Child Visits for Members 10–14 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 10 through 14 years of age attributed to Metro Community Provider Network (MCPN).
SMART Aim Statement	By June 30, 2020, increase the percentage of well child visits among members 10–14 years of age attributed to MCPN, from 33.44% to 38.44%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 10 through 14 years of age attributed to MCPN during the rolling 12-month measurement period who received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

COA Region 3: Strengths

COA selected an accountable care PIP topic focused on increasing the rate of well-child visits among members 10 through 14 years of age. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, COA will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

COA Region 3: Behavioral Health PIP

Table 3-24 displays the FY 2018–2019 validation findings for COA's *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP.

Table 3-24—Validation Findings for *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 10 through 14 years of age with a positive depression screening received in a primary care setting.
SMART Aim Statement	By June 30, 2020, increase the percentage of members with a positive depression screen who received at least one follow-up service within 30 days among Members 10–14 years of age, from 0.82% to 5.00%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 10 through 14 years of age with a positive depression screen in a primary care setting who received at least one follow-up behavioral health service during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

COA Region 3: Strengths

COA selected a BH PIP topic focused on increasing the percentage of members 10 through 14 years of age who received follow-up mental health services within 30 days of screening positive for depression. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

In the next phase of the BH PIP, COA will have the opportunity to analyze existing processes related to improving the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening* rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey

Table 3-25 shows the adult PCMH CAHPS results achieved by COA Region 3 for FY 2018–2019.

Table 3-25—Adult PCMH CAHPS Question Summary Rates and Global Proportions for COA Region 3

Measure	FY 2018–2019 Rate
Rating of Provider	62.5%
Rating of Specialist Seen Most Often	68.6%
Rating of All Health Care	59.8%
Rating of Health Plan	61.5%
Getting Timely Appointments, Care, and Information	44.9%
How Well Providers Communicate with Patients	73.4%
Providers' Use of Information to Coordinate Patient Care	62.6%
Talking with You About Taking Care of Your Own Health	49.8%
Comprehensiveness	54.4%
Helpful, Courteous, and Respectful Office Staff	64.9%

Measure	FY 2018–2019 Rate
Health First Colorado Customer Service	61.8%
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.8%
Reminders about Care from Provider Office	70.7%
Saw Provider Within 15 Minutes of Appointment	40.9%
Received Health Care and Mental Health Care at Same Place	58.0%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

COA Region 3: Strengths

For the COA adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (73.4 percent)
- *Reminders about Care from Provider Office* (70.7 percent)
- *Rating of Specialist Seen Most Often* (68.6 percent)

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the COA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (23.8 percent)
- *Saw Provider Within 15 Minutes of Appointment* (40.9 percent)
- *Getting Timely Appointments, Care, and Information* (44.9 percent)

Table 3-26 shows the child PCMH CAHPS results achieved by COA Region 3 for FY 2018–2019.

Table 3-26—Child PCMH CAHPS Question Summary Rates and Global Proportions for COA Region 3

Measure	FY 2018–2019 Rate
Rating of Provider	74.9%
Rating of Specialist Seen Most Often	77.2%
Rating of All Health Care	74.1%
How Well Providers Communicate with Child	80.0%
Getting Timely Appointments, Care, and Information	68.4%
How Well Providers Communicate with Parents or Caretakers	81.7%
Providers' Use of Information to Coordinate Patient Care	73.9%

Measure	FY 2018–2019 Rate
Comprehensiveness: Child Development	66.8%
Comprehensiveness: Child Safety and Healthy Lifestyles	59.6%
Helpful, Courteous, and Respectful Office Staff	66.2%
Received Information on Evening, Weekend, or Holiday Care for Child	80.9%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	25.9%+
Saw Provider Within 15 Minutes of Appointment	41.4%
Reminders about Child's Care from Provider Office	69.1%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

COA Region 3: Strengths

For the COA child population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Parents or Caretakers* (81.7 percent)
- *Received Information on Evening, Weekend, or Holiday Care for Child* (80.9 percent)
- *How Well Providers Communicate with Child* (80.0 percent)

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the COA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (25.9 percent)
- *Saw Provider Within 15 Minutes of Appointment* (41.4 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (59.6 percent)

HSAG recommends that COA develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that COA explore areas that may be contributing to low experience scores for the *Comprehensiveness: Child Safety and Healthy Lifestyles* measure for children and develop initiatives designed to improve the score for this measure.

ECHO Survey

Table 3-27 shows the adult ECHO survey results achieved by COA Region 3 for FY 2018–2019.

Table 3-27—Adult ECHO Question Summary Rates and Global Proportions for COA Region 3

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	50.7%
Getting Treatment Quickly	62.7%
How Well Clinicians Communicate	86.7%
Perceived Improvement	54.3%
Information About Treatment Options	55.4%
Office Wait	80.0%
Told About Medication Side Effects	76.5%
Including Family	44.5%
Information to Manage Condition	78.3%
Patient Rights Information	88.5%
Patient Feels He or She Could Refuse Treatment	82.3%
Privacy	91.6%
Cultural Competency	NA
Amount Helped	79.5%
Improved Functioning	53.8%
Social Connectedness	63.6%

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

COA Region 3: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (91.6 percent)
- *Patient Rights Information* (88.5 percent)
- *How Well Clinicians Communicate* (86.7 percent)

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the COA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (44.5 percent)
- *Rating of All Counseling or Treatment* (50.7 percent)
- *Improved Functioning* (53.8 percent)

HSAG recommends that COA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-28 shows the child ECHO survey results achieved by COA Region 3 for FY 2018–2019.

Table 3-28—Child ECHO Question Summary Rates and Global Proportions for COA Region 3

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	43.7%
Getting Treatment Quickly	68.6%+
How Well Clinicians Communicate	87.6%
Perceived Improvement	73.4%
Information About Treatment Options	74.1%
Office Wait	84.2%
Told About Medication Side Effects	85.1%+
Information to Manage Condition	70.1%
Patient Rights Information	86.5%
Respondent Feels He or She Could Refuse Treatment for Their Child	79.8%
Privacy	90.1%
Cultural Competency	NA
Amount Helped	78.8%
Improved Functioning	62.4%
Social Connectedness	83.7%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

COA Region 3: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (90.1 percent)
- *How Well Clinicians Communicate* (87.6 percent)
- *Patient Rights Information* (86.5 percent)

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the COA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (43.7 percent)
- *Improved Functioning* (62.4 percent)
- *Getting Treatment Quickly* (68.6 percent)

HSAG recommends that COA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

COA Region 3: Strengths

COA's questionnaire responses, documentation, and follow-up responses suggest that COA maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. Of note, COA was a BHO during ACC Phase I and reported that it uses existing EDI infrastructure and data management policies and procedures from other lines of business (e.g., CHP+) to produce BH encounter data files for both legacy flat file and X12 submissions to the Department.

COA reported using a claims and encounter data dashboard system that produces daily inventory reports containing claims transaction volume, adjudication status, list errors, and issues associated with pended claims and encounters, as well as the resolution status for pended records. COA supplemented its questionnaire responses with a sample daily inventory report and noted that it uses dashboard information for rate setting and performance data reporting.

COA's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Consequently, COA reported no issues with BH encounter flat file submission, though it did not provide an exact flat file rejection rate.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

COA reported relatively high rejection rates for X12 837 I/P transaction files (70.0 percent each for institutional and professional encounters), though the Department reported rejection rates of 90.0 percent for professional encounter files and 41.0 percent for institutional encounter files. Both COA and the Department indicated that compliance with FFS-based business rules and provider information discrepancies contributed to X12 transaction file rejections.

As of the March 2019 questionnaire responses, COA indicated that it was not submitting X12 transaction files to the Department due to issues occurring during September 2018 test submissions. Though COA participates in regular meetings with the Department and its EDI vendor, COA reported no modifications to its existing data management and processing policies, nor did COA supply any documentation to indicate that encounter data process changes were in progress as of the March 2019 IS review questionnaire responses.

Based on the IS review findings, HSAG offers the following recommendations to improve COA's BH encounter data quality:

- COA reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which COA may enhance its encounter data oversight.
- While COA reported submitting no X12 transaction files to the Department as of March 2019, COA should conduct a thorough comparative analysis between its flat file submissions and any successfully submitted X12 transaction files since that time to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on COA's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Validation of Network Adequacy

COA Region 3: Strengths

COA's Provider Data Structure Questionnaire responses noted that COA updates its provider data using the providers' triennial recredentialing information. COA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contract provider. COA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

COA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify providers into applicable BH provider categories.

COA identified PNC providers as individuals with an OB/GYN or nurse midwifery specialties, but also included selected family medicine practitioners who offer OB/GYN services.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. COA also did not indicate that it uses the NPPES Registry, the American Board of Medical Specialties board certification database, or the providers' CHCP applications to validate providers' type and specialty information.

Although COA consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, COA did not restrict these data indicators by degree or credential. Further, COA reported that it does not collect providers' taxonomy codes and COA's data included similar, but not identical, data values for the provider type and specialty fields. These factors complicated HSAG's efforts to map COA's provider data to the Department's provider categories.

As the first comprehensive review of COA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing COA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, COA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 4—Health Colorado, Inc. (HCI)

Assessment of Compliance With Medicaid Managed Care Regulations

HCI Overall Evaluation

Table 3-29 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-29—Summary of HCI Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	11	9	2	0	0	82%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	14	14	0	0	5	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**45**	**40**	**37**	**3**	**0**	**5**	**93%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

HCI: Strengths

HCI provided care coordination activities to all members through seven delegated Accountable Care Coordination (CC) entities. HCI's *Care Coordination Plan* presented an overview of HCI's comprehensive care coordination program, principals, processes, and overall organization. HCI's *Care Coordination* policy outlined processes for member care coordination and addressed all care coordination requirements of the RAE contract. The *Primary Care Medical Provider (PCMP) Agreement*—executed with each Accountable CC entity—designated the Accountable CC entity as the primary care case manager and delegated responsibility for care coordination requirements articulated in the RAE's contract with the State. The delegated Accountable CC entities also provided care coordination for members attributed to those PCMPs who were assessed as unable to fulfill the comprehensive care coordination requirements for members with complex needs. HCI had developed a comprehensive care coordination audit tool for assessing each delegated care coordination entity's

compliance with delegated care coordination requirements. HCI's stratification methodology identified members with high-risk, high-cost, or complex care coordination needs. HCI's call center assigned requesting members to a BH provider and members were given the contact information for those assigned providers. HCI also had a process to provide members a single point of contact for care coordination activities with a phone number for that designated care coordinator. HCI had processes to ensure that care coordinators performed member needs assessments on all members and individual care plans were developed according to each member's needs and goals. Processes included sharing member care coordinator's assessments with other providers involved in the member's care, including BH providers. Care plans described provider interventions and face-to-face visits were employed for more complex care coordination interventions when needed. Complex care coordination activities included arranging for and maintaining communications with diverse clinical providers and making appropriate arrangements with various agencies and community services, based on members' needs. Beacon used the Connect 4 Care care coordination documentation system to collect and communicate some of the required components of care coordination to the delegated Accountable CC entities; however, each Accountable CC entity maintained its own electronic care coordination system to complete care coordination documentation for each member. Accountable CC entities enabled seamless care coordination of PH and BH services through a variety of mechanisms, including embedding BH care coordinators in PCMP locations; providing BH providers with direct access to the PCMP's EHR; and maintaining communication with BH providers involved in the member's care.

Beacon, HCI's ASO, maintained the policies and procedures related to member rights and protections for HCI. The Beacon *Member Rights and Responsibilities* policy clearly outlined the intent to protect member rights afforded under 42 CFR §438.100. Beacon maintained additional polices to address anti-discrimination, advance directives, and privacy and confidentiality guaranteed under HIPAA. HCI has designed numerous processes to ensure members and providers were aware of members' rights and that members were allowed to exercise those rights. Staff, members, and providers received training and communication about these rights via in-person and webinar trainings, town hall meetings, MEAC meetings, and the HCI website.

HCI had multiple mechanisms to assist members with understanding the benefits and services available to them. HCI had processes for testing member materials for sixth grade readability and to ensure that specific documents available electronically on HCI's website comply with Section 508 guidelines. HCI also used a texting campaign to send welcome messages and care reminders. HCI offered language line assistance for translation and provided materials in other formats when needed. HCI's provider directory included most required information about providers, including information about providers' cultural competency training and accommodations for members with physical disabilities, as available.

The *EPSDT* policy and procedures addressed the provision of EPSDT services for members 20 years old and younger, including requirements for BH providers to communicate with members about well-child screening services and refer members to the PCMP when necessary. Procedures also required BH practitioners to provide mental health diagnostic and treatment services for EPSDT-eligible members when appropriate. The HCI provider handbook outlined detailed information on EPSDT benefits and services, informed about assistance available through the Healthy Communities program, and referred providers to Health First Colorado to obtain additional information. HCI's clinical record audit tools

included assessment of documentation in the member's medical record regarding EPSDT-related services. Members were informed of EPSDT benefits through the HCI website. UM policies and procedures outlined the complete and accurate listing of EPSDT medical necessity criteria and UM staff members arranged for provision of vocational services, clubhouse and drop-in center services, intensive case management, residential care, respite services, and other capitated or waiver BH benefits as needed. Numerous HCI staff members assisted members and providers with overcoming barriers to accessing EPSDT-related benefits. HCI care coordinator teams had established alliances with State and county agencies and community organizations in local areas of the region to enable EPSDT-related referrals for individual members. HCI was engaged in active discussions with Healthy Communities contractors throughout the region to complete the process of developing an onboarding plan for Medicaid members and families. HCI demonstrated overall vigilance by providers, care coordinators, support staff members, and local agencies and organizations for the provision of EPSDT benefits and services for members.

HCI: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections and Standard V—Member Information.

Standard III—Coordination and Continuity of Care

Each delegated Accountable CC entity operated an independent electronic care coordination documentation system. HCI's PCMP Full Accountable Agreement did not specify the elements required to be included in the delegate's electronic care coordination tool. In addition, the pre-delegation assessment tool did not reflect HCI's review of each delegate's care coordination tool to verify inclusion of the minimum required elements. HCI demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining member health records and for maintaining confidentiality and security of members' health records, as well as for sharing members' needs assessments among providers. HCI, however, provided no documents that clearly communicated expectations that all providers share member medical records with other providers or organizations directly involved with the member's care. HCI was required to:

- Implement mechanisms to ensure that the electronic care coordination tool used by each Accountable CC entity includes the minimum required elements outlined in the RAE contract with the State.
- Enhance provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Although HCI was actively engaged in discussions with four of the five Healthy Communities contractors in the region and had developed a template MOU and business associate agreement (BAA), HCI had not fully executed an onboarding plan with each HC contractor in the region. HCI was required to:

- Complete the process of developing and executing an onboarding plan with each Healthy Communities contractor in the region.

Validation of Performance Improvement Projects

HCI: Accountable Care PIP

Table 3-30 displays the FY 2018–2019 validation findings for HCI's *Increasing Well Checks for Members 21–64 Years of Age* PIP.

Table 3-30—Validation Findings for the *Increasing Well Checks for Members 21–64 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Male members, 21–64 years of age who are attributed to Castillo Primary Care.
SMART Aim Statement	By 6/30/2020, Increase Well Checks for adult male (ages 21–64) members from 32.33 percent to 37.33 percent at Castillo Primary Care.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	Percentage of male members ages 21–64 who received an annual well check at Castillo Primary Care during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly based on a rolling 12-month measurement period.

HCI: Strengths

HCI selected an accountable care PIP topic focused on increasing the rate of well visits among male members 21 to 64 years of age. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that HCI designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. HCI has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, HCI will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As HCI continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

HCI: Behavioral Health PIP

Table 3-31 displays the FY 2018–2019 validation findings for HCI's *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP.

Table 3-31—Validation Findings for the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Module 1—PIP Initiation	
Narrowed Focus Population*	*Not yet determined.* In October 2019, when 12 months of baseline data have been collected and analyzed for narrowed focus selection, the health plan will provide the narrowed focus.
SMART Aim Statement*	By 6/30/2020 increase the percentage of members AGE Group TBD who receive a mental health services in a physical or mental health care setting within 30 days of a positive depression screening at TBD PROVIDER (from TBD% to TBD%).
Module 2—SMART Aim Data Collection	
SMART Aim Measure*	Percentage of members AGE GROUP TBD who received a positive depression screening at PROVIDER TBD and then received a mental health service in a primary care or mental health care setting within 30 days of the positive depression screen during the rolling 12-month measurement period.

Module 1—PIP Initiation	
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly based on a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

**The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

HCI: Strengths

HCI selected a BH PIP topic focused on increasing the percentage of members who received follow-up mental health services within 30 days of screening positive for depression. The RAE designed a methodologically sound project and achieved a *Conditional Pass* on Module 1 and Module 2, achieving all validation criteria that did not require 12 months of historical data.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

HCI will have the opportunity to update Module 1 and Module 2 after 12 months of baseline data have been collected for the PIP. At that time, the RAE will set a goal for improvement in relation to the baseline rate. Additionally, in the next phase of the BH PIP, HCI will have the opportunity to analyze existing processes related to improving the *Increasing Mental Healthcare Services After a Positive Depression Screening* rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As HCI continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Set a SMART Aim goal that represents real improvement over the baseline rate and is attainable within the time frame defined by the SMART Aim end date.
- Design a SMART Aim data collection methodology that is comparable to the baseline data collection methodology and supports the rapid-cycle process.
- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.

- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey

Table 3-32 shows the adult PCMH CAHPS results achieved by HCI for FY 2018–2019.

Table 3-32—Adult PCMH CAHPS Question Summary Rates and Global Proportions for HCI

Measure	FY 2018–2019 Rate
Rating of Provider	63.3%
Rating of Specialist Seen Most Often	62.6%
Rating of All Health Care	61.0%
Rating of Health Plan	60.5%
Getting Timely Appointments, Care, and Information	51.9%
How Well Providers Communicate with Patients	75.0%
Providers' Use of Information to Coordinate Patient Care	61.1%
Talking with You About Taking Care of Your Own Health	44.6%
Comprehensiveness	43.2%
Helpful, Courteous, and Respectful Office Staff	72.3%
Health First Colorado Customer Service	66.9%
Received Care from Provider Office During Evenings, Weekends, or Holidays	38.5%+
Reminders about Care from Provider Office	73.0%
Saw Provider Within 15 Minutes of Appointment	35.9%
Received Health Care and Mental Health Care at Same Place	57.8%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

HCI: Strengths

For the HCI adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (75.0 percent)
- *Reminders about Care from Provider Office* (73.0 percent)
- *Helpful, Courteous, and Respectful Office Staff* (72.3 percent)

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the HCI adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Saw Provider Within 15 Minutes of Appointment* (35.9 percent)
- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (38.5 percent)
- *Comprehensiveness* (43.2 percent)

HSAG recommends that HCI develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that HCI explore areas that may be contributing to low experience scores for the *Comprehensiveness* measure and develop initiatives designed to improve the score for this measure.

Table 3-33 shows the child PCMH CAHPS results achieved by HCI for FY 2018–2019.

Table 3-33—Child PCMH CAHPS Question Summary Rates and Global Proportions for HCI

Measure	FY 2018–2019 Rate
Rating of Provider	65.3%
Rating of Specialist Seen Most Often	69.5%+
Rating of All Health Care	69.9%
How Well Providers Communicate with Child	78.1%
Getting Timely Appointments, Care, and Information	60.6%
How Well Providers Communicate with Parents or Caretakers	78.1%
Providers' Use of Information to Coordinate Patient Care	72.3%
Comprehensiveness: Child Development	56.8%
Comprehensiveness: Child Safety and Healthy Lifestyles	49.0%
Helpful, Courteous, and Respectful Office Staff	63.5%
Received Information on Evening, Weekend, or Holiday Care for Child	79.6%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	20.8%+
Saw Provider Within 15 Minutes of Appointment	29.6%
Reminders about Child's Care from Provider Office	59.9%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

HCI: Strengths

For the HCI child population, the following three measures had the highest rates compared to the other measures' rates:

- *Received Information on Evening, Weekend, or Holiday Care for Child* (79.6 percent)
- *How Well Providers Communicate with Child* (78.1 percent)
- *How Well Providers Communicate with Parents or Caretakers* (78.1 percent)

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the HCI child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (20.8 percent)
- *Saw Provider Within 15 Minutes of Appointment* (29.6 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (49.0 percent)

HSAG recommends that HCI develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that HCI explore areas that may be contributing to low experience scores for the *Comprehensiveness: Child Safety and Healthy Lifestyles* measure for children and develop initiatives designed to improve the score for this measure.

ECHO Survey

Table 3-34 shows the adult ECHO survey results achieved by HCI for FY 2018–2019.

Table 3-34—Adult ECHO Question Summary Rates and Global Proportions for HCI

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	44.1%
Getting Treatment Quickly	70.5%+
How Well Clinicians Communicate	87.7%
Perceived Improvement	62.7%
Information About Treatment Options	53.0%
Office Wait	84.9%
Told About Medication Side Effects	65.2%+
Including Family	37.4%
Information to Manage Condition	77.6%

Measure	FY 2018–2019 Rate
Patient Rights Information	83.5%
Patient Feels He or She Could Refuse Treatment	75.4%
Privacy	94.8%
Cultural Competency	NA
Amount Helped	80.1%
Improved Functioning	62.3%
Social Connectedness	67.9%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

HCI: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (94.8 percent)
- *How Well Clinicians Communicate* (87.7 percent)
- *Office Wait* (84.9 percent)

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the HCI adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (37.4 percent)
- *Rating of All Counseling or Treatment* (44.1 percent)
- *Information About Treatment Options* (53.0 percent)

HSAG recommends that HCI work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-35 shows the child ECHO survey results achieved by HCI for FY 2018–2019.

Table 3-35—Child ECHO Question Summary Rates and Global Proportions for HCI

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	50.9%
Getting Treatment Quickly	73.0%+
How Well Clinicians Communicate	86.4%
Perceived Improvement	67.4%
Information About Treatment Options	72.9%
Office Wait	85.4%
Told About Medication Side Effects	78.0%+
Information to Manage Condition	74.0%
Patient Rights Information	91.0%
Respondent Feels He or She Could Refuse Treatment for Their Child	86.8%
Privacy	96.8%
Cultural Competency	NA
Amount Helped	81.4%
Improved Functioning	63.4%
Social Connectedness	84.8%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

HCI: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (96.8 percent)
- *Patient Rights Information* (91.0 percent)
- *Respondent Feels He or She Could Refuse Treatment for Their Child* (86.8 percent)

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the HCI child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (50.9 percent)
- *Improved Functioning* (63.4 percent)
- *Perceived Improvement* (67.4 percent)

HSAG recommends that HCI work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

HCI: Strengths

HCI's questionnaire responses, documentation, and follow-up responses suggest that HCI maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. HCI delegates network management responsibilities to Beacon; though Beacon submitted X12 transaction files for BH encounters during ACC Phase I, Beacon initiated a 30 percent reconfiguration of the software historically used to produce X12 transaction files in response to the Department's MMIS business edits for X12 transaction files. HCI reported that, as of March 2019, Beacon created an ETL program to identify and document encounter response file rejection information received from the Department's EDI vendor, DXC; rejection information review is ongoing, and Beacon's final development of BH encounter data policies and procedures is contingent on its resolution.

HCI reported that Beacon uses Edifecs to assess providers' claims and encounter submissions for completeness, accuracy, and timeliness, and produces error logs to facilitate the CMHCs' record corrections and file resubmission. Monthly report cards are generated and submitted for review of data quality issues by key internal staff members, as well as contracted CMHCs' IT divisions. HCI provided an example of a monthly report card to supplement its IS review questionnaire responses.

HCI's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Consequently, HCI reported no issues with BH encounter flat file submission, though it did not provide an exact flat file rejection rate.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

HCI's ASO, Beacon, required contracted CMHCs to modify their EHR systems to produce flat files to meet the Department's specifications, though independent providers are allowed to submit claims in 837 I/P transaction files. As the X12 transaction file format is the Department's defined format for BH encounter record submission, HCI indicated that it is working to develop a data infrastructure that will permit submission of 837 I/P transaction files for claims from all providers, allowing data review and adjudication processes to be streamlined regardless of data source. HCI's survey responses indicated that Beacon employs separate processes to create X12 transaction files for claims data from individual providers and encounter data from CMHCs. Though encounters of all statuses (e.g., paid and denied) are produced from independent providers' claims, CMHC encounters are limited to paid encounters; denied encounters from CMHCs are not included in X12 transaction file submissions to the Department.

HCI reported moderate rejection rates for X12 837 I/P transaction files (30.0 percent each for institutional and professional encounters), though the Department reported higher rejection rates for HCI's encounter files (99.0 percent and 31.0 percent for professional and institutional encounters, respectively). In addition to compliance issues with FFS-based business rules and provider information discrepancies, HCI also indicated that the Department's rejection of split encounters contributed to X12 transaction file rejection.

As of the March 2019 questionnaire responses, HCI indicated that Beacon was not submitting X12 transaction files to the Department due to issues occurring during two test submissions. Though HCI participates in regular meetings with the Department and its EDI vendor, HCI reported an ongoing process through which adjudication and processing software is being reconfigured to meet the Department's encounter submission specifications. HCI also indicated that it has notified the Department and DXC of X12 file rejections based on submission specifications that conflict with other compliance documentation.

Based on the IS review findings, HSAG offers the following recommendations to improve HCI's BH encounter data quality:

- HCI reported that it includes no zero payment encounters from sub-capitated providers or denied encounters from CMHCs in its encounter data submissions to the Department. HCI should work with the Department to determine whether these practices are consistent with encounter data submission standards.
- HCI reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which HCI may enhance its encounter data oversight.
- HCI should conduct a thorough comparative analysis between its flat file submissions and successfully submitted X12 transaction files to identify factors contributing to the Department's rejection of its X12 transaction files.

- Based on HCI's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Validation of Network Adequacy

HCI: Strengths

HCI's Provider Data Structure Questionnaire responses noted that HCI validated providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. HCI reported permitting single case agreements only for BH providers. HCI reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contracted provider.

HCI reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties. HCI also reported limiting EPSDT providers to BH professionals. HCI reported conducting monthly outreach to PCPs to verify demographic, location, and panel capacity information.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although HCI consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, HCI did not restrict these data indicators by degree or credential.

HCI's provider data extract for the study contained several limitations, suggesting the data did not accurately reflect HCI's provider network. For example, data included similar, but not identical, data values for the provider type field, complicating HSAG's efforts to map HCI's provider data to the Department's provider categories. Further, HCI classified PH and BH providers using a "Practitioner" type value, while other health plans offered separate provider type values for physicians, osteopaths, and NPs. HCI also listed no attribute values for providers groups or practices, indicating that group-level provider records, if available, may be identified using other database elements. Finally, HCI submitted data with only provider type values of "Primary Care," "Physician Assistants/Nurse Practitioners," or "Pediatrics," and did not include data values for providers' specialty, degree, or taxonomy code(s). Based on the Department's approved provider category definitions, HSAG was unable to assign these providers to any provider categories for the PCA.

As the first comprehensive review of HCI's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing HCI's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, HCI should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 5—Colorado Access (COA)

Assessment of Compliance With Medicaid Managed Care Regulations

COA Region 5 Overall Evaluation

Table 3-36 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-36—Summary of COA Region 5 Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	12	11	10	1	0	1	91%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	17	16	1	0	2	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**46**	**43**	**40**	**3**	**0**	**3**	**93%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

COA Region 5: Strengths

COA's *Care Coordination* policy addressed all care coordination program requirements applicable to members with high-risk or complex needs. Care coordination teams were organized according to areas of expertise—behavioral health, physical health, criminal justice, long-term care, community-based (social support), pediatric care, and adolescent care. COA care coordinators were also embedded in select facilities within the region and transition of care teams were aligned with specific hospital facilities. The COA provider manual described that the PCMP was responsible for coordinating care and making referrals for each member. PCMPs could refer members with higher-level coordination of care needs to COA's care management program. In addition, COA had designated 15 PCMP entities as ECPs that were responsible for providing a higher level of care coordination for members within their practice. COA adopted the four-quadrant model for stratifying members into care coordination intervention categories and was developing data-driven stratification to assign each member to a risk quadrant. COA

care navigators telephonically outreached to members assigned to lower risk categories, while members identified as high risk received an individualized comprehensive needs assessment and care plan. Facility-based care managers conducted face-to-face meetings with members transitioning from acute-care facilities. All care coordination activities—e.g., assessments, care plan, and interventions—were documented in COA's Altruista Guiding Care system, which met all required elements of an electronic care coordination tool. COA's care coordination process included sharing the results of assessments and planned interventions with other entities involved with the member's care and facilitating exchange of information among providers.

COA maintained policies which addressed member rights and responsibilities under 42 CFR §438.100 and other applicable laws and regulations, including anti-discrimination, equal access for members with disabilities, advance directives, and privacy and confidentiality assured under HIPAA. Policies described processes to ensure that member materials were easily understood and readily accessible. Members, providers, and staff members were informed on these policies through staff and provider training, member newsletters, topic-specific mailings, and the Member Advisory Council. Ongoing auditing and monitoring were conducted to identify any compliance issues that may have an impact on member rights and to address and mitigate issues.

COA maintained a robust process for testing and ensuring member materials available in paper and electronic form were easy to understand and complied with Section 508 guidelines. Member materials were also reviewed by COA's Member Advisory Council. COA's new member packet, annual member mailings, and information available on COA's website were clear and designed to help members understand the requirements and services offered under the State plan. Topic-specific written communications and IVR calls also assisted members in understanding preventive and routine services available. COA demonstrated an effective process for providing members with language line assistance for translation, while also providing materials in other languages and formats when needed, including Braille and audio formats. COA's website included all required information either through direct description or through links to pages within the website or links to the State's website. The RAE provider directory included the required information about providers, including cultural competency training and disability access for members. COA has plans to enhance the provider directory with more robust details related to the type of disability access offered.

COA provided information about EPSDT benefits and services, including specific BH services, to members via the member website. The website provided links to the *Health First Colorado Member Handbook*, the Department's EPSDT fact sheet, a training video for parents, and COA care management staff contact numbers. The *EPSDT* policy stated that providers were informed of the EPSDT program through the provider manual, in which the *Behavioral Health Policies and Standards* document listed the services available through EPSDT. Providers were also informed about EPSDT updates via newsletters and quarterly forums. The *EPSDT* policy and the provider manual stated that COA care coordination services were available to assist providers in resolving barriers related to EPSDT benefits and also referred providers to the Healthy Communities program. COA care coordination staff members included EPSDT subject-matter experts. COA and Denver Health and Hospital Authority (DHHA) had created an MOU and SOW to document the commitment of both organizations to work together in developing an onboarding plan for newly enrolled Medicaid members. Pending completion of the

onboarding plan, COA continued to refer members and providers to the Healthy Communities program for assistance in accessing EPSDT-related services.

COA Region 5: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections.

Standard III—Coordination and Continuity of Care

COA had processes in place to coordinate transitions of care between multiple settings and organizations; however, for members not engaged in transitions of care but receiving ongoing PH services through Denver Health clinics, it was unclear how COA coordinates BH services being received through the RAE with the PH services delivered through the MCO. COA Region 5 was required to:

- More clearly outline procedures for coordinating BH services received by individual members with those services provided by the Denver Health MCO—DHMP.

Standard V—Member Information

While COA's website included clear and concise information about required website elements, the section of the website that addressed filing and processing appeals contained outdated information. COA Region 5 was required to:

- Ensure that information on its website includes updated and correct information regarding appeals procedures.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

The MOU between DHHA's Healthy Communities program and COA and the associated SOW outlined an agreement for COA and DHHA to participate in an up to two-year formal planning process that would result in a collaborative onboarding plan for children and families receiving Medicaid. COA had not yet completed the onboarding plan in partnership with the Healthy Communities program. COA Region 5 was required to:

- Expedite the planning and implementation process with the DHHA Healthy Communities contractor to create an annual plan for onboarding children and families receiving Medicaid services.

Limited Managed Care Capitation Initiative—DHMP Evaluation

Table 3-37 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-37—Summary of DHMP Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	10	7	3	0	1	70%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	17	14	3	0	2	82%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**44**	**41**	**34**	**7**	**0**	**3**	**83%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

DHMP: Strengths

Care coordination services for DHMP Medicaid members are provided through the resources of the DHHA healthcare delivery system. Members received most healthcare services from the DHHA clinic system. DHMP assigned the member to a medical home—i.e., one of the DHHA primary care clinics—based on residential geographic location of the member. Each clinic has a multidisciplinary team of clinicians and care managers assigned by DHHA's Ambulatory Care Services (ACS) division to provide on-site services to members who present at the clinic. Care managers assist members with chronic, complex, and catastrophic disorders requiring coordination of care across multiple provider disciplines or settings. The *ACS Care Coordination EPSDT* policy and the *ACS Care Plan* policy addressed all requirements related to RAE care coordination. DHHA has adopted predictive risk modeling to categorize members into four tiers of risk—Tier 1 (lower risk) to Tier 4 (higher risk). DHHA had developed a variety of assessment tools used to determine member needs and develop care plan interventions. DHHA had processes to ensure that all members who presented to a DHHA clinic, regardless of risk stratification level, receive an intake assessment and a plan of care documented in the EPIC EHR system (EPIC). The use of EPIC enabled communication of the care plan among all DHHA staff members and providers as well as among DHMP provider partners. DHMP had the ability to maintain oversight of all DHHA care manager activities through the DHMP medical director and medical management staff members. While

ACS care teams conducted an intake assessment of members presenting at a clinic site, DHMP staff members stated that DHMP was also considering implementing an additional intake assessment specifically for new Medicaid enrollees.

DHMP's *Member Rights and Responsibilities* policy included all rights afforded members per 42 CFR §438.100. DHMP's policies listed other applicable laws and regulations, while articulating the MCO's commitment to comply with all regulations pertaining to member rights. The MCO submitted specific policies demonstrating compliance with regulations related to advance directives and privacy and confidentiality rights guaranteed under HIPAA. Member and provider communications and training were designed to ensure that members and providers understand member rights and that members may exercise those rights without fear of retaliation.

DHMP processes were in place for testing member materials for sixth grade readability and to ensure that specific documents available electronically on the DHMP website complied with Section 508 guidelines. DHMP had a variety of materials designed to assist members in understanding the requirements and benefits of the managed care plan and State plan benefits. Materials included a member welcome packet, the DHMP Medicaid handbook, DHMP website information, and member newsletters. Member written materials were printed in English and Spanish, included appropriate font sizes, and were available in alternative formats as needed. DHMP provided language line assistance for translation.

DHMP informed members and parents about EPSDT benefits; the pediatric well-child periodicity schedule; how to obtain scheduling and transportation assistance; the Healthy Communities program; and how to obtain more information through the DHMP website, the DHMP member handbook, and member newsletters. Providers received comprehensive training on the EPSDT program and benefits through the provider manual, the provider website, DHHA's Pediatric and Adolescent Preventative Healthcare Guidelines, and the Department's EPSDT webinar training for providers. The *EPSDT Program* policy addressed all required components of PH EPSDT services and referrals and stated that the DHMP quality improvement staff members monitor providers' compliance with the EPSDT periodicity schedule. DHMP used a comprehensive tool for provider-specific tracking and reporting compliance with numerous EPSDT screening and immunization requirements. DHHA's ACS care manager standard work documents outlined expectations for following up on referrals for EPSDT-related services. The *EPSDT Program* policy and the *UM* policy appropriately described medical necessity criteria for EPSDT services. DHMP refers members and providers to the Healthy Communities program for assistance in accessing EPSDT-related services.

DHMP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections.

Standard III—Coordination and Continuity of Care

While DHMP assigned each newly enrolled Medicaid member to a primary care clinic within DHHA's clinic system, DHMP did not inform members of their individually assigned clinic provider until the member called DHHA central scheduling for an appointment. In addition, a member may have several care managers from throughout the DHHA system but is not informed of how to contact his or her lead/primary care coordinator. While DHMP demonstrated coordinating services for members transitioning between settings of care, coordinating with other organizations, and making referrals to community organizations, DHMP was unable to demonstrate ongoing active care coordination with COA concerning BH services members were receiving through the RAE (COA), or with community organizations and agencies providing social support services to members. While DHHA had processes to provide each member an intake assessment and plan of care upon presentation to a DHHA clinic, DHMP had no mechanism to ensure that every member (i.e., those who had not yet presented to a clinic provider) received an intake assessment and related care plan. DHMP was required to:

- Implement mechanisms to provide information to members about how to contact the person or entity primarily responsible for coordinating his or her healthcare services, including the PCMP and, as applicable, his or her lead care manager.
- Enhance and implement procedures to actively coordinate the services the member receives from DHHA with the services the member receives from the RAE (i.e., BH services) and from external community organizations and social support providers.
- Implement a mechanism to provide an individual intake assessment and related service plan for each member.

Standard V—Member Information

DHMP developed its own member handbook, member welcome packet, and annual member letter; however, DHMP did not have a process in place to have its materials member-tested. DHMP's member handbook included information about the grievance and appeal system that was outdated and did not reflect the revised Medicaid managed care regulations released in May 2016. While DHMP's written and electronic member materials addressed all requirements to assist newly enrolled members in understanding DHMP's program, none of the materials described the basic features of the RAE's (COA's) managed care functions as a PCCM entity, PIHP, or MCO, nor DHMP's relationship to COA. DHMP was required to:

- Ensure that all member materials critical to obtaining services are member-tested.
- Revise the member handbook to ensure compliance with the managed care regulations released in May 2016.

- Include in its written enrollment materials and its website, a description of the basic features of the RAE's managed care functions as a PCCM entity, PIHP, and MCO, along with DHMP's relationship to COA.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

The MOU between the DHHA Healthy Communities program and COA and the associated SOW outlined an agreement for COA and DHHA's Healthy Communities program to participate in an up to two-year formal planning process that would result in a collaborative onboarding plan for children and families receiving Medicaid. DHMP was not included as a participant or signatory in either the MOU or the SOW, and DHMP had not completed an annual onboarding plan in partnership with the DHHA Healthy Communities contractor. DHMP was required to:

- Engage in and expedite the planning and implementation process with the DHHA Healthy Communities contractor to create an annual plan for onboarding children and families receiving Medicaid.

DHMP: Trended Performance for Compliance With Regulations

Table 3-38—Compliance With Regulations—Trended Performance for DHMP

Standard and Applicable Review Years	DHMP Average—Previous Review	DHMP Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	91%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	80%	92%
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*	**92%**	**70%**
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*	**100%**	**100%**
Standard V—Member Information (2017–2018, 2018–2019)*	**69%**	**82%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	65%	86%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	100%	80%
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	94%	98%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	0%
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	85%	88%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019)*	**62%**	**86%**

**Bold text indicates standards that HSAG reviewed during FY 2018–2019.*

In the most recent year of review, DHMP demonstrated significant (10 percentage points or more) performance improvement in four of 11 standards: Standard II—Access and Availability; Standard V—Member Information; Standard VI—Grievance and Appeal System; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services, with the most significant improvement (24 percentage points) being in the Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. When compared to previous review years, three additional standards also demonstrated overall improvement. Three of the 10 standards demonstrated a substantial decline—20 percentage points or more—when compared to previous review years: Standard III—Coordination and Continuity of Care, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. When compared to previous review years, one standard remained unchanged at 100 percent. Changes in federal regulations, changes in State contract requirements, and design of the compliance monitoring tool may have impacted comparability of the compliance results between review cycles.

HEDIS Measure Rates and Validation—DHMP

DHMP: Information Systems Standards Review Results

According to the 2019 HEDIS Compliance Audit Report, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted DHMP's HEDIS performance measure reporting.

DHMP: Performance Measure Results

Table 3-39 shows the performance measure results for DHMP for HEDIS 2017 through HEDIS 2019, along with the percentile ranking for each HEDIS 2019 rate.

Table 3-39—Performance Measure Results for DHMP

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	72.57%	68.27%	67.97%	10th–24th
Combination 3	71.58%	65.94%	64.72%	10th–24th
Combination 4	71.42%	64.23%	64.60%	25th–49th
Combination 5	59.46%	58.09%	56.73%	25th–49th
Combination 6	53.76%	43.39%	45.13%	50th–74th
Combination 7	59.35%	56.77%	56.61%	25th–49th
Combination 8	53.76%	42.53%	45.07%	50th–74th
Combination 9	46.50%	39.50%	40.69%	50th–74th
Combination 10	46.50%	38.80%	40.63%	50th–74th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	75.37%	75.69%	76.89%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	47.30%	49.46%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	7.03%	9.12%	7.08%	<10th
Six or More Visits	3.52%	4.39%	52.28%^	10th–24th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.59%	60.91%	63.59%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	34.68%	36.33%	41.29%^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[1]	7.68%	16.75%	21.89%^	<10th
Counseling for Nutrition—Total	1.08%	5.97%	7.45%	<10th
Counseling for Physical Activity—Total	0.55%	1.36%	5.90%^	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.52%	83.93%	88.28%	75th–89th
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	96.04%	97.70%	97.09%	≥90th
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	74.04%	64.59%	71.90%^	10th–24th
Postpartum Care	44.42%	49.06%	56.69%^	10th–24th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	88.32%	86.84%	88.52%	<10th
Ages 25 Months to 6 Years	71.74%	72.12%	75.09%	<10th
Ages 7 to 11 Years	76.19%	75.53%	80.08%^	<10th
Ages 12 to 19 Years	76.40%	75.43%	80.30%^	<10th
Adults' Access to Preventive/Ambulatory Health Services[1]				
Total	59.87%	55.19%	53.89%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Total	68.73%	66.68%	69.58%	75th–89th
Breast Cancer Screening[1]				
Breast Cancer Screening	—	50.65%	**46.48%^^**	<10th
Cervical Cancer Screening				
Cervical Cancer Screening	45.77%	43.03%	43.07%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.06%	0.14%	0.00%	≥90th
Adult BMI Assessment[1]				
Adult BMI Assessment	81.03%	83.25%	81.44%	10th–24th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	49.05%	54.88%	54.20%	50th–74th
Effective Continuation Phase Treatment	31.02%	33.52%	33.96%	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	26.88%	37.40%	39.69%	25th–49th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	NB	46.34%	75th–89th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	0.00%	0.00%	NA	—
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack[1]				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	69.77%	**46.88%^^**	<10th
Comprehensive Diabetes Care[1]				
HbA1c Testing	82.60%	82.16%	82.06%	<10th
*HbA1c Poor Control (>9.0%)**	44.02%	42.92%	40.38%	25th–49th
HbA1c Control (<8.0%)	44.33%	45.45%	47.88%	25th–49th
Eye Exam (Retinal) Performed	45.70%	46.59%	45.83%	10th–24th
Medical Attention for Nephropathy	87.35%	82.47%	81.51%	<10th
Blood Pressure Control (<140/90 mm Hg)	57.41%	64.01%	61.67%	25th–49th
Statin Therapy for Patients With Diabetes[1]				
Received Statin Therapy	59.83%	54.64%	57.75%	10th–24th
Statin Adherence 80%	54.71%	59.47%	60.63%	50th–74th
Statin Therapy for Patients With Cardiovascular Disease[1]				
Received Statin Therapy—Total	72.18%	75.00%	72.41%	10th–24th
Statin Adherence 80%—Total	54.17%	58.33%	69.52%	75th–89th
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	85.93%	85.24%	86.46%	25th–49th
Diuretics	84.95%	83.78%	86.05%	10th–24th
Total	—	84.66%	86.29%	25th–49th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	65.53%	69.33%	72.83%	50th–74th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	65.57%	59.29%	56.90%	≥90th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	64.16%	55.69%	50.34%	<10th
Bronchodilator	81.82%	67.06%	72.21%	10th–24th
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	47.83%	54.19%	58.80%	25th–49th
Medication Compliance 75%—Total	22.64%	27.75%	33.10%	25th–49th
Asthma Medication Ratio[1]				
Total	42.41%	63.77%	**46.60%^^**	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.47%	27.44%	28.57%	25th–49th
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis[1]				
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	86.49%	73.56%	88.75%^	≥90th
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total**	42.22	41.79	43.95	75th–89th
Outpatient Visits—Total[1]	193.35	183.12	203.78	<10th
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Discharges per 1,000 Member Months (Total Inpatient)—Total	4.85	4.58	5.06	10th–24th
Average Length of Stay (Total Inpatient)—Total	4.41	4.73	4.59	75th–89th
Discharges per 1,000 Member Months (Medicine)—Total	2.63	2.55	2.90	25th–49th
Average Length of Stay (Medicine)—Total	3.94	4.25	4.17	50th–74th
Discharges per 1,000 Member Months (Surgery)—Total	0.81	0.78	0.90	10th–24th
Average Length of Stay (Surgery)—Total	8.79	9.40	8.49	75th–89th
Discharges per 1,000 Member Months (Maternity)—Total	2.07	1.75	1.72	10th–24th
Average Length of Stay (Maternity)—Total	2.79	2.77	2.76	50th–74th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.31	0.31	0.32	≥90th
Average Days Supplied per Antibiotic Script—Total	9.28	9.27	9.44	25th–49th
Average Scripts PMPY for Antibiotics of Concern—Total	0.09	0.09	0.09	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	27.79%	27.52%	28.74%	≥90th
Plan All-Cause Readmissions*[1]				
Index Total Stays—Observed Readmissions—Total	—	16.03%	**19.34%^^**	10th–24th
Index Total Stays—O/E Ratio—Total	—	0.72	0.85	25th–49th
Use of Opioids at High Dosage*[2]				
Use of Opioids at High Dosage	—	—	3.23%	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
Use of Opioids From Multiple Providers**[2]				
Multiple Prescribers	—	—	18.61%	—
Multiple Pharmacies	—	—	12.09%	—
Multiple Prescribers and Multiple Pharmacies	—	—	6.32%	—

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
— Indicates that the rate is not presented as the measure was not required to be reported during HEDIS 2017. This symbol may also indicate that NCQA recommends a break in trending; therefore, no prior year rates are displayed and comparisons to benchmarks are not performed for this measure.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB (No Benefit) indicates that the MCO did not offer the health benefit required by the measure.
Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a significant decline in performance from the previous year.

DHMP: Strengths

The following HEDIS 2019 measure rates were determined to be high performers for DHMP (i.e., ranked at or above the 75th percentiles without a significant decline in performance from HEDIS 2018 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018):

- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Chlamydia Screening in Women—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*

For HEDIS 2019, DHMP demonstrated strength with the appropriate testing and treatment of members with respiratory infections, as evidenced by the following measure rates above the 75th percentile: *Appropriate Testing for Children With Pharyngitis*, *Appropriate Treatment for Children With Upper Respiratory Infection*, and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*. Additionally, the MCO's performance for preventive screenings for young members was positive, with *Chlamydia Screening in Women—Total* and *Non-Recommended Screenings for Cervical Cancer in Adolescent Females* above the 75th percentile.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2019 measure rates were determined to be low performers for DHMP (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018):

- *Childhood Immunization Status—Combination 2* and *Combination 3*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*
- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed,* and *Medical Attention for Nephropathy*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*

With the rates for *Prenatal and Postpartum Care, Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services—Total* below the 25th percentile, DHMP has opportunities to improve access to care for both children and adults. Improvement in the access to care rates may also result in improvement related to the quality of care provided, as evidenced by low rates related to the care and medication management of members with chronic conditions (e.g., diabetes, cardiovascular disease, COPD, asthma). DHMP should focus efforts on identifying the factors contributing to the low rates for these measures (e.g., barriers to outpatient care and pharmacies, provider training and prescribing patterns, community outreach and education) and implement strategies to improve the care for all members.

Validation of Performance Improvement Projects

COA Region 5: Accountable Care PIP

Table 3-40 displays the FY 2018–2019 validation findings for COA's *Well-Child Visits for Members 10–14 Years of Age* PIP.

Table 3-40—Validation Findings for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 10 through 14 years of age attributed to Guardian Angels Health Care.
SMART Aim Statement	By June 30, 2020, increase the percentage of well child visits among members 10–14 years of age attributed to Guardian Angels Health Care, from 47.62% to 52.62%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 10 through 14 years of age attributed to Guardian Angels Health Care during the rolling 12-month measurement period who each received a preventive or wellness visit during the measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

COA Region 5: Strengths

COA selected an accountable care PIP topic focused on increasing the rate of well-child visits among members 10 through 14 years of age. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, COA will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

COA Region 5: Behavioral Health PIP

Table 3-41 displays the FY 2018–2019 validation findings for COA's *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP.

Table 3-41—Validation Findings for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 10 through 14 years of age with a positive depression screening received in a primary care setting.
SMART Aim Statement	By June 30, 2020, increase the percentage of members with a positive depression screen who received at least one follow-up service within 30 days among Members 10–14 years of age, from 1.13% to 7.34%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 10 through 14 years of age with positive depression screens received in primary care settings and who received at least one follow-up behavioral health service during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

COA Region 5: Strengths

COA selected a BH PIP topic focused on increasing the percentage of members 10 through 14 years of age who received follow-up mental health services within 30 days of screening positive for depression. The health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

In the next phase of the BH PIP, COA will have the opportunity to analyze existing processes related to improving the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening* rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

DHMP PIP

Table 3-42 displays the FY 2018–2019 validation findings for DHMP's *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP.

Table 3-42—Validation Findings for the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Webb Pediatrics Patient Centered Medical Home (PCMH).
SMART Aim Statement	By June 30, 2020, increase the percentage of Denver Health Medicaid Choice Members aged 15–18 assigned to the Webb Pediatrics PCMH who attend at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner year from 51.06% to 56.93%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of Denver Health Medicaid Choice members ages 15 through 18 as of the last day of each rolling 12-month measurement period, assigned to the Webb Pediatrics PCMH, and who attended at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner within each rolling 12-month measurement period.

Module 1—PIP Initiation	
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims and electronic medical records (EMR) data. • **Methodology:** Monthly data collection, using a rolling 12-month measurement period.

DHMP: Strengths

DHMP selected a PIP topic focused on increasing the rate of well-care visits among members 15 through 18 years of age. The MCO has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that DHMP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. DHMP has progressed to Module 3, where the MCO will determine potential interventions to test for the PIP.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to the DHMP PIP

In the next phase of the PIP, DHMP will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The MCO will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As DHMP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the MCO progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey—COA Region 5

Table 3-43 shows the adult PCMH CAHPS results achieved by COA Region 5 for FY 2018–2019.

Table 3-43—Adult PCMH CAHPS Question Summary Rates and Global Proportions for COA Region 5

Measure	FY 2018–2019 Rate
Rating of Provider	62.2%
Rating of Specialist Seen Most Often	56.7%
Rating of All Health Care	55.2%
Rating of Health Plan	61.3%
Getting Timely Appointments, Care, and Information	53.8%
How Well Providers Communicate with Patients	69.6%
Providers' Use of Information to Coordinate Patient Care	58.6%
Talking with You About Taking Care of Your Own Health	44.6%
Comprehensiveness	43.2%
Helpful, Courteous, and Respectful Office Staff	68.3%
Health First Colorado Customer Service	59.8%
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.9%
Reminders about Care from Provider Office	65.7%
Saw Provider Within 15 Minutes of Appointment	34.5%
Received Health Care and Mental Health Care at Same Place	58.3%

COA Region 5: Strengths

For the COA adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (69.6 percent)
- *Helpful, Courteous, and Respectful Office Staff* (68.3 percent)
- *Reminders about Care from Provider Office* (65.7 percent)

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the COA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (23.9 percent)
- *Saw Provider Within 15 Minutes of Appointment* (34.5 percent)
- *Comprehensiveness* (43.2 percent)

HSAG recommends that COA develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that COA explore areas that may be contributing to low experience scores for the *Comprehensiveness* measure and develop initiatives designed to improve the score for this measure.

Table 3-44 shows the child PCMH CAHPS results achieved by COA Region 5 for FY 2018–2019.

Table 3-44—Child PCMH CAHPS Question Summary Rates and Global Proportions for COA Region 5

Measure	FY 2018–2019 Rate
Rating of Provider	81.2%
Rating of Specialist Seen Most Often	74.8%+
Rating of All Health Care	81.9%
How Well Providers Communicate with Child	84.7%
Getting Timely Appointments, Care, and Information	75.2%
How Well Providers Communicate with Parents or Caretakers	84.8%
Providers' Use of Information to Coordinate Patient Care	74.5%
Comprehensiveness: Child Development	69.8%
Comprehensiveness: Child Safety and Healthy Lifestyles	62.8%
Helpful, Courteous, and Respectful Office Staff	79.5%
Received Information on Evening, Weekend, or Holiday Care for Child	82.4%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	56.0%+
Saw Provider Within 15 Minutes of Appointment	51.0%
Reminders about Child's Care from Provider Office	75.6%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

COA Region 5: Strengths

For the COA child population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Parents or Caretakers* (84.8 percent)
- *How Well Providers Communicate with Child* (84.7 percent)
- *Received Information on Evening, Weekend, or Holiday Care for Child* (82.4 percent)

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the COA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Saw Provider Within 15 Minutes of Appointment* (51.0 percent)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (56.0 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (62.8 percent)

HSAG recommends that COA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

CAHPS Survey—DHMP

Table 3-45 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2016–2017 through FY 2018–2019.

Table 3-45—Adult Medicaid Question Summary Rates and Global Proportions for DHMP

Measure	FY 2016–2017 Rate	FY 2017–2018 Rate	FY 2018–2019 Rate
Getting Needed Care	76.1%	77.5%	71.8%
Getting Care Quickly	76.1%	78.0%	74.7%
How Well Doctors Communicate	92.6%	92.5%	92.0%
Customer Service	86.6%+	85.7%	90.0%+
Shared Decision Making	82.6%+	77.8%	84.5%+
Rating of Personal Doctor	71.8%	70.9%	66.0%
Rating of Specialist Seen Most Often	69.0%+	61.4%+	70.7%+
Rating of All Health Care	61.7%	52.2%	50.3%
Rating of Health Plan	57.4%	59.1%	56.4%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

DHMP: Adult Medicaid Strengths

For the DHMP adult Medicaid population, two measure rates increased substantially between FY 2017–2018 and FY 2018–2019:

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*

For the DHMP adult Medicaid population, no measure rates increased substantially between FY 2016–2017 and FY 2018–2019.

Four measure rates were higher than the 2018 national averages:

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*

Of these, no measure rates were considered substantially higher than the 2018 national averages.

DHMP: Adult Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For the DHMP adult Medicaid population, one measure rate decreased substantially between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*

For the DHMP adult Medicaid population, two measure rates decreased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor*
- *Rating of All Health Care*

Five measures were lower than the 2018 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Rating of Personal Doctor*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, two measure rates were considered substantially lower, being more than 5 percentage points less than the 2018 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*

HSAG recommends that DHMP develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that DHMP explore areas that may be contributing to low experience scores for the measures that assess members' experiences with their personal doctor, health plan, and the overall healthcare they receive from DHMP and develop initiatives designed to improve scores for these measures.

Table 3-46 shows the child Medicaid CAHPS results achieved by DHMP for FY 2016–2017 through FY 2018–2019.

Table 3-46—Child Medicaid Question Summary Rates and Global Proportions for DHMP

Measure	FY 2016–2017 Rate	FY 2017–2018 Rate	FY 2018–2019 Rate
Getting Needed Care	79.5%	84.8%	78.2%
Getting Care Quickly	84.0%	86.1%	87.2%
How Well Doctors Communicate	93.9%	94.7%	95.5%
Customer Service	85.5%+	91.2%	86.1%+
Shared Decision Making	74.3%+	78.0%+	77.8%+
Rating of Personal Doctor	79.2%	86.0%	85.9%
Rating of Specialist Seen Most Often	66.7%+	75.0%+	75.7%+
Rating of All Health Care	70.2%	76.9%	73.5%
Rating of Health Plan	68.1%	77.0%	73.2%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

DHMP: Child Medicaid Strengths

For the DHMP child Medicaid population, no measure rates increased substantially.

For the DHMP child Medicaid population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Five measures were higher than the 2018 national averages:

- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, one measure rate was considered substantially higher, being more than 5 percentage points greater than the 2018 national average:

- *Rating of Personal Doctor*

DHMP: Child Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For the DHMP child Medicaid population, two measure rates decreased substantially between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Customer Service*

For the DHMP child Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four measures were lower than the 2017 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*

Of these, one measure rate was considered substantially lower, being more than 5 percentage points less than the 2017 national average:

- *Getting Needed Care*

HSAG recommends that DHMP develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that DHMP explore areas that may be contributing to low experience scores for the measures that assess members' experiences with their personal doctor, health plan, and the overall healthcare they receive from DHMP and develop initiatives designed to improve scores for these measures.

ECHO Survey

Table 3-47 shows the adult ECHO survey results achieved by COA Region 5 for FY 2018–2019.

Table 3-47—Adult ECHO Question Summary Rates and Global Proportions for COA Region 5

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	45.1%
Getting Treatment Quickly	68.9%+
How Well Clinicians Communicate	89.9%
Perceived Improvement	53.7%
Information About Treatment Options	47.3%
Office Wait	82.5%
Told About Medication Side Effects	78.8%+
Including Family	34.0%
Information to Manage Condition	81.7%
Patient Rights Information	88.3%
Patient Feels He or She Could Refuse Treatment	82.6%
Privacy	95.8%
Cultural Competency	NA
Amount Helped	88.4%
Improved Functioning	52.8%
Social Connectedness	68.6%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

COA Region 5: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (95.8 percent)
- *How Well Clinicians Communicate* (89.9 percent)
- *Amount Helped* (88.4 percent)

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the COA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (34.0 percent)
- *Rating of All Counseling or Treatment* (45.1 percent)
- *Information About Treatment Options* (47.3 percent)

HSAG recommends that COA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-48 shows the child ECHO survey results achieved by COA Region 5 for FY 2018–2019.

Table 3-48—Child ECHO Question Summary Rates and Global Proportions for COA Region 5

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	53.8%+
Getting Treatment Quickly	70.1%+
How Well Clinicians Communicate	85.4%+
Perceived Improvement	72.9%
Information About Treatment Options	72.0%+
Office Wait	77.8%+
Told About Medication Side Effects	89.7%+
Information to Manage Condition	72.5%+
Patient Rights Information	87.3%+
Respondent Feels He or She Could Refuse Treatment for Their Child	85.9%+
Privacy	92.1%+
Cultural Competency	NA

Measure	FY 2018–2019 Rate
Amount Helped	72.1%
Improved Functioning	67.9%
Social Connectedness	80.8%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

COA Region 5: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (92.1 percent)
- *Told About Medication Side Effects* (89.7 percent)
- *Patient Rights Information* (87.3 percent)

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the COA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (53.8 percent)
- *Improved Functioning* (67.9 percent)
- *Getting Treatment Quickly* (70.1 percent)

HSAG recommends that COA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

COA Region 5: Strengths

COA's questionnaire responses, documentation, and follow-up responses suggest that COA maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. Of note, COA was a BHO during ACC Phase I and reported that it uses existing EDI infrastructure and data management policies and procedures from other lines of business (e.g., CHP+) to produce BH encounter data files for both legacy flat file and X12 submissions to the Department.

COA reported using a claims and encounter data dashboard system that produces daily inventory reports containing claims transaction volume, adjudication status, list errors, and issues associated with pended claims and encounters, as well as the resolution status for pended records. COA supplemented its questionnaire responses with a sample daily inventory report and noted that it uses dashboard information for rate setting and performance data reporting.

COA's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Consequently, COA reported no issues with BH encounter flat file submission, though it did not provide an exact flat file rejection rate.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

COA reported relatively high rejection rates for X12 837 I/P transaction files (70.0 percent each for institutional and professional encounters), though the Department reported rejection rates of 95.0 percent for professional encounter files and 30.0 percent for institutional encounter files. Both COA and the Department indicated that compliance with FFS-based business rules and provider information discrepancies contributed to X12 transaction file rejections.

As of the March 2019 questionnaire responses, COA indicated that it was not submitting X12 transaction files to the Department due to issues occurring during September 2018 test submissions. Though COA participates in regular meetings with the Department and its EDI vendor, COA reported no modifications to its existing data management and processing policies, nor did COA supply any documentation to indicate that encounter data process changes were in progress as of the March 2019 IS review questionnaire responses.

Based on the IS review findings, HSAG offers the following recommendations to improve COA's BH encounter data quality:

- COA reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which COA may enhance its encounter data oversight.
- While COA reported submitting no X12 transaction files to the Department as of March 2019, COA should conduct a thorough comparative analysis between its flat file submissions and any successfully submitted X12 transaction files since that time to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on COA's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Encounter Data Validation—MCO 412 Audit Over-Read

FY 2018–2019 was DHMP's fourth year participating in the independent MCO audit and subsequent over-read. HSAG's over-read results indicated complete agreement with DHMP's internal audit results for 68 of the 80 sampled encounters, resulting in an 85.0 percent agreement rate. Table 3-49 shows case-level and element-level accuracy rates by service category.

Table 3-49—Percent of Cases in Total Agreement and Percent of Element Accuracy by Service Category

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	75.0	120	89.2
Outpatient	20	95.0	100	99.0
Professional	20	85.0	100	96.0
FQHC	20	85.0	100	96.0
Total	**80**	**85.0**	**420**	**94.8**

HSAG's reviewers determined that, rather than insufficient medical record documentation, misalignment between medical record documentation and encounter data contributed to nearly all cases in which HSAG's coders disagreed with DHMP's audit results. DHMP provided medical record documentation for 77 of the 80 sampled over-read cases, and HSAG's over-read results were not impacted by DHMP's medical record procurement.

DHMP: Strengths

Overall results from HSAG's FY 2018–2019 MCO over-read showed improved agreement between HSAG's and DHMP's reviewers compared to the previous year; HSAG's reviewers agreed with DHMP's reviewers for 94.8 percent of individual audited data elements, with agreement at or greater than 96.0 percent for outpatient, professional, and FQHC encounters. Additionally, DHMP 412 internal audit results show a high level of service coding accuracy among encounter data dates of services, with over 90.0 percent of sampled encounters having date of service documentation that supported the encounter data.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to MCO 412 Audit Over-Read

Results from HSAG's FY 2018–2019 MCO over-read suggest opportunities for DHMP to improve its encounter data quality. Specifically, DHMP's 412 internal audit results showed greater than 15.0 percent of cases with diagnosis code and/or procedure code encounter data values not supported by medical record documentation, as well as variation in disagreement rates between service categories. To address encounter data deficiencies, HSAG recommends that DHMP implement robust encounter data quality

monitoring procedures, and ensure contracted providers are trained to submit encounters that accurately reflect medical record documentation and services rendered.

Validation of Network Adequacy

COA Region 5: Strengths

COA's Provider Data Structure Questionnaire responses noted that COA updates its provider data using the providers' triennial recredentialing information. COA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contract provider. COA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

COA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify providers into applicable BH provider categories.

COA identified PNC providers as individuals with OB/GYN or nurse midwifery specialties, but also included selected family medicine practitioners who offer OB/GYN services.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. COA also did not indicate that it uses the NPPES Registry, the American Board of Medical Specialties board certification database, or the providers' CHCP applications to validate providers' type and specialty information.

Although COA consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, COA did not restrict these data indicators by degree or credential. Further, COA reported that it does not collect providers' taxonomy codes and COA's data included similar, but not identical, data values for the provider type and specialty fields. These factors complicated HSAG's efforts to map COA's provider data to the Department's provider categories.

As the first comprehensive review of COA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing COA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, COA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

DHMP: Strengths

DHMP's Provider Data Structure Questionnaire responses noted that DHMP updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. DHMP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the DHMP data system, these individual providers were not listed on network provider rosters. DHMP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contract provider.

DHMP reported including Denver Public Health within its provider network, facilitating the identification of providers who serve members with clinical conditions of public health importance.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although DHMP noted using the self-reported provider specialty information to identify PCPs or PNC providers, DHMP did not restrict these data indicators by degree or credential. Additionally, DHMP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map DHMP's provider data to the Department's provider categories. Further, DHMP reported that panel capacity information was not available in its provider data system, though DHMP did not state whether such information may be obtained during PCPs' application or credentialing process. Finally, provider data submitted by DHMP included no records for substance abuse treatment facilities.

As the first comprehensive review of DHMP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing DHMP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, DHMP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 6—Colorado Community Health Alliance (CCHA)

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 6 Overall Evaluation

Table 3-50 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-50—Summary of CCHA Region 6 Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	11	11	0	0	0	100%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	14	12	2	0	5	86%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	6	2	0	0	75%
Totals	**45**	**40**	**36**	**4**	**0**	**5**	**90%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

CCHA Region 6: Strengths

CCHA demonstrated multiple strengths in the organization and implementation of care coordination processes for members with complex needs. CCHA's CC program for members with complex needs had been organized into multidisciplinary teams associated with specialized program areas, which included BH transitions of care; complex care management; ED follow-up; justice-involved members; maternity, pediatric, and foster care; medical transitions of care; and Member Support Services. CCHA members were assigned to a program team according to individual needs and goals. CCHA also strategically co-located CCs throughout the region in large PCMP practices, hospitals, criminal justice facilities, and community-based locations. In addition, CCHA delegated care coordination to six large PCMP partners, known as Accountable Care Networks (ACNs), supported by an ACN provider contract with each entity. The contracts specified requirements to perform comprehensive care coordination for RAE members. CCHA demonstrated that it had audited each ACN provider's care coordination documentation system to ensure

compliance with the contractually required elements. CCHA's *Care Coordination* policy addressed all care coordination program requirements for acute, complex, and high-risk members and was supported by procedures outlined in program descriptions for each specialized program area. CCHA had processes for Member Support Services staff members to perform outreach to each newly enrolled member to conduct onboarding, administer member needs assessments, assist members with correct attribution to PCMPs, and to arrange services as indicated in the results of the assessments. CCHA's processes also included conducting a more comprehensive needs assessment with any member identified (through Member Support Services, stratification data, or provider or community referrals) as needing complex care coordination services. For members not engaged in complex care coordination, the member's medical home provider was responsible for coordinating care for members. Practice transformation coaches assisted PCMPs in developing care coordination resources within each practice. PCMPs could also refer any member to CCHA care coordinators at any time. CCHA documented all member care coordination information in CCHA's Essette care management software. Care coordinators shared results of assessments and the care coordination plan with other providers involved with each member's care through secured faxed copies from the Essette system.

CCHA maintained numerous policies and procedures that together outlined the health plan's effort to define and uphold member rights. HSAG found all member rights present in policies and procedures, as required by the State contract and afforded members under 42 CFR §438.100. In addition, CCHA's policies and procedures addressed CCHA compliance with other federal or State laws pertaining to member rights. Members were given information about their rights through distribution of the HFC Member Handbook and directly on the CCHA website. Providers were informed of member rights through the PH provider manual and the BH provider manual. CCHA tracked and trended member grievances to determine which grievances were due to potential violations of member rights. CCHA's policies and procedures pertaining to advance directives addressed all required components. Members received information concerning advance directives through the CCHA website and from care coordination staff members and peer support specialists.

CCHA provided required member information in a manner and format that is easily understood. The information was available to all members via CCHA's website. Written and electronic information was tested with CCHA's Member Advisory Committee prior to distribution or posting, to ensure that content in English and Spanish was easily understood. CCHA contracted with a vendor for language translation services, which were available to members at each point of contact when requested. CCHA had several mechanisms in place to help members understand the benefits and requirements of the plan. Mechanisms included phone call access to Member Support Services staff members, the CCHA website, and the HFC Member Handbook. CCHA's website was easily navigable by members and provided members with information about how to find a provider through its provider directory, a link to the Department's formulary, the Health First Colorado nurse line phone number, the Colorado Crisis Services phone number, a list of member benefits, how to obtain care coordination services, and contact information for CCHA staff members.

CCHA members were able to obtain information about EPSDT benefits through multiple mechanisms, which included the member website, the HFC Member Handbook, and a link to the HFC EPSDT fact sheet. Hard copy handouts of the EPSDT fact sheet were also distributed to members at various points of contact with members and their families. CCHA stated that individual member contact was more

effective than mass communications to educate members on EPSDT benefits and services. In the future, CCHA is considering a member outreach campaign for all members stratified as "healthy members" to engage those members in well-care visits. Providers were educated on EPSDT benefits through provider manuals, provider newsletters, and information on the provider website. Provider KPIs were aligned with achieving well-child visits outlined in the pediatric well-child periodicity schedule. In the future, CCHA plans to update providers on EPSDT benefits by incorporating webinars in joint PH/BH town hall meetings. CCHA's *EPSDT* policy outlined all requirements for provision of medically necessary BH services for EPSDT-eligible members and included EPSDT-related requirements in the BH provider manual. CCHA indicated that provider relations, care coordination, practice transformation, UM, and Member Services staff members assisted providers with resolving barriers related to EPSDT services. CCHA pediatric program care coordinators maintained relationships with numerous community partners, community agencies, and community support providers to meet members' EPSDT service needs. CCHA had finalized an MOU with all Healthy Communities contractors in the region for onboarding newly enrolled members, conducting an enrollment screening, and referring members as appropriate to CCHA care coordinators.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections.

Standard V—Member Information

Although CCHA's website included comprehensive information for members, HSAG found that various pages of the website contained accessibility and contrast errors per Section 508 guidelines. In addition, HSAG found that the searchable provider directory had significant accessibility and contrast errors. CCHA Region 6 was required to:

- Ensure that the content of the CCHA website is fully machine-readable and readily accessible per Section 508 guidelines.
- Ensure that the electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

While CCHA's *EPSDT* policy addressed all requirements for provisions of medically necessary BH services for EPSDT-eligible members, neither the BH provider manual nor other provider communications clearly addressed the responsibilities of BH providers for provision of the required components of the capitated BH benefits related to EPSDT. In addition, CCHA's *Clinical Criteria for Utilization Management Decisions* policy and procedure defined "medical necessity" using language that did not correspond to the most recent version of medical necessity criteria outlined in the Code of Colorado Regulations, including the EPSDT-specific medical necessity criteria. CCHA Region 6 was required to:

- Enhance provider communications to ensure that BH providers understand all requirements for the provisions of applicable EPSDT-related capitated BH services for members ages 20 and under.
- Ensure that medical necessity criteria for UM decisions pertaining to EPSDT-related services are consistent with CCHA's *EPSDT* policy and correspond with the complete definition of "medical necessity" as outlined in the most recent version of the Colorado Code of Regulations.

Validation of Performance Improvement Projects

CCHA Region 6: Accountable Care PIP

Table 3-51 displays the FY 2018–2019 validation findings for CCHA's *Well-Care Visits for Children Ages 15–18 Years* PIP.

Table 3-51—Validation Findings for the *Well-Care Visits for Children Ages 15–18 Years* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Rocky Mountain Pediatrics.
SMART Aim Statement	To increase well-care visits in children at Rocky Mountain Pediatrics 15–18 years of age from 5.2% to 10.2% by June 30, 2020.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	Percentage of children aged 15 through 18 years who had at least one comprehensive well-care visit with a primary care practitioner during the rolling 12-month measurement period at Rocky Mountain Pediatrics.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection using a rolling 12-month measurement period.

CCHA Region 6: Strengths

CCHA selected an accountable care PIP topic focused on increasing the rate of well-care visits among members 15 to 18 years of age. The RAE has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that CCHA designed a methodologically sound project and was successful in building quality improvement teams and establishing collaborative partnerships. CCHA has progressed to Module 3, where the RAE will determine potential interventions to test for the PIP.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, CCHA will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As CCHA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

CCHA Region 6: Behavioral Health PIP

Table 3-52 displays the FY 2018–2019 validation findings for CCHA's *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP.

Table 3-52—Validation Findings for *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Module 1—PIP Initiation	
Narrowed Focus Population*	*Not yet determined.* The health plan will provide the narrowed focus in October 2019 when 12 months of baseline data have been collected and analyzed for narrowed focus selection.
SMART Aim Statement*	By June 30, 2020, increase the percentage of members who had a follow-up Behavioral Health assessment visit within 30 days following a positive depression screening among [targeted population] from [baseline rate] to [goal].
Module 2—SMART Aim Data Collection	
SMART Aim Measure*	Percentage of [targeted population] members with a positive depression screen who had a follow-up behavioral health assessment visit within 30 days during the rolling 12-month measurement period.

Module 1—PIP Initiation	
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly, based on a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

**The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

CCHA Region 6: Strengths

CCHA selected a BH PIP topic focused on increasing the percentage of members who received follow-up mental health services within 30 days of screening positive for depression. The RAE designed a methodologically sound project and received a *Conditional Pass* on Module 1 and Module 2, achieving all validation criteria that did not require 12 months of historical data.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

CCHA will have the opportunity to update Module 1 and Module 2 after 12 months of baseline data have been collected for the PIP. At that time, the RAE will set a goal for improvement in relation to the baseline rate. Additionally, in the next phase of the BH PIP, CCHA will have the opportunity to analyze existing processes related to improving the follow-up rates for members with a positive depression screen at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As CCHA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Set a SMART Aim goal that represents real improvement over the baseline rate and is attainable within the time frame defined by the SMART Aim end date.
- Design a SMART Aim data collection methodology that is comparable to the baseline data collection methodology and supports the rapid-cycle process.
- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.

- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey

Table 3-53 shows the adult PCMH CAHPS results achieved by CCHA Region 6 for FY 2018–2019.

Table 3-53—Adult PCMH CAHPS Question Summary Rates and Global Proportions for CCHA Region 6

Measure	FY 2018–2019 Rate
Rating of Provider	61.1%
Rating of Specialist Seen Most Often	55.3%
Rating of All Health Care	55.8%
Rating of Health Plan	57.6%
Getting Timely Appointments, Care, and Information	43.4%
How Well Providers Communicate with Patients	71.5%
Providers' Use of Information to Coordinate Patient Care	58.4%
Talking with You About Taking Care of Your Own Health	51.0%
Comprehensiveness	58.3%
Helpful, Courteous, and Respectful Office Staff	69.3%
Health First Colorado Customer Service	56.4%
Received Care from Provider Office During Evenings, Weekends, or Holidays	22.2%
Reminders about Care from Provider Office	74.5%
Saw Provider Within 15 Minutes of Appointment	32.9%
Received Health Care and Mental Health Care at Same Place	58.5%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

CCHA Region 6: Strengths

For the CCHA adult population, the following three measures had the highest rates compared to the other measures' rates:

- *Reminders about Care from Provider Office* (74.5 percent)
- *How Well Providers Communicate with Patients* (71.5 percent)
- *Helpful, Courteous, and Respectful Office Staff* (69.3 percent)

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the CCHA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (22.2 percent)
- *Saw Provider Within 15 Minutes of Appointment* (32.9 percent)
- *Getting Timely Appointments, Care, and Information* (43.4 percent)

HSAG recommends that CCHA develop initiatives designed to improve access and timeliness of care provided.

Table 3-54 shows the child PCMH CAHPS results achieved by CCHA Region 6 for FY 2018–2019.

Table 3-54—Child PCMH CAHPS Question Summary Rates and Global Proportions for CCHA Region 6

Measure	FY 2018–2019 Rate
Rating of Provider	81.2%
Rating of Specialist Seen Most Often	66.1%+
Rating of All Health Care	76.5%
How Well Providers Communicate with Child	79.5%
Getting Timely Appointments, Care, and Information	72.3%
How Well Providers Communicate with Parents or Caretakers	84.1%
Providers' Use of Information to Coordinate Patient Care	78.2%
Comprehensiveness: Child Development	67.7%
Comprehensiveness: Child Safety and Healthy Lifestyles	58.1%
Helpful, Courteous, and Respectful Office Staff	80.8%
Received Information on Evening, Weekend, or Holiday Care for Child	86.1%
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	31.7%+
Saw Provider Within 15 Minutes of Appointment	54.8%
Reminders about Child's Care from Provider Office	72.5%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

CCHA Region 6: Strengths

For the CCHA child population, the following three measures had the highest rates compared to the other measures' rates:

- *Received Information on Evening, Weekend, or Holiday Care for Child* (86.1 percent)
- *How Well Providers Communicate with Parents or Caretakers* (84.1 percent)
- *Rating of Provider* (81.2 percent)

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the CCHA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (31.7 percent)
- *Saw Provider Within 15 Minutes of Appointment* (54.8 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (58.1 percent)

HSAG recommends that CCHA develop initiatives designed to improve access and timeliness of care and comprehensiveness of care for children.

ECHO Survey

Table 3-55 shows the adult ECHO survey results achieved by CCHA Region 6 for FY 2018–2019.

Table 3-55—Adult ECHO Question Summary Rates and Global Proportions for CCHA Region 6

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	44.3%
Getting Treatment Quickly	66.3%
How Well Clinicians Communicate	88.7%
Perceived Improvement	59.9%
Information About Treatment Options	66.1%
Office Wait	83.0%
Told About Medication Side Effects	76.6%
Including Family	38.0%
Information to Manage Condition	71.8%
Patient Rights Information	91.3%

Measure	FY 2018–2019 Rate
Patient Feels He or She Could Refuse Treatment	85.6%
Privacy	91.8%
Cultural Competency	NA
Amount Helped	77.3%
Improved Functioning	53.6%
Social Connectedness	64.5%

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

CCHA Region 6: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (91.8 percent)
- *Patient Rights Information* (91.3 percent)
- *How Well Clinicians Communicate* (88.7 percent)

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the CCHA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Including Family* (38.0 percent)
- *Rating of All Counseling or Treatment* (44.3 percent)
- *Improved Functioning* (53.6 percent)

HSAG recommends that CCHA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-56 shows the child ECHO survey results achieved by CCHA Region 6 for FY 2018–2019.

Table 3-56—Child ECHO Question Summary Rates and Global Proportions for CCHA Region 6

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	46.7%
Getting Treatment Quickly	66.9%+
How Well Clinicians Communicate	86.5%
Perceived Improvement	70.1%
Information About Treatment Options	72.9%
Office Wait	89.2%
Told About Medication Side Effects	81.6%+
Information to Manage Condition	67.0%
Patient Rights Information	91.5%
Respondent Feels He or She Could Refuse Treatment for Their Child	89.1%
Privacy	94.2%
Cultural Competency	NA
Amount Helped	78.3%
Improved Functioning	66.9%
Social Connectedness	86.0%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

CCHA Region 6: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (94.2 percent)
- *Patient Rights Information* (91.5 percent)
- *Respondent Feels He or She Could Refuse Treatment for Their Child* (89.1 percent)

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the CCHA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (46.7 percent)
- *Getting Treatment Quickly* (66.9 percent)
- *Improved Functioning* (66.9 percent)

HSAG recommends that CCHA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

CCHA Region 6: Strengths

CCHA's questionnaire responses, documentation, and follow-up responses suggest that CCHA maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. Anthem (an owner of CCHA) regularly generates internal reports to monitor encounter data quality using metrics for completeness, accuracy, and timeliness of claims and encounter data. However, CCHA supplied no sample reports to supplement its IS review questionnaire responses.

CCHA's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Though CCHA reported an institutional flat file acceptance rate of 80.0 percent, it reported no issues with BH encounter flat file submission.

CCHA's questionnaire responses indicated that it uses a robust, multi-source verification system to obtain timely information on members' third-party liability (TPL) and Medicare dual enrollment. CCHA reported that it adjusts BH claims and encounters requiring updated TPL information and resubmits these encounters to the Department in a timely manner.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

CCHA reported high rejection rates for X12 837 I/P transaction files (90.0 percent each for institutional and professional encounters). In contrast, the Department reported no rejection rates for CCHA's X12 encounter data files, noting that CCHA had not successfully submitted files as of January 2019. CCHA indicated that insufficiently detailed X12 transaction file business validation rules in the Department's Encounter Data Compliance Guides contributed to CCHA's high encounter file rejection rate.

As of the March 2019 questionnaire responses, CCHA indicated that it was submitting X12 transaction files to the Department despite high rejection rates. CCHA participates in regular meetings with the Department and its EDI vendor, and reported making ongoing modifications to its existing data management policies and procedures. CCHA noted that it was making coding changes to accommodate data specifications unique to the X12 transaction files (i.e., requirements that were not needed for the legacy flat files).

Based on the IS review findings, HSAG offers the following recommendations to improve CCHA's BH encounter data quality:

- As of the March 2019 questionnaire responses, CCHA indicated that its encounter data policies and procedures were being updated; the Department should verify that the policies and procedures were updated by requesting and reviewing copies of CCHA's documents.

- CCHA reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which CCHA may enhance its encounter data oversight.
- As CCHA reported high rejection rates for X12 837 I/P transaction files to the Department as of March 2019, CCHA should conduct a thorough comparative analysis between its flat file submissions and any successfully submitted X12 transaction files since that time to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on CCHA's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Validation of Network Adequacy

CCHA Region 6: Strengths

CCHA's Provider Data Structure Questionnaire responses noted that CCHA updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. CCHA noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the CCHA data system, these individual providers were not listed on network provider rosters. CCHA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contract provider. CCHA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

CCHA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify these providers into applicable BH provider categories.

CCHA reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. CCHA used self-reported provider specialty information to identify PNC providers. CCHA's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map CCHA's provider data to the Department's provider categories.

While CCHA noted that it supported provider data monitoring processes, it offered no sample reports or supporting documentation showing processes for regularly assessing provider data completeness and accuracy.

As the first comprehensive review of CCHA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing CCHA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, CCHA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Region 7—Colorado Community Health Alliance

Assessment of Compliance With Medicaid Managed Care Regulations

CCHA Region 7 Overall Evaluation

Table 3-57 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; the percent compliant for each standard; and the overall compliance score for FY 2018–2019.

Table 3-57—Summary of CCHA Region 7 Scores for the FY 2018–2019 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard III—Coordination and Continuity of Care	11	11	11	0	0	0	100%
Standard IV—Member Rights and Protections	7	7	7	0	0	0	100%
Standard V—Member Information	19	14	12	2	0	5	86%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	6	2	0	0	75%
Totals	**45**	**40**	**36**	**4**	**0**	**5**	**90%***

**The overall compliance score is calculated by summing the total number of Met elements and dividing by the total number of applicable elements.*

CCHA Region 7: Strengths

CCHA demonstrated multiple strengths in the organization and implementation of care coordination processes for members with complex needs. CCHA's care coordination program for members with complex needs had been organized into multidisciplinary care coordination teams associated with specialized program areas, which included BH transitions of care; complex care management; ED follow-up; justice-involved members; maternity, pediatric, and foster care; medical transitions of care; and Member Support Services. CCHA members were assigned to a program team according to individual needs and goals. CCHA also strategically co-located care coordinators throughout the region in large PCMP practices, hospitals, criminal justice facilities, El Paso DHS, and community-based locations. In addition, CCHA delegated care coordination to two large PCMP partners known as ACNs supported by an ACN provider contract with each entity. The contracts specified requirements to perform comprehensive care coordination for RAE members. CCHA demonstrated that it had audited

each ACN provider's care coordination documentation system to ensure compliance with required elements. Within Region 7, a well-established network of community agencies and providers collaborate to improve services for members in the community. Through individualized service and support teams, these collaborative groups coordinated and managed provision of services to children and families through integrated multi-agency service plans. CCHA's *Care Coordination* policy addressed all care coordination program requirements for acute, complex, and high-risk members and was supported by procedures outlined in program descriptions for each specialized program area. CCHA had processes for Member Support Services staff members to perform outreach to each newly enrolled member to conduct onboarding, administer member needs assessments, assist members with correct attribution to PCMPs, and arrange services as indicated in the results of the assessments. CCHA's processes also included conducting a more comprehensive needs assessment with any member identified (through Member Support Services, stratification data, or provider or community referrals) as needing complex care coordination services. CCHA developed a service plan for each member based on results of the assessments. For members not engaged in complex care coordination, the member's medical home provider was responsible for coordinating care for members. Practice transformation coaches assisted PCMPs to develop care coordination resources within each practice. PCMPs could also refer any member to CCHA care coordinators at any time. CCHA documented all member care coordination information in CCHA's Essette care management software. Care coordinators shared results of assessments and the care coordination plan with other providers involved with each member's care through secured faxed copies from the Essette system.

CCHA maintained numerous policies and procedures that together outlined the health plan's effort to define and uphold member rights. HSAG found all member rights present in policies and procedures, as required by the State contract and afforded members under 42 CFR §438.100. In addition, CCHA's policies and procedures addressed CCHA compliance with other federal or State laws pertaining to member rights. Members were given information about their rights through distribution of the HFC Member Handbook and directly on the CCHA website. Providers were informed of member rights through the PH provider manual and the BH provider manual. CCHA tracked and trended member grievances to determine which grievances were due to potential violations of member rights. CCHA's policies and procedures pertaining to advance directives addressed all required components. Members received information concerning advance directives through the CCHA website and from care coordination staff members and peer support specialists. Providers were encouraged to discuss and educate members around advance directives.

CCHA provided required member information in a manner and format that is easily understood. The information was available to all members via CCHA's website. Written and electronic information was tested with CCHA's Member Advisory Committee prior to distribution or posting, to ensure that content in English and Spanish was easily understood. CCHA contracted with a vendor for language translation services, which were available to members at each point of contact when requested. CCHA had several mechanisms in place to help members understand the benefits and requirements of the plan. Mechanisms included phone call access to Member Support Services staff members, the CCHA website, and the HFC Member Handbook. CCHA's website was easily navigable by members and provided members with information on how to find a provider through its provider directory, a link to the Department's formulary, the Health First Colorado nurse line phone number, the Colorado Crisis Services phone number, a list of

member benefits, how to obtain care coordination services, and contact information for CCHA staff members.

CCHA informed members about EPSDT benefits through multiple mechanisms, which included the member website, the HFC Member Handbook, and a link to the HFC EPSDT fact sheet. CCHA also distributed hard copy handouts of the EPSDT fact sheet at various points of contact with members and families. CCHA stated that individual member contact was more effective than mass communications to educate members on EPSDT benefits and services. In the future, CCHA is considering a member outreach campaign for all members stratified as "healthy members" to engage those members in well-care visits. Providers were educated on EPSDT benefits through provider manuals, provider newsletters, and information on the provider website. Provider KPIs were aligned with achieving well-child visits outlined in the pediatric well-child periodicity schedule. In the future, CCHA plans to update providers on EPSDT benefits by incorporating webinars in joint PH/BH town hall meetings. CCHA's *EPSDT* policy outlined all requirements for provision of medically necessary BH services for EPSDT-eligible members and included EPSDT-related requirements in the BH provider manual. CCHA stated that Region 7 UM staff members and medical directors regularly interacted with CCs and participated in integrated rounds to discuss complex cases potentially related to EPSDT benefits. CCHA had finalized an MOU with all Healthy Communities contractors in the region for onboarding newly enrolled members, conducting an enrollment screening, and referring members as appropriate to CCHA care coordinators. In addition, CCHA reported that Healthy Communities staff members housed at Memorial Hospital attempt to visit every Medicaid mother and baby born in El Paso County to provide information about the RAE.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections.

Standard V—Member Information

Although CCHA's website included comprehensive information for members, HSAG found that various pages of the website contained accessibility and contrast errors per Section 508 guidelines. In addition, HSAG found that the searchable provider directory had significant accessibility and contrast errors. CCHA Region 7 was required to:

- Ensure that the content of the CCHA website is fully machine-readable and readily accessible per Section 508 guidelines.
- Ensure that the electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

While CCHA's *EPSDT* policy addressed all requirements for provisions of medically necessary BH services for EPSDT-eligible members, neither the BH provider manual nor other provider

communications clearly addressed the responsibilities of BH providers for provision of the required components of the capitated BH benefits related to EPSDT. In addition, CCHA's *Clinical Criteria for Utilization Management Decisions* policy and procedure defined "medical necessity" using language that did not correspond to the most recent version of medical necessity criteria outlined in the Colorado Code of Regulations, including the EPSDT-specific medical necessity criteria. CCHA Region 7 was required to:

- Enhance provider communications to ensure that BH providers understand all requirements for the provisions of applicable EPSDT-related capitated BH services for members ages 20 and under.
- Ensure that medical necessity criteria for UM decisions pertaining to EPSDT-related services are consistent with CCHA's *EPSDT* policy and correspond with the complete definition of "medical necessity" as outlined in the most recent version of the Colorado Code of Regulations.

Validation of Performance Improvement Projects

CCHA Region 7: Accountable Care PIP

Table 3-58 displays the FY 2018–2019 validation findings for CCHA's *Well-Care Visits for Children Ages 15–18 Years* PIP.

Table 3-58—Validation Findings for the *Well-Care Visits for Children Ages 15–18 Years* PIP

Module 1—PIP Initiation	
Narrowed Focus Population	Members 15 through 18 years of age attributed to Iron Horse Pediatrics.
SMART Aim Statement	To increase well-care visits in children at Iron Horse Pediatrics 15–18 years of age from 14.8% to 19.8% by June 30, 2020.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	Percentage of children aged 15 through 18 years who had at least one comprehensive well-care visit with a primary care practitioner during the rolling 12-month measurement period at Iron Horse Pediatrics.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Methodology:** Monthly data collection, using a rolling 12-month measurement period.

CCHA Region 7: Strengths

CCHA selected an accountable care PIP topic focused on increasing the rate of well-care visits among members 15 to 18 years of age. The RAE has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that CCHA designed a methodologically sound project, and was successful in building quality improvement teams and

establishing collaborative partnerships. CCHA has progressed to Module 3, where the RAE will determine potential interventions to test for the PIP.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

In the next phase of the accountable care PIP, CCHA will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As CCHA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

CCHA Region 7: Behavioral Health PIP

Table 3-59 displays the FY 2018–2019 validation findings for CCHA's *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP.

Table 3-59—Validation Findings for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Module 1—PIP Initiation	
Narrowed Focus Population*	*Not yet determined.* The health plan will provide the narrowed focus in October 2019 when 12 months of baseline data have been collected and analyzed for narrowed focus selection.
SMART Aim Statement*	By June 30, 2020, increase the percentage of members who had a follow-up Behavioral Health assessment visit within 30 days following a positive depression screening among [targeted population] from [baseline rate] to [goal].

Module 1—PIP Initiation	
Module 2—SMART Aim Data Collection	
SMART Aim Measure*	Percentage of [targeted population] members with a positive depression screen who had a follow-up behavioral health assessment visit within 30 days during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	• **Data Source:** Administrative claims. • **Data Collection:** Monthly, based on a rolling 12-month measurement period. Denominator events must occur at least 30 days prior to the last day of each measurement period to allow for follow-up within the measurement period.

**The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

CCHA Region 7: Strengths

CCHA selected a BH PIP topic focused on increasing the percentage of members who received follow-up mental health services within 30 days of screening positive for depression. The RAE designed a methodologically sound project and received a *Conditional Pass* on Module 1 and Module 2, achieving all validation criteria that did not require 12 months of historical data.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

CCHA will have the opportunity to update Module 1 and Module 2 after 12 months of baseline data have been collected for the PIP. At that time, the RAE will set a goal for improvement in relation to the baseline rate. Additionally, in the next phase of the BH PIP, CCHA will have the opportunity to analyze existing processes related to improving the follow-up rates for members with a positive depression screen at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The RAE will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As CCHA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Set a SMART Aim goal that represents real improvement over the baseline rate and is attainable within the time frame defined by the SMART Aim end date.
- Design a SMART Aim data collection methodology that is comparable to the baseline data collection methodology and supports the rapid-cycle process.
- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Survey

Table 3-60 shows the adult PCMH CAHPS results achieved by CCHA Region 7 for FY 2018–2019.

Table 3-60—Adult PCMH CAHPS Question Summary Rates and Global Proportions for CCHA Region 7

Measure	FY 2018–2019 Rate
Rating of Provider	74.9%
Rating of Specialist Seen Most Often	65.0%
Rating of All Health Care	67.6%
Rating of Health Plan	60.5%
Getting Timely Appointments, Care, and Information	54.3%
How Well Providers Communicate with Patients	82.4%
Providers' Use of Information to Coordinate Patient Care	68.4%
Talking with You About Taking Care of Your Own Health	53.5%
Comprehensiveness	60.1%
Helpful, Courteous, and Respectful Office Staff	71.6%
Health First Colorado Customer Service	66.0%+
Received Care from Provider Office During Evenings, Weekends, or Holidays	28.8%+
Reminders about Care from Provider Office	76.8%
Saw Provider Within 15 Minutes of Appointment	44.2%
Received Health Care and Mental Health Care at Same Place	51.2%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

CCHA Region 7: Strengths

For the CCHA adult population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Patients* (82.4 percent)
- *Reminders about Care from Provider Office* (76.8 percent)
- *Rating of Provider* (74.9 percent)

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the CCHA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (28.8 percent)
- *Saw Provider Within 15 Minutes of Appointment* (44.2 percent)
- *Received Health Care and Mental Health Care at Same Place* (51.2 percent)

HSAG recommends that CCHA develop initiatives designed to improve access and timeliness of care provided.

Table 3-61 shows the child PCMH CAHPS results achieved by CCHA Region 7 for FY 2018–2019.

Table 3-61—Child PCMH CAHPS Question Summary Rates and Global Proportions for CCHA Region 7

Measure	FY 2018–2019 Rate
Rating of Provider	78.3%
Rating of Specialist Seen Most Often	71.6%
Rating of All Health Care	77.5%
How Well Providers Communicate with Child	83.7%
Getting Timely Appointments, Care, and Information	73.4%
How Well Providers Communicate with Parents or Caretakers	85.3%
Providers' Use of Information to Coordinate Patient Care	72.6%
Comprehensiveness: Child Development	64.9%
Comprehensiveness: Child Safety and Healthy Lifestyles	55.1%
Helpful, Courteous, and Respectful Office Staff	71.2%
Received Information on Evening, Weekend, or Holiday Care for Child	82.7%

Measure	FY 2018–2019 Rate
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	43.0%+
Saw Provider Within 15 Minutes of Appointment	46.2%
Reminders about Child's Care from Provider Office	70.0%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

CCHA Region 7: Strengths

For the CCHA child population, the following three measures had the highest rates compared to the other measures' rates:

- *How Well Providers Communicate with Parents or Caretakers* (85.3 percent)
- *How Well Providers Communicate with Child* (83.7 percent)
- *Received Information on Evening, Weekend, or Holiday Care for Child* (82.7 percent)

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the CCHA child population, the following three measures had the lowest rates compared to the other measures' rates:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (43.0 percent)
- *Saw Provider Within 15 Minutes of Appointment* (46.2 percent)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (55.1 percent)

HSAG recommends that CCHA develop initiatives designed to improve access and timeliness of care and comprehensiveness of care for children.

ECHO Survey

Table 3-62 shows the adult ECHO survey results achieved by CCHA Region 7 for FY 2018–2019.

Table 3-62—Adult ECHO Question Summary Rates and Global Proportions for CCHA Region 7

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	45.7%
Getting Treatment Quickly	61.7%+
How Well Clinicians Communicate	85.0%
Perceived Improvement	49.6%
Information About Treatment Options	54.2%
Office Wait	73.0%
Told About Medication Side Effects	73.4%+
Including Family	47.9%
Information to Manage Condition	71.3%
Patient Rights Information	87.5%
Patient Feels He or She Could Refuse Treatment	80.0%
Privacy	89.8%
Cultural Competency	NA
Amount Helped	78.3%
Improved Functioning	45.9%
Social Connectedness	55.3%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

CCHA Region 7: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (89.8 percent)
- *Patient Rights Information* (87.5 percent)
- *How Well Clinicians Communicate* (85.0 percent)

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the CCHA adult population, the following three measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (45.7 percent)
- *Improved Functioning* (45.9 percent)
- *Including Family* (47.9 percent)

HSAG recommends that CCHA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Table 3-63 shows the child ECHO survey results achieved by CCHA Region 7 for FY 2018–2019.

Table 3-63—Child ECHO Question Summary Rates and Global Proportions for CCHA Region 7

Measure	FY 2018–2019 Rate
Rating of All Counseling or Treatment	42.3%
Getting Treatment Quickly	73.3%+
How Well Clinicians Communicate	87.2%
Perceived Improvement	72.5%
Information About Treatment Options	72.8%
Office Wait	87.3%
Told About Medication Side Effects	90.0%+
Information to Manage Condition	76.0%
Patient Rights Information	88.8%
Respondent Feels He or She Could Refuse Treatment for Their Child	87.6%
Privacy	96.0%
Cultural Competency	NA
Amount Helped	84.2%
Improved Functioning	58.9%
Social Connectedness	81.8%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

CCHA Region 7: Strengths

The following three measures had the highest rates compared to the other measures' rates:

- *Privacy* (96.0 percent)
- *Told About Medication Side Effects* (90.0 percent)
- *Patient Rights Information* (88.8 percent)

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the CCHA child population, the following two measures had the lowest rates compared to the other measures' rates:

- *Rating of All Counseling or Treatment* (42.3 percent)
- *Improved Functioning* (58.9 percent)

HSAG recommends that CCHA work with the Department to explore areas that may be contributing to low experience scores for these measures and to develop initiatives for improvement, where appropriate.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

CCHA Region 7: Strengths

CCHA's questionnaire responses, documentation, and follow-up responses suggest that CCHA maintains robust policies and procedures to process BH claims and encounters and to generate encounter records in flat file and X12 transaction file formats. Anthem regularly generates internal reports to monitor encounter data quality using metrics for completeness, accuracy, and timeliness of claims and encounter data. However, CCHA supplied no sample reports to supplement its IS review questionnaire responses.

CCHA's questionnaire responses indicated that it has designed internal data "scrubbing" processes to capture, pend, and resolve encounter records that do not meet legacy flat file specifications. Though CCHA reported an institutional flat file acceptance rate of 80.0 percent, it reported no issues with BH encounter flat file submission.

CCHA's questionnaire responses indicated that it uses a robust, multi-source verification system to obtain timely information on members' TPL and Medicare dual enrollment. CCHA reported that it adjusts BH claims and encounters requiring updated TPL information and resubmits these encounters to the Department in a timely manner.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE IS Review

CCHA reported high rejection rates for X12 837 I/P transaction files (90.0 percent each for institutional and professional encounters). In contrast, the Department reported no rejection rates for CCHA's X12 encounter data files, noting that CCHA had not successfully submitted files as of January 2019. CCHA indicated that insufficiently detailed X12 transaction file business validation rules in the Department's Encounter Data Compliance Guides contributed to CCHA's high encounter file rejection rate.

As of the March 2019 questionnaire responses, CCHA indicated that it was submitting X12 transaction files to the Department despite high rejection rates. CCHA participates in regular meetings with the Department and its EDI vendor, and reported making ongoing modifications to its existing data management policies and procedures. CCHA noted that it was making coding changes to accommodate data specifications unique to the X12 transaction files (i.e., requirements that were not needed for the legacy flat files).

Based on the IS review findings, HSAG offers the following recommendations to improve CCHA's BH encounter data quality:

- As of the March 2019 questionnaire responses, CCHA indicated that its encounter data policies and procedures were being updated; the Department should verify that the policies and procedures were updated by requesting and reviewing copies of CCHA's documents.

- CCHA reported monitoring its encounter data quality and the Department should review examples of flat file and X12 encounter data quality monitoring reports across the RAEs. These reports may offer potential best practices or monitoring metrics by which CCHA may enhance its encounter data oversight.
- As CCHA reported high rejection rates for X12 837 I/P transaction files to the Department as of March 2019, CCHA should conduct a thorough comparative analysis between its flat file submissions and any successfully submitted X12 transaction files since that time to identify factors contributing to the Department's rejection of its X12 transaction files.
  - Based on CCHA's comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.

Validation of Network Adequacy

CCHA Region 7: Strengths

CCHA's Provider Data Structure Questionnaire responses noted that CCHA updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP application. CCHA noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the CCHA data system, these individual providers were not listed on network provider rosters. CCHA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodation(s), and panel capacity for each contract provider. CCHA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

CCHA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify providers into applicable BH provider categories.

CCHA reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. CCHA used self-reported data to further identify PNC providers. Additionally, CCHA's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map CCHA's provider data to the Department's provider categories.

While CCHA noted that it supported provider data monitoring processes, it offered no sample reports or supporting documentation showing processes for regularly assessing provider data completeness and accuracy.

As the first comprehensive review of CCHA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing CCHA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, CCHA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

4. Evaluation of Colorado's Behavioral Health Organizations

Access Behavioral Care—Denver (ABC-D)

Validation of Performance Measures

Information Systems Standards Review Results

HSAG identified no concerns with how ABC-D received and processed enrollment data; however, HSAG did identify an area for process improvement. ABC-D received daily 834 files and monthly full eligibility files from the Department's secure file transfer protocol (FTP) site. The daily files contained reinstatements, adds, terminations, and changes. The monthly files contained all members enrolled for the month it was received. ABC-D's data system automatically downloaded and scrubbed the files to determine if the information was a duplicate, new entry, or if errors were present. If errors were present, ABC-D's vendor, Colorado Medical Assistance Program (CMAP), reviewed and corrected the issues. If CMAP was unable to correct the entry, ABC-D reached out to the contract manager at the Department to obtain a resolution, and a manual update would be made until a new 834 file was received.

The scrub process confirmed whether a member already existed in the system by searching via state identification (ID) number, name, date of birth, and social security number before creating a new entry. Once scrubbed and validated, the data were automatically mapped by the system into tables and loaded into QNXT™, the BHO's transactional system. QNXT processed the files and loaded them into the enterprise data warehouse (EDW). New members loaded into QNXT were automatically assigned a unique ID number. Each member's state ID number was kept as a secondary identifier. ABC-D experienced limited instances in which members were issued more than one Medicaid ID number; these included members who changed their names and a few foster care members. In these instances, ABC-D linked both ID numbers and retained the assigned QNXT number within the system.

ABC-D submitted eligibility files to providers and affiliated CMHCs daily via secure FTP site. Providers also accessed the Department's eligibility portal to obtain eligibility information for members. ABC-D had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

HSAG identified no issues or concerns with how ABC-D received, processed, or reported claims and encounter data.

ABC-D required that providers submit all professional and institutional claims and encounters within 120 days. Claims and encounters were received and processed the same way. Electronic professional and institutional claims and encounters data were received in an 837 file through a secure FTP site or provider clearinghouse. The files were loaded into QNXT, and ABC-D performed checks using BizTalk,

a Microsoft software, to identify accurate formatting and complete data. A 999-file format response file was generated in addition to a 277 acceptance or rejection report and sent to the providers via the FTP site.

Approximately 4 percent of all professional and institutional claims that ABC-D received were submitted via paper. Paper claims were received via the mailroom where they were stamped with the date of receipt, sorted, scanned, and uploaded to Cognizant's FTP site daily, through which these documents were converted into 837 I/P files using optical character recognition (OCR) software before being loaded into QNXT. If the paper claim could not be converted automatically via OCR, then it was manually entered. Less than 1 percent of claims were manually entered.

The BHO received State hospital data from the Department quarterly via a secure email in an Excel spreadsheet file. The data included member name, Medicaid ID number, admit and discharge dates, and the total number of inpatient days. This information was saved on a shared drive then loaded into the EDW to be included in the BHO's performance measure calculations. ABC-D notified HSAG that data for May 2018 and June 2018 were not provided by the Department but, due to the small number of claims estimated for this time frame, this did not impact the BHO's ability to report the measures that included these data.

Auto-adjudication was outsourced to Cognizant. A mass auto-adjudication job was performed so that pended claims were opened and edited nightly. All professional and institutional claims and encounters were verified to ensure that appropriate enrollment and provider information were submitted. Approximately 75 to 80 percent of all claims received by ABC-D were auto-adjudicated. If claims failed and could not be edited in the system, Cognizant manually updated the claims.

ABC-D submitted standard 837 I/P files and flat files to the Department through a secure FTP site monthly. ABC-D experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, ABC-D sent both 837 and flat files to ensure the Department received all necessary information.

HSAG identified no major concerns with ABC-D's data integration and measure calculation process.

ABC-D had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Claims and encounters were extracted from QNXT and loaded into the EDW for rate calculation. ABC-D generated a query in the EDW to generate both denominator and numerator compliant members for each indicator. Once the data were queried, they were extracted and loaded into an Oracle system in which tables were created. The BHO loaded state hospital data into Oracle, and the data were integrated with the data contained in the Oracle tables in the EDW. COA's business intelligence department generated the indicator rates and submitted them to ABC-D's quality department. The quality department conducted Primary Source Verification (PSV) on a selection of entries every 45 days and ran new preliminary quarterly counts to ensure accuracy before the data were finalized and submitted to the Department.

Performance Measure Results

Table 4-1 shows the MY 2016–2017 and MY 2017–2018 measure results for ABC-D and the corresponding incentive performance targets. Cells shaded green would indicate the BHO's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 4-1—Measure Results for ABC-D

Performance Measures	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	35.56%	45.52%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	55.84%	62.02%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	19.32%	16.92%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	36.58%	36.75%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	53.48%	52.72%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	23.26	21.00	7.20
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	42.51	40.78	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).

For MY 2017–2018, ABC-D did not meet the performance target for any incentive measures. Of note, the *Mental Health Engagement (All Members Excluding Foster Care)* and *Mental Health Engagement (Only Foster Care)* measure rates demonstrated a relative improvement in performance from MY 2016–2017 to MY 2017–2018 of approximately 10 percent or more. Additionally, the measure rates for *Mental Health Engagement (All Members Excluding Foster Care)* and *Mental Health Engagement (Only Foster Care)* were within 3 percentage points of the incentive performance targets. Conversely, several of the remaining measure rates would need to improve by more than 20 percentage points to meet or exceed their respective incentive performance targets.

Access Behavioral Care—Northeast (ABC-NE)

Validation of Performance Measures

Information Systems Standards Review Results

HSAG identified no concerns with how ABC-NE received and processed enrollment data; however, HSAG did identify an area for process improvement.

ABC-NE received daily 834 files and monthly full eligibility files from the Department's secure FTP site. The daily files contained reinstatements, adds, terminations, and changes. The monthly files contained all members enrolled for the month it was received. ABD-NE's data system automatically downloaded and scrubbed the files to determine if the information was a duplicate, new entry, or if errors were present. If errors were present, ABC-NE's vendor, CMAP, reviewed and corrected the issues. If CMAP was unable to correct the entry, ABC-NE reached out to the contract manager at the Department to obtain a resolution, and a manual update would be made until a new 834 file was received.

The scrub process confirmed whether a member already existed in the system by searching via state ID number, name, date of birth, and social security number before creating a new entry. Once scrubbed and validated, the data were automatically mapped by the system into tables and loaded into QNXT, the BHO's transactional system. QNXT processed the files and loaded them into the EDW. New members loaded into QNXT were automatically assigned a unique ID number. Each member's state ID number was kept as a secondary identifier. ABC-NE experienced limited instances in which members were issued more than one Medicaid ID number; these included members who changed their names and a few foster care members. In these instances, ABC-NE linked both ID numbers and retained the assigned QNXT number within the system.

ABC-NE submitted eligibility files to providers and affiliated CMHCs daily via secure FTP site. Providers also accessed the Department's eligibility portal to obtain eligibility information for members. ABC-NE had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

HSAG identified no issues or concerns with how ABC-NE received, processed, or reported claims and encounter data.

ABC-NE required that providers submit all professional and institutional claims and encounters within 120 days. Claims and encounters were received and processed the same way. Electronic professional and institutional claims and encounters data were received in an 837 file through a secure FTP site or provider clearinghouse. The files were loaded into QNXT, and ABC-NE performed checks using BizTalk, a Microsoft software, to identify accurate formatting and complete data. A 999-file format response file was generated in addition to a 277 acceptance or rejection report and sent to the providers via the FTP site.

Approximately 4 percent of all professional and institutional claims that ABC-NE received were submitted via paper. Paper claims were received via the mailroom where they were stamped with the date of receipt, sorted, scanned, and uploaded to Cognizant's FTP site daily, through which these documents were converted into 837 I/P files using OCR software before being loaded into QNXT. If the paper claim could not be converted automatically via OCR, then it was manually entered. Less than 1 percent of claims were manually entered.

The BHO received State hospital data from the Department quarterly via a secure email in an Excel spreadsheet file. The data included member name, Medicaid ID number, admit and discharge dates, and the total number of inpatient days. This information was saved on a shared drive then loaded into the EDW to be included in the BHO's performance measure calculations. ABC-NE notified HSAG that data for May 2018 and June 2018 were not provided by the Department but, due to the small number of claims estimated for this time frame, this did not impact the BHO's ability to report the measures that included these data.

Auto-adjudication was outsourced to Cognizant. A mass auto-adjudication job was performed so that pended claims were opened and edited nightly. All professional and institutional claims and encounters were verified to ensure that appropriate enrollment and provider information were submitted. Approximately 75 to 80 percent of all claims received by ABC-NE were auto-adjudicated. If claims failed and could not be edited in the system, Cognizant manually updated the claims.

ABC-NE submitted standard 837 I/P files and flat files to the Department through a secure FTP site monthly. ABC-NE experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, ABC-NE sent both 837 and flat files to ensure the Department received all necessary information.

HSAG identified no major concerns with ABC-NE's data integration and measure calculation process.

ABC-NE had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Claims and encounters were extracted from QNXT and loaded into the EDW for rate calculation. ABC-NE generated a query in the EDW to generate both denominator and numerator compliant members for each indicator. Once the data were queried, they were extracted and loaded into an Oracle system in which tables were created. The BHO loaded State hospital data into Oracle, and the data were integrated with the data contained in the Oracle tables in the EDW. The business intelligence department generated the indicator rates and submitted them to the quality department. The quality department conducted PSV on a selection of entries every 45 days and ran new preliminary quarterly counts to ensure accuracy before the data were finalized and submitted to the Department.

Performance Measure Results

Table 4-2 shows the MY 2016–2017 and 2017–2018 measure results for ABC-NE and the corresponding incentive performance targets. Cells shaded green would indicate the BHO's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 4-2—Measure Results for ABC-NE

Performance Measure	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	45.83%	48.30%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	59.01%	59.51%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	22.43%	24.49%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	40.40%	42.00%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	55.92%	58.90%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	16.16	14.46	7.20
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	21.74	24.37	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).

For MY 2017–2018, ABC-NE did not meet the performance target for any incentive measures, with little variation in performance from MY 2016–2017 to 2017–2018. Of note, the *Emergency Department Utilization for Mental Health Condition (per 1,000 Members)* measure rate demonstrated a relative improvement in performance from MY 2016–2017 to 2017–2018 of more than 10 percent. Additionally, the measure rates for *Mental Health Engagement (All Members Excluding Foster Care)* and *Mental Health Engagement (Only Foster Care)* were within 3 percentage points of the incentive performance targets. Conversely, the remaining measure rates would need to improve by up to 15 percentage points to meet or exceed their respective incentive performance targets.

Behavioral Healthcare, Inc. (BHI)

Validation of Performance Measures

Information Systems Standards Review Results

HSAG identified no concerns with how BHI received and processed enrollment data; however, HSAG did identify an area for process improvement.

BHI's ASO, COA, received daily 834 files and monthly full eligibility files from the Department's secure FTP site. The daily files contained reinstatements, adds, terminations, and changes. The monthly files contained all members enrolled for the month they were received. COA's data system automatically downloaded and scrubbed the files to determine if the information was a duplicate, new entry, or if errors were present. If errors were present, COA's vendor, CMAP, reviewed and corrected the issues. If CMAP was unable to correct the entry, BHI reached out to the contract manager at the Department to obtain a resolution, and a manual update would be made until a new 834 file was received.

The scrub process confirmed whether a member already existed in the system by searching via state ID number, name, date of birth, and social security number before creating a new entry. Once scrubbed and validated, the data were automatically mapped by the system into tables and loaded into QNXT, the BHO's transactional system. QNXT processed the files and loaded them into the EDW. New members loaded into QNXT were automatically assigned a unique ID number. Each member's state ID number was kept as a secondary identifier. BHI experienced limited instances in which members were issued more than one Medicaid ID number; these included members who changed their names and a few foster care members. In these instances, BHI linked both ID numbers and retained the assigned QNXT number within the system. COA provided the processed enrollment information to BHI via Structured Query Language (SQL) code daily.

BHI submitted eligibility files to providers and affiliated CMHCs daily via secure FTP site. Providers also accessed the Department's eligibility portal to obtain eligibility information for members. BHI had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

HSAG identified no issues or concerns with how BHI received, processed, or reported claims and encounter data.

BHI required that providers submit all professional and institutional claims and encounters within 60 days. Claims and encounters were received and processed the same way. Electronic professional and institutional claims and encounters data were received in an 837 file through a secure FTP site or provider clearinghouse. The files were loaded into QNXT, and BHI's ASO (COA) performed checks using BizTalk, a Microsoft software, to identify accurate formatting and complete data. A 999-file

format response file was generated in addition to a 277 acceptance or rejection report and sent to the providers via the FTP site.

Approximately 4 percent of all professional and institutional claims that BHI received were submitted via paper. Paper claims were received via the mailroom where they were stamped with the date of receipt, sorted, scanned, and uploaded to Cognizant's FTP site daily, through which these documents were converted into 837 I/P files using OCR software before being loaded into QNXT. If the paper claim could not be converted automatically via OCR, then it was manually entered. Less than 1 percent of claims were manually entered.

The BHO received State hospital data from the Department quarterly via a secure email in an Excel spreadsheet file. The data included member name, Medicaid ID number, admit and discharge dates, and the total number of inpatient days. This information was saved on a shared drive then loaded into the EDW to be included in the BHO's performance measure calculations. BHI notified HSAG that data for May 2018 and June 2018 were not provided by the Department but, due to the small number of claims estimated for this time frame, this did not impact the BHO's ability to report the measures that included these data.

Auto-adjudication was outsourced to Cognizant. A mass auto-adjudication job was performed so that pended claims were opened and edited nightly. All professional and institutional claims and encounters were verified to ensure that appropriate enrollment and provider information were submitted. Approximately 75 to 80 percent of all claims received by BHI were auto-adjudicated. If claims failed and could not be edited in the system, Cognizant manually updated the claims.

BHI submitted standard 837 I/P files and flat files to the Department through a secure FTP site monthly. BHI experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, BHI sent both 837 and flat files to ensure the Department received all necessary information.

HSAG identified no major concerns with BHI's data integration and measure calculation process.

BHI had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Claims and encounters were extracted from QNXT and loaded into the EDW for rate calculation. BHI generated a query in the EDW to generate both denominator and numerator compliant members for each indicator. Once the data were queried, they were extracted and loaded into an Oracle system in which tables were created. COA loaded state hospital data into Oracle, and the data were integrated with the data contained in the Oracle tables in the EDW. COA's business intelligence department generated the indicator rates and submitted them to COA's quality department. The quality department conducted PSV on a selection of entries every 45 days and ran new preliminary quarterly counts to ensure accuracy before the data were finalized and submitted to the Department.

Performance Measure Results

Table 4-3 shows the MY 2016–2017 and 2017–2018 measure results for BHI and the corresponding incentive performance targets. Cells shaded green indicate the BHO's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 4-3—Measure Results for BHI

Performance Measure	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	45.53%	51.43%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	46.84%	59.01%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	21.73%	20.04%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	38.68%	41.59%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	57.03%	57.71%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	17.10	14.77	7.20
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	20.38	23.53	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).
Cells shaded green indicate the rate met or exceeded the MY 2017–2018 incentive performance target.

For MY 2017–2018, BHI did not meet the performance target for six of seven (85.7 percent) incentive measures. Of note, the rate for the *Mental Health Engagement (All Members Excluding Foster Care)* measure demonstrated improvement from the prior year to exceed the incentive performance target. Additionally, the *Mental Health Engagement (Only Foster Care)* and *Emergency Department Utilization for Mental Health Condition (per 1,000 Members)* measure rates demonstrated a relative improvement in performance from MY 2016–2017 to 2017–2018 of more than 10 percent. Additionally, the measure rate for *Mental Health Engagement (Only Foster Care)* was just over 3 percentage points below the incentive performance target. Conversely, several of the measure rates would need to improve by up to 15 percentage points or more to meet or exceed their respective incentive performance targets.

Colorado Health Partnerships, LLC (CHP)

Validation of Performance Measures

Information Systems Standards Review Results

HSAG had no concerns with how CHP received and processed eligibility data; however, HSAG identified an area for process improvement.

CHP received daily 834 files and monthly full eligibility files from the Department's secure FTP site. The files were downloaded through an automated process daily from the Department's vendor, DXC. The daily files contained reinstatements, terminations, adds, and updated member demographic information. The monthly files contained all member eligibility information for the month the file was received. Upon receipt of the enrollment files, CHP's eligibility team performed validation checks to identify any errors that may have been present. If errors were found, an error report was generated, and CHP staff members worked with the Department and DXC to find a resolution.

Once the files were clear of errors, they were processed and loaded into the Connection Administrative System (CAS), CHP's eligibility and transaction system. A file load program within CAS processed the files and performed validation to ensure only complete enrollment information was received before it was loaded into the data warehouse. Files were stored in tables in the data warehouse. CHP's eligibility production team validated the data and contacted DXC or the Department if there was discrepancy. CHP experienced no issues receiving eligibility data during the measurement period. CHP used each member's state Medicaid ID number to uniquely identify its members. It experienced no issues with duplicate IDs but confirmed that it performed secondary checks using the member's first name, last name, date of birth, and social security number to confirm the ID. CHP also confirmed that if a member was given a new/different Medicaid ID number by the State, then CHP's internal ID number was modified and synced to the member's history.

CHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect, a front-end system that connected to CAS. SQL code generated a flat file from the data warehouse, and the flat file was sent weekly to the CMHCs. CMHCs also verified eligibility in real time using the Department's eligibility portal. CHP had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

HSAG identified no issues or concerns with how CHP processed or reported claims and encounter data.

All claims and encounter data were housed and processed in CAS. Professional and institutional claims received electronically were downloaded daily using an automated process through a clearinghouse, ProviderConnect. Providers submitted claims to ProviderConnect or sent them electronically to the BHO through FileConnect within 90 days of service. Once loaded into ProviderConnect, claims that did not auto-adjudicate were assigned to CHP staff members to finalize and authorize.

Paper claims that were received via mail were processed by CHP's vendor, Fidelity National Information Systems (FIS). FIS stamped all claims with the time and date of receipt, verified claims for completeness, and scanned the claims using OCR technology to create the 837 file. Once the 837 file was created, Edifecs, a third-party vendor, sent the file to CHP where it was automatically loaded into CAS. If the paper claim could not be converted automatically via OCR, the claim was manually entered into the 837 file. Electronic images of paper claims were kept for 10 years, and the original paper copies were shredded after 60 days. FIS processed claims within three to four days of receipt.

Affiliated CMHCs submitted encounter data monthly in a flat file through FileConnect. A notification was generated by the system and sent to CHP staff members upon receipt of the file, and a programmer moved the flat file into a local SQL server where the file would be scrubbed for errors. If any errors were found, an error report would be generated and sent to the CMHCs via FileConnect for reconciliation. CHP received the flat files on the tenth day of each month.

The BHO received State hospital data from the Department quarterly via a secure email in an Excel format. Manual validation was conducted on this file to remove any duplicate records. Once validated, the file was loaded into a table on the local server and sent to the data warehouse.

CHP submitted standard 837 I/P files and flat files to the Department through a secure FTP site monthly. CHP experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, CHP sent both 837 and flat files to ensure the Department received all necessary information.

CHP had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and accuracy. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Several verification processes were in place to ensure data completeness and accuracy.

CHP generated data from its corporate data warehouse. All denominator and numerator compliant members were exported into an Excel spreadsheet and included member ID, dates of service, member name, and date of birth. CHP staff members reviewed the data to ensure counts matched the member-level detail data, reasonability of lengths of stays, and that inpatient stays matched the total number of discharge counts. A quality manager reviewed the data before submission to the Department to check for reasonability. CHP submitted data to the Department through a secure FTP site and notified the Department of the submission.

During PSV for Indicators 4 and 5, it was discovered that CHP included covered and non-covered mental health diagnoses in the calculations of the measures. Although CHP calculated these measures differently than the other BHOs in the State, the impact of including these non-covered diagnoses in CHP's rates was small (i.e., 2–3 percent of the numerator-positive cases were based on non-covered diagnoses). Therefore, the Department determined that the rates did not need to be recalculated for CHP. HSAG recommends that, in the future, the Department clarify in the specification document if reporting should only include follow-up visits for covered mental health diagnoses or if non-covered diagnoses should also be included.

Performance Measure Results

Table 4-4 shows the MY 2016–2017 and 2017–2018 measure results for CHP and the corresponding incentive performance targets. Cells shaded green indicate the BHO's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 4-4—Measure Results for CHP

Performance Measure	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	39.21%	51.40%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	56.40%	62.17%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	31.73%	31.94%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	42.75%	55.13%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	63.75%	70.40%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	12.86	10.32	7.20
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	17.19	20.43	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).
Cells shaded green indicate the rate met or exceeded the MY 2017–2018 incentive performance target.

For MY 2017–2018, CHP did not meet the performance target for five of seven (71.4 percent) incentive measures. Of note, the rates for the *Mental Health Engagement (All Members Excluding Foster Care)* and *Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition* measures demonstrated improvement from the prior year to exceed the incentive performance targets. Additionally, the *Emergency Department Utilization for Mental Health Condition (per 1,000 Members)* measure rate demonstrated a relative improvement in performance from MY 2016–2017 to 2017–2018 of more than 20 percent. The remaining measure rates, except *Emergency Department Utilization for Mental Health Condition (per 1,000 Members*), would need to improve by less than 5 percent to meet or exceed their respective incentive performance targets.

Foothills Behavioral Health Partners, LLC (FBHP)

Validation of Performance Measures

Information Systems Standards Review Results

HSAG had no concerns with how FBHP received and processed eligibility data; however, HSAG identified an area for process improvement.

FBHP received daily 834 files and monthly full eligibility files from the Department's secure FTP site. The files were downloaded through an automated process daily from the Department's vendor, DXC. The daily files contained reinstatements, terminations, adds, and updated member demographic information. The monthly files contained all member eligibility information for the month the file was received. Upon receipt of the enrollment files, FBHP's eligibility team ran logic to identify any errors that may have been present. If errors were found, an error report was generated, and FBHP staff members worked with the Department and DXC to find a resolution.

Once the files were clear of errors, they were processed and loaded into the CAS, FBHP's eligibility and transaction system. A file load program within CAS processed the files and performed validation to ensure only complete enrollment information was received before it was loaded into the data warehouse. Files were stored in tables in the data warehouse. FBHP's eligibility production team validated the data and contacted DXC or the Department if there was discrepancy. FBHP experienced no issues receiving eligibility data during the measurement period. FBHP used each member's state Medicaid ID number to uniquely identify its members. It experienced no issues with duplicate IDs but confirmed that it performed secondary checks using the member's first name, last name, date of birth, and social security number to confirm the ID. FBHP also confirmed that if a member was given a new/different Medicaid ID number by the State, then FBHP's internal ID number was modified and synced to the member's history.

FBHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect, a front-end system that connected to CAS. SQL code generated a flat file from the data warehouse, and the flat file was sent weekly to the CMHCs. CMHCs also verified eligibility in real time using the Department's portal. FBHP had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

HSAG identified no issues or concerns with how FBHP processed or reported claims and encounter data.

All claims and encounter data were housed and processed in CAS. Professional and institutional claims received electronically were downloaded daily using an automated process through a clearinghouse, ProviderConnect. Providers submitted claims to ProviderConnect or sent them electronically to the BHO through FileConnect within 90 days of service. Once loaded into ProviderConnect, claims that did not auto-adjudicate were assigned to FBHP staff members to finalize and authorize.

Paper claims that were received via mail were processed by FBHP's vendor, FIS. FIS stamped all claims with the time and date of receipt, verified claims for completeness, and scanned the claims using OCR technology to create the 837 file. Once the 837 file was created, Edifecs, a third-party vendor, sent the file to FBHP where it was automatically loaded into CAS. If the paper claim could not be converted automatically via OCR, the claim was manually entered into the 837 file. Electronic images of paper claims were kept for 10 years, and the original paper copies were shredded after 60 days. FIS processed claims within three to four days of receipt.

Affiliated CMHCs submitted encounter data monthly in a flat file through FileConnect. A notification was sent to FBHP staff members upon receipt of the file, and a programmer moved the flat file into a local SQL server where the file would be scrubbed for errors. If any errors were found, an error report would be generated and sent to the CMHCs via FileConnect for reconciliation. FBHP received the flat files on the tenth day of each month.

The BHO received State hospital data from the Department quarterly via a secure email in an Excel format. Manual validation was conducted on this file to remove any duplicate records. Once validated, the file was loaded into a table on the local server and sent to the data warehouse.

FBHP submitted standard 837 I/P files and flat files to the Department through a secure FTP site monthly. FBHP experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, FBHP sent both 837 and flat files to ensure the Department received all necessary information.

FBHP had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and accuracy. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Several verification processes were in place to ensure data completeness and accuracy.

FBHP generated data from its corporate data warehouse. All denominator and numerator compliant members were exported into an Excel spreadsheet and included member ID, dates of service, member name, and date of birth. FBHP staff members reviewed the data to ensure counts matched the member-level detail data, reasonability of lengths of stays, and that inpatient stays matched the total number of discharge counts. A quality manager reviewed the data before submission to the Department to check for reasonability. FBHP submitted data to the Department through a secure FTP site and notified the Department of the submission.

During PSV for Indicators 4 and 5, it was discovered that FBHP included covered and non-covered mental health diagnoses in the calculations of the measures. Although FBHP calculated these measures differently than the other BHOs in the State, the impact of including these non-covered diagnoses in FBHP's rates was small (i.e., 2–3 percent of the numerator-positive cases were based on non-covered diagnoses). Therefore, the Department determined that the rates did not need to be recalculated for FBHP. HSAG recommends that, in the future, the Department clarify in the specification document if reporting should only include follow-up visits for covered mental health diagnoses or if non-covered diagnoses should also be included.

Performance Measure Results

Table 4-5 shows the MY 2016–2017 and 2017–2018 measure results for FBHP and the corresponding incentive performance targets. Cells shaded green indicate the BHO's performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 4-5—Measure Results for FBHP

Performance Measure	MY 2016–2017 Rate[1]	MY 2017–2018 Rate[2]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)			
Mental Health Engagement (All Members Excluding Foster Care)	46.13%	47.46%	48.48%
Mental Health Engagement (Only Foster Care)			
Mental Health Engagement (Only Foster Care)	51.00%	58.12%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment			
Engagement of Alcohol and Other Drug Dependence Treatment	26.67%	29.16%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	45.21%	45.37%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition			
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	65.71%	61.01%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*			
Emergency Department Utilization for Mental Health Condition	17.38	14.68	7.20
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*			
Emergency Department Utilization for Substance Use Condition	24.76	29.63	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).
[2] Indicates that the rates contained within this column represent MY 2017–2018 (i.e., July 1, 2017–June 30, 2018).

For MY 2017–2018, FBHP did not meet the performance target for any incentive measures. Of note, the *Mental Health Engagement (Only Foster Care)* and *Emergency Department Utilization for Mental Health Condition (per 1,000 Members)* measure rates demonstrated a relative improvement in performance from MY 2016–2017 to 2017–2018 of more than 10 percentage points. Additionally, the measure rates for *Mental Health Engagement (All Members Excluding Foster Care)* and *Mental Health Engagement (Only Foster Care)* were within 5 percentage points of the incentive performance targets. Conversely, the remaining measure rates would need to improve by more than 10 percent to meet or exceed their respective incentive performance targets.

5. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

Table 5-1—Statewide Results for Medicaid Managed Care MCO Standards

Standard and Applicable Review Years	DHMP	RMHP Prime	Statewide Average
Standard I—Coverage and Authorization of Services (2016–2017)	94%	94%	94%
Standard II—Access and Availability (2016–2017)	92%	100%	96%
Standard III—Coordination and Continuity of Care (2018–2019)*	**70%**	**100%**	**86%**
Standard IV—Member Rights and Protections (2018–2019)*	**100%**	**86%**	**93%**
Standard V—Member Information (2018–2019)*	**82%**	**83%**	**83%**
Standard VI—Grievance and Appeal System (2017–2018)	86%	89%	87%
Standard VII—Provider Participation and Program Integrity (2017–2018)	80%	93%	86%
Standard VIII—Credentialing and Recredentialing (2015–2016)	98%	100%	99%
Standard IX—Subcontracts and Delegation (2017–2018)	0%	100%	50%
Standard X—Quality Assessment and Performance Improvement (2015–2016)	88%	100%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)*	**86%**	**100%**	**93%**

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.

Table 5-2—Statewide Results for Medicaid RAE Standards

Standard and Applicable Review Years	RMHP Region 1	NHP Region 2	COA Region 3	HCI Region 4	COA Region 5	CCHA Region 6	CCHA Region 7	Statewide Average
Standard I—Coverage and Authorization of Services (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard II—Access and Availability (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard III—Coordination and Continuity of Care (2018–2019)*	**100%**	**91%**	**100%**	**82%**	**91%**	**100%**	**100%**	**95%**
Standard IV—Member Rights and Protections (2018–2019)*	**86%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**98%**
Standard V—Member Information (2018–2019)*	**83%**	**100%**	**94%**	**100%**	**94%**	**86%**	**86%**	**92%**
Standard VI—Grievance and Appeal System (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard VII—Provider Participation and Program Integrity (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard VIII—Credentialing and Recredentialing (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard IX—Subcontracts and Delegation (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard X—Quality Assessment and Performance Improvement (not yet scored*)	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2018–2019)*	**100%**	**100%**	**88%**	**88%**	**88%**	**75%**	**75%**	**88%**

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.
**Not yet scored as the RAE contract did not begin until July 1, 2018.*

Statewide Conclusions and Recommendations Related to Assessment of Compliance

For the four standards reviewed in 2018–2019, the Medicaid health plans demonstrated compliance in many areas. Most Medicaid health plans statewide—both RAEs and MCOs—demonstrated the following strengths:

- Produced robust and comprehensive policies and procedures regarding Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.
- Had processes in place to identify members with high-risk, high-cost, and complex care coordination needs.
- Used multi-disciplinary teams of care coordinators to address members' complex needs.
- Had care coordinators who were widely distributed throughout each region, assisting in needs assessment and trouble-shooting barriers members and providers faced with care coordination.
- Had procedures, tools, and systems to perform and document care coordination activities in compliance with requirements.
- Utilized secured information sharing platforms to allow care coordinators and care team members to collaborate and share vital information about the members' needs.
- Coordinated care with a variety of providers, agencies, and community support organizations.
- Supplied information and/or training surrounding member rights and protections to providers, staff members, and members through webinars, handouts, townhalls, newsletters, the health plan's website, the Health First Colorado Member Handbook, and/or newsletters.
- Ensured handouts and information being offered to members were member tested and vetted through a Member Advisory Council.
- Confirmed language translation assistance was offered and provided to the member at no additional cost to the member.
- Maintained robust websites for providing information to members.
- Provided information and/or training regarding EPSDT services to providers, staff members, and members through welcome phone calls, webinars, handouts, townhalls, newsletters, the health plan's website, and/or the Health First Colorado Member Handbook.

For Medicaid health plans statewide—both RAEs and MCOs—the most common required actions assigned were the following:

- Enhance care coordination procedures and communications to providers to ensure that:
  - Providers understand expectations for delegated providers to meet the defined requirements.
  - Those requirements are completely and clearly outlined for providers.
- Improve the health plan's website for compliance with Section 508 accessibility guidelines.

- Improve the electronic provider directory either for compliance with Section 508 accessibility guidelines, to include adequate information concerning providers' cultural competency training, and/or to include information about providers' offices accessibility for members with disabilities.
- Ensure that polices and written materials for providers and members are updated for consistency with the most current revisions of federal and State regulatory requirements related to Standard V—Member Information and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.
- Expedite completion of collaborative onboarding plans with Healthy Communities contractors.

HEDIS Measure Rates and Validation—Limited Managed Care Capitation Initiative

Statewide Results

Information Systems Standards Review Results

HSAG reviewed each MCO's FAR. Each MCO's licensed HEDIS auditor evaluated the MCO's IS and made a determination about the accuracy of its HEDIS reporting. For the current reporting period, both MCOs were fully compliant with all IS standards relevant to the scope of the PMV performed by the health plans' licensed HEDIS auditors. During review of the IS standards, the HEDIS auditors identified no notable issues with negative impact on HEDIS reporting. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

In Table 5-3, plan-specific and Colorado Medicaid weighted averages are presented for the Limited Managed Care Capitation Initiative MCOs for HEDIS 2019. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the MCOs' eligible populations. For the MCOs with rates reported as *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. Due to differences in member eligibility for children in RMHP Prime (i.e., the MCO only serves children with disabilities), measure rates related to providing services to children are not comparable to those of DHMP; therefore, these measures have been removed.

Table 5-3—Limited Managed Care Capitation Initiative and Statewide Results

Performance Measures	DHMP	RMHP Prime	Statewide Weighted Average
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	71.90%	44.69%	58.07%
Postpartum Care	56.69%	28.58%	42.40%
Adults' Access to Preventive/Ambulatory Health Services			
Total	53.89%	71.84%	61.75%
Preventive Screening			
Chlamydia Screening in Women			
Total	69.58%	46.46%	62.43%
Breast Cancer Screening			
Breast Cancer Screening	46.48%	50.10%	48.53%
Cervical Cancer Screening			
Cervical Cancer Screening	43.07%	41.93%	42.52%
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	2.86%	0.23%
Adult BMI Assessment			
Adult BMI Assessment	81.44%	27.74%	52.30%
Mental/Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	54.20%	52.20%	53.24%
Effective Continuation Phase Treatment	33.96%	33.85%	33.91%
Living With Illness			
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	46.88%	NA	50.98%
Comprehensive Diabetes Care			
HbA1c Testing	82.06%	84.59%	83.24%
*HbA1c Poor Control (>9.0%)**	40.38%	76.08%	56.98%
HbA1c Control (<8.0%)	47.88%	19.55%	34.71%
Eye Exam (Retinal) Performed	45.83%	50.14%	47.83%
Medical Attention for Nephropathy	81.51%	83.21%	82.30%
Blood Pressure Control (<140/90 mm Hg)	61.67%	8.91%	37.14%
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	57.75%	46.70%	52.77%
Statin Adherence 80%	60.63%	60.05%	60.40%

Performance Measures	DHMP	RMHP Prime	Statewide Weighted Average
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	72.41%	64.86%	68.18%
Statin Adherence 80%—Total	69.52%	60.83%	64.89%
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	86.46%	83.59%	85.16%
Diuretics	86.05%	85.88%	85.98%
Total	86.29%	84.48%	85.49%
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	72.83%	71.67%	72.28%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	56.90%	47.50%	49.79%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	50.34%	40.28%	47.02%
Bronchodilator	72.21%	56.48%	67.02%
Medication Management for People With Asthma			
Medication Compliance 50%—Total	58.80%	64.91%	60.91%
Medication Compliance 75%—Total	33.10%	38.60%	35.00%
Asthma Medication Ratio			
Total	46.60%	53.74%	49.08%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.57%	30.09%	29.47%
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis			
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	88.75%	71.00%	78.89%
Use of Services			
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits—Total**	43.95	61.52	49.10
Outpatient Visits—Total	203.78	326.38	239.73
Inpatient Utilization—General Hospital/Acute Care—Total			
Discharges per 1,000 Member Months (Total Inpatient)—Total	5.06	9.42	6.34
Average Length of Stay (Total Inpatient)—Total	4.59	3.68	4.19
Discharges per 1,000 Member Months (Medicine)—Total	2.90	4.39	3.34
Average Length of Stay (Medicine)—Total	4.17	3.74	4.01
Discharges per 1,000 Member Months (Surgery)—Total	0.90	2.23	1.29
Average Length of Stay (Surgery)—Total	8.49	5.26	6.85
Discharges per 1,000 Member Months (Maternity)—Total	1.72	2.96	2.15
Average Length of Stay (Maternity)—Total	2.76	2.33	2.56

Performance Measures	DHMP	RMHP Prime	Statewide Weighted Average
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics—Total	0.32	0.64	0.41
Average Days Supplied per Antibiotic Script—Total	9.44	9.11	9.29
Average Scripts PMPY for Antibiotics of Concern—Total	0.09	0.25	0.14
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	28.74%	39.52%	33.58%
Plan All-Cause Readmissions*			
Index Total Stays—Observed Readmissions—Total	19.34%	11.71%	15.90%
Index Total Stays—O/E Ratio—Total	0.85	0.64	0.77
Use of Opioids at High Dosage*			
Use of Opioids at High Dosage	3.23%	4.19%	3.68%
Use of Opioids From Multiple Providers*			
Multiple Prescribers	18.61%	25.73%	22.10%
Multiple Pharmacies	12.09%	4.22%	8.23%
Multiple Prescribers and Multiple Pharmacies	6.32%	2.79%	4.59%

**For this measure, a lower rate indicates better performance.*
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statewide Conclusions and Recommendations Related to HEDIS Measure Rates and Validation

The following HEDIS 2019 measure rates were determined to be high performers for the Limited Managed Care Capitation Initiative statewide weighted average (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018):

- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

The following HEDIS 2019 measure rates were determined to be low performers for the Limited Managed Care Capitation Initiative statewide weighted average (i.e., fell below the 25th percentile or ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018):

- *Childhood Immunization Status—Combination 2* and *Combination 3*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*
- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*

At the statewide level, the appropriate testing and treatment of respiratory infections was identified as a strength. Conversely, statewide performance across all domains consistently fell below the 25th percentile, indicating opportunities to improve the access to care and appropriate services for both child and adult members exist.

Validation of Performance Measures—Behavioral Health Organization

Statewide Results

Information Systems Standards Review Results

HSAG evaluated the health plans' accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. For the current reporting period, HSAG determined that the data collected and reported by all five BHOs for the Department-selected measures followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

In Table 5-4, plan-specific and statewide weighted averages are presented for the Medicaid BHOs for MY 2017–2018. Cells shaded green indicate performance met or exceeded the MY 2017–2018 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Table 5-4—BHO and Statewide Results

Performance Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Mental Health Engagement (All Members Excluding Foster Care)						
Mental Health Engagement (All Members Excluding Foster Care)	45.52%	48.30%	51.43%	51.40%	47.46%	49.81%
Mental Health Engagement (Only Foster Care)						
Mental Health Engagement (Only Foster Care)	62.02%	59.51%	59.01%	62.17%	58.12%	60.54%
Engagement of Alcohol and Other Drug Dependence Treatment						
Engagement of Alcohol and Other Drug Dependence Treatment	16.92%	24.49%	20.04%	31.94%	29.16%	25.00%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition						
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	36.75%	42.00%	41.59%	55.13%	45.37%	46.49%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition						
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	52.72%	58.90%	57.71%	70.40%	61.01%	62.41%

Performance Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*						
Emergency Department Utilization for Mental Health Condition	21.00	14.46	14.77	10.32	14.68	14.10
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*						
Emergency Department Utilization for Substance Use Condition	40.78	24.37	23.53	20.43	29.63	25.97

** For this measure, a lower rate indicates better performance.*

Cells shaded green indicate the rate met or exceeded the MY 2017–2018 incentive performance target.

During the second year of reporting these measure rates for the BHOs (i.e., MY 2017–2018), only one statewide average (*Mental Health Engagement [All Members Excluding Foster Care]*) met the incentive performance target. Additionally, only three BHO measure rates exceeded the performance targets for the incentive measures.

FY 2018–2019 was the last year the BHOs were in operation; therefore, no statewide recommendations are provided.

Validation of Performance Improvement Projects

Statewide Results

Table 5-5 shows the FY 2018–2019 statewide PIP results for the RAEs.

Table 5-5—FY 2018–2019 Statewide PIP Results

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 1—Rocky Mountain Health Plans				
	ACC	*Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18*	*Completed Module 1 and Module 2*	NA*
	BH	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	*Completed Module 1 and Module 2*	NA*
	MCO	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	*Completed Module 1 and Module 2*	NA*
Region 2—Northeast Health Partners				
	ACC	*Increasing Well Checks for Members 21–64 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*
Region 3—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 4—Health Colorado				
	ACC	*Increasing Well Checks for Members 21–64 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*
Region 5—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 1 and Module 2*	NA*
	MCO	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	*Completed Module 1 and Module 2*	NA*
Region 6—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years*	*Completed Module 1 and Module 2*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*
Region 7—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years*	*Completed Module 1 and Module 2*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 1 and Module 2***	NA*

**NA— No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.*

***The RAE received a Conditional Pass on Module 1 and Module 2. At the PIP initiation, the RAE did not have the 12 months of baseline data required to guide selection of the narrowed focus and to determine the SMART Aim measure goal. The RAE will resubmit Module 1 and Module 2 when 12 months of baseline data are available to calculate the baseline rate and set a goal for the PIP. The Conditional Pass allowed the RAE to progress to Module 3 while collecting 12 months of baseline data.*

During FY 2018–2019, the RAEs initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs addressed the following topic areas:

- Well-child visits
- Adolescent well-care visits
- Adult well-care visits
- Referral from primary care to behavioral health care following a positive depression screening
- Substance use disorder treatment

The PIPs run on an 18-month schedule and will continue into the next FY. The PIPs will be evaluated on outcomes and receive a final validation status after the RAEs complete all five modules of the rapid-cycle PIP process and submit final documentation for validation.

During the FY 2018–2019 validation cycle, the RAEs received training and technical assistance on the rapid-cycle PIP process and developed the foundation of the projects in the first two modules of the process. The RAEs submitted documentation on Module 1 and Module 2 for a total of 16 PIPs. HSAG provided feedback to the RAEs on the initial submissions and the RAEs revised the module documentation and resubmitted Module 1 and Module 2 until all criteria were achieved. The RAEs passed Module 1 and Module 2, achieving all validation criteria for the first two modules for 12 of the 16 PIPs. The remaining four PIPs were BH PIPs submitted by Region 2, Region 4, Region 6, and Region 7; these four PIPs received a Conditional Pass for Module 1 and Module 2. These RAEs lacked historical data in their respective regions to completely address some validation criteria. The Conditional Pass assigned to the four PIPs allowed the RAEs to continue progressing through subsequent PIP modules while collecting data to fully address remaining validation criteria for Module 1 and Module 2. The RAEs will resubmit Module 1 and Module 2, once complete baseline data have been collected, and HSAG will conduct a final validation of these modules.

Statewide Conclusions and Recommendations Related to Validation of PIPs

The FY 2018–2019 validation findings for all 16 PIPs suggested that all RAEs designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. The RAEs used data to identify a narrowed focus for each project, established PIP teams to include necessary internal and external partners, defined a goal for improvement, and designed a measure and data collection plan to evaluate progress toward achieving the goal. In the next FY, the RAEs will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. As the RAEs continue working on the PIPs, HSAG recommends:

- For PIPs that received a *Conditional Pass* for Module 1 and Module 2, set a SMART Aim goal that represents real improvement over the baseline rate and is attainable within the time frame defined by the SMART Aim end date.

- For PIPs that received a *Conditional Pass* for Module 1 and Module 2, design a SMART Aim data collection methodology that is comparable to the baseline data collection methodology and supports the rapid-cycle process.
- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the RAE progresses through the steps for determining and testing interventions.

PCMH CAHPS Surveys—RAEs

Statewide Results

Adult

Table 5-6 shows the adult PCMH results for the seven RAEs and the statewide average for FY 2018–2019.

Table 5-6—Adult Statewide PCMH CAHPS Results for RAEs*

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Rating of Provider	66.8%	72.1%	62.5%	63.3%	62.2%	61.1%	74.9%	63.6%
Rating of Specialist Seen Most Often	63.9%	69.7%	68.6%	62.6%	56.7%	55.3%	65.0%	62.3%
Rating of All Health Care	60.2%	64.3%	59.8%	61.0%	55.2%	55.8%	67.6%	59.1%
Rating of Health Plan	58.2%	64.4%	61.5%	60.5%	61.3%	57.6%	60.5%	60.3%
Getting Timely Appointments, Care, and Information	48.3%	58.8%	44.9%	51.9%	53.8%	43.4%	54.3%	47.7%

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
How Well Providers Communicate with Patients	76.7%	79.2%	73.4%	75.0%	69.6%	71.5%	82.4%	73.9%
Providers' Use of Information to Coordinate Patient Care	66.4%	67.0%	62.6%	61.1%	58.6%	58.4%	68.4%	61.8%
Talking with You About Taking Care of Your Own Health	47.5%	47.1%	49.8%	44.6%	44.6%	51.0%	53.5%	48.9%
Comprehensiveness	55.7%	54.9%	54.4%	43.2%	43.2%	58.3%	60.1%	52.8%
Helpful, Courteous, and Respectful Office Staff	71.8%	74.3%	64.9%	72.3%	68.3%	69.3%	71.6%	69.1%
Health First Colorado Customer Service	65.5%	59.7%+	61.8%	66.9%	59.8%	56.4%	66.0%+	62.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	34.8%	24.7%+	23.8%	38.5%+	23.9%	22.2%	28.8%+	27.3%
Reminders about Care from Provider Office	73.4%	63.1%	70.7%	73.0%	65.7%	74.5%	76.8%	71.6%
Saw Provider Within 15 Minutes of Appointment	43.5%	52.7%	40.9%	35.9%	34.5%	32.9%	44.2%	38.4%
Received Health Care and Mental Health Care at Same Place	52.9%	54.5%	58.0%	57.8%	58.3%	58.5%	51.2%	57.6%

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a member's experiences with a provider at a specific practice.*

Child

Table 5-7 shows the child PCMH results for the seven RAEs and the statewide average for FY 2018–2019.

Table 5-7—Child Statewide PCMH CAHPS Results for RAEs*

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Rating of Provider	75.1%	83.3%	74.9%	65.3%	81.2%	81.2%	78.3%	76.0%
Rating of Specialist Seen Most Often	67.0%+	76.4%+	77.2%	69.5%+	74.8%+	66.1%+	71.6%	74.0%
Rating of All Health Care	67.9%	75.8%	74.1%	69.9%	81.9%	76.5%	77.5%	74.3%
How Well Providers Communicate with Child	77.7%	79.0%+	80.0%	78.1%	84.7%	79.5%	83.7%	80.6%
Getting Timely Appointments, Care, and Information	61.7%	73.7%+	68.4%	60.6%	75.2%	72.3%	73.4%	66.2%
How Well Providers Communicate with Parents or Caretakers	81.0%	84.1%	81.7%	78.1%	84.8%	84.1%	85.3%	81.9%
Providers' Use of Information to Coordinate Patient Care	71.1%	80.0%+	73.9%	72.3%	74.5%	78.2%	72.6%	74.7%
Comprehensiveness: Child Development	61.7%	68.3%	66.8%	56.8%	69.8%	67.7%	64.9%	65.7%
Comprehensiveness: Child Safety and Healthy Lifestyles	54.5%	59.3%	59.6%	49.0%	62.8%	58.1%	55.1%	58.2%
Helpful, Courteous, and Respectful Office Staff	67.1%	70.3%	66.2%	63.5%	79.5%	80.8%	71.2%	69.3%
Received Information on Evening, Weekend, or Holiday Care for Child	80.3%	70.1%	80.9%	79.6%	82.4%	86.1%	82.7%	80.9%

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Child Received Care from Provider Office During Evenings, Weekends, or Holidays	40.4%+	20.9%+	25.9%+	20.8%+	56.0%+	31.7%+	43.0%+	32.1%
Saw Provider Within 15 Minutes of Appointment	39.6%	48.1%	41.4%	29.6%	51.0%	54.8%	46.2%	42.1%
Reminders about Child's Care from Provider Office	58.7%	54.7%	69.1%	59.9%	75.6%	72.5%	70.0%	67.9%

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a member's experiences with a provider at a specific practice.*

Statewide Conclusions and Recommendations Related to PCMH CAHPS

HSAG identified areas related to access to care, timeliness of care, communication, and care coordination where the RAEs can focus quality improvement activities. The RAEs could consider establishing performance goals for measures with notably lower scores than other measures.

RAE Adult Survey

For the adult Medicaid population, RMHP (Region 1) had two measure rates that were substantially higher than the statewide averages:

- *Received Care from Provider Office During Evenings, Weekends, or* Holidays (7.5 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (5.1 percentage points)

Ten of RMHP (Region 1)'s measure rates were higher than the statewide averages:

- *Rating of Provider*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Patients*
- *Providers' Use of Information to Coordinate Patient Care*
- *Comprehensiveness*
- *Helpful, Courteous, and Respectful Office Staff*

- *Health First Colorado Customer Service*
- *Reminders about Care from Provider Office*

For the adult Medicaid population, RMHP (Region 1) did not have any measure rates that were substantially lower than the statewide averages.

The remaining three measure rates were lower than the statewide averages.

For the adult Medicaid population, NHP (Region 2) had eight measure rates that were substantially higher than the statewide averages:

- *Rating of Provider* (8.5 percentage points)
- *Rating of Specialist Seen Most Often* (7.4 percentage points)
- *Rating of All Health Care* (5.2 percentage points)
- *Getting Timely Appointments, Care, and Information* (11.1 percentage points)
- *How Well Providers Communicate with Patients* (5.3 percentage points)
- *Providers' Use of Information to Coordinate Patient Care* (5.2 percentage points)
- *Helpful, Courteous, and Respectful Office Staff* (5.2 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (14.3 percentage points)

Two of NHP (Region 2)'s measure rates were higher than the statewide averages:

- *Rating of Health Plan*
- *Comprehensiveness*

One of NHP (Region 2)'s adult Medicaid population measure rates was substantially lower than the statewide average:

- *Reminders about Care from Provider Office* (8.5 percentage points)

The remaining four measure rates were lower than the statewide averages.

For the adult Medicaid population, COA (Region 3) had one measure rate that was substantially higher than the statewide average:

- *Rating of Specialist Seen Most Often* (6.3 percentage points)

Seven of COA (Region 3)'s measure rates were higher than the statewide averages:

- *Rating of All Health Care*
- *Rating of Health Plan*
- *Providers' Use of Information to Coordinate Patient Care*

- *Talking with You About Taking Care of Your Own Health*
- *Comprehensiveness*
- *Saw Provider Within 15 Minutes of Appointment*
- *Received Health Care and Mental Health Care at Same Place*

For the adult Medicaid population, COA (Region 3) did not have any measure rates that were substantially lower than the statewide averages.

The remaining seven measure rates were lower than the statewide averages.

For the adult Medicaid population, HCI (Region 4) had one measure rate that was substantially higher than the statewide average:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (11.2 percentage points)

Nine of HCI (Region 4)'s measure rates were higher than the statewide averages:

- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*
- *Getting Timely Appointments, Care, and Information*
- *How Well Providers Communicate with Patients*
- *Helpful, Courteous, and Respectful Office Staff*
- *Health First Colorado Customer Service*
- *Reminders about Care from Provider Office*
- *Received Health Care and Mental Health Care at Same Place*

One of HCI (Region 4)'s adult Medicaid population measure rates was substantially lower than the statewide average:

- *Comprehensiveness* (9.6 percentage points)

The remaining four measure rates were lower than the statewide averages.

For the adult Medicaid population, COA (Region 5) had one measure rate that was substantially higher than the statewide average:

- *Getting Timely Appointments, Care, and Information* (6.1 percentage points)

Two of COA (Region 5)'s measure rates were higher than the statewide averages:

- *Rating of Health Plan*
- *Received Health Care and Mental Health Care at Same Place*

Three of COA (Region 5)'s adult Medicaid population measure rates were substantially lower than the statewide averages:

- *Rating of Specialist Seen Most Often* (5.6 percentage points)
- *Comprehensiveness* (9.6 percentage points)
- *Reminders about Care from Provider Office* (5.9 percentage points)

The remaining nine measure rates were lower than the statewide averages.

For the adult Medicaid population, CCHA (Region 6) had one measure rate that was substantially higher than the statewide average:

- *Comprehensiveness* (5.5 percentage points)

Four of CCHA (Region 6)'s measure rates were higher than the statewide averages:

- *Talking with You About Taking Care of Your Own Health*
- *Helpful, Courteous, and Respectful Office Staff*
- *Reminders about Care from Provider Office*
- *Received Health Care and Mental Health Care at Same Place*

Four of CCHA (Region 6)'s adult Medicaid population measure rates were substantially lower than the statewide averages:

- *Rating of Specialist Seen Most Often* (7 percentage points)
- *Health First Colorado Customer Service* (6.2 percentage points)
- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (5.1 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (5.5 percentage points)

The remaining six measure rates were lower than the statewide averages.

For the adult Medicaid population, CCHA (Region 7) had eight measure rates that were substantially higher than the statewide averages:

- *Rating of Provider* (11.3 percentage points)
- *Rating of All Health Care* (8.5 percentage points)

- *Getting Timely Appointments, Care, and Information* (6.6 percentage points)
- *How Well Providers Communicate with Patients* (8.5 percentage points)
- *Providers' Use of Information to Coordinate Patient Care* (6.6 percentage points)
- *Comprehensiveness* (7.3 percentage points)
- *Reminders about Care from Provider Office* (5.2 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (5.8 percentage points)

Six of CCHA (Region 7)'s measure rates were higher than the statewide averages:

- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*
- *Talking with You About Taking Care of Your Own Health*
- *Helpful, Courteous, and Respectful Office Staff*
- *Health First Colorado Customer Service*
- *Received Care from Provider Office During Evenings, Weekends, or Holidays*

One of CCHA (Region 7)'s adult Medicaid population measure rates was substantially lower than the statewide average:

- *Received Health Care and Mental Health Care at Same Place* (6.4 percentage points)

None of CCHA (Region 7)'s measure rates were lower than the statewide averages.

Based on statewide comparisons, HSAG had the following observations related to adult PCMH CAHPS. For the adult PCMH CAHPS statewide results, for four measures (*Rating of Provider*; *Talking with You About Taking Care of Your Own Health*; *Health First Colorado Customer Service*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*), four RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve member perceptions related to these measures.

Of note, only one RAE region (RAE Region 7) experienced a single measure that was lower than the statewide average. In addition, the State's three most rural RAE regions (RAE Regions 1, 2, and 4) experienced a generally lesser number of measure rates that were lower than the statewide averages than the State's most urban RAE regions (RAE Regions 5 and 6). RAE Regions 5 and 6, which are within the Denver metropolitan area, experienced the greatest number of measure rates that were lower than the statewide averages (12 and 10 measure rates, respectively). RAE Region 3, which is considered within the Denver metropolitan area, had seven measure rates that were lower than the statewide averages. The Department may want to focus efforts on evaluating barriers to receiving quality and timely care for adults served by the RAEs in Colorado's most urban regions.

RAE Child Survey

For the child Medicaid population, RMHP (Region 1) had one measure rate that was substantially higher than the statewide average:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (8.3 percentage points)

None of RMHP (Region 1)'s measure rates were higher than the statewide averages.

Three of RMHP (Region 1)'s child Medicaid population measure rates were substantially lower than the statewide averages:

- *Rating of Specialist Seen Most Often* (7.0 percentage points)
- *Rating of All Health Care* (6.4 percentage points)
- *Reminders about Child's Care from Provider Office* (9.2 percentage points)

The remaining 10 measure rates were lower than the statewide averages.

For the child Medicaid population, NHP (Region 2) had four measure rates that were substantially higher than the statewide averages:

- *Rating of Provider* (7.3 percentage points)
- *Getting Timely Appointments, Care, and Information* (7.5 percentage points)
- *Providers' Use of Information to Coordinate Patient Care* (5.3 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (6.0 percentage points)

Six of NHP (Region 2)'s measure rates were higher than the statewide averages:

- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *How Well Providers Communicate with Parents or Caretakers*
- *Comprehensiveness: Child Development*
- *Comprehensiveness: Child Safety and Healthy Lifestyles*
- *Helpful, Courteous, and Respectful Office Staff*

Three of NHP (Region 2)'s child Medicaid population measure rates were substantially lower than the statewide averages:

- *Received Information on Evening, Weekend, or Holiday Care for Child* (10.8 percentage points)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (11.2 percentage points)

- *Reminders about Child's Care from Provider Office* (13.2 percentage points)

The remaining one measure rate was lower than the statewide average.

For the child Medicaid population, COA (Region 3) did not have any measure rates that were substantially higher than the statewide averages.

Six of COA (Region 3)'s measure rates were equal to or higher than the statewide averages:

- *Rating of Specialist Seen Most Often*
- *Getting Timely Appointments, Care, and Information*
- *Comprehensiveness: Child Development*
- *Comprehensiveness: Child Safety and Healthy Lifestyles*
- *Received Information on Evening, Weekend, or Holiday Care for Child*
- *Reminders about Child's Care from Provider Office*

One of COA (Region 3)'s child Medicaid population measure rates was substantially lower than the statewide average:

- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (6.2 percentage points)

The remaining seven measure rates were lower than the statewide averages.

For the child Medicaid population, HCI (Region 4) did not have any measure rates that were substantially higher than the statewide averages.

None of HCI (Region 4)'s measure rates were higher than the statewide averages.

Eight of HCI (Region 4)'s child Medicaid population measure rates were substantially lower than the statewide averages:

- *Rating of Provider* (10.7 percentage points)
- *Getting Timely Appointments, Care, and Information* (5.6 percentage points)
- *Comprehensiveness: Child Development* (8.9 percentage points)
- *Comprehensiveness: Child Safety and Healthy Lifestyles* (9.2 percentage points)
- *Helpful, Courteous, and Respectful Office Staff* (5.8 percentage points)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (11.3 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (12.5 percentage points)
- *Reminders about Child's Care from Provider Office* (8.0 percentage points)

The remaining six measure rates were lower than the statewide averages.

For the child Medicaid population, COA (Region 5) had seven measure rates that were substantially higher than the statewide averages:

- *Rating of Provider* (5.2 percentage points)
- *Rating of All Health Care* (7.6 percentage points)
- *Getting Timely Appointments, Care, and Information* (9.0 percentage points)
- *Helpful, Courteous, and Respectful Office Staff* (10.2 percentage points)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (23.9 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (8.9 percentage points)
- *Reminders about Child's Care from Provider Office* (7.7 percentage points)

Six of COA (Region 5)'s measure rates were higher than the statewide averages:

- *Rating of Specialist Seen Most Often*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Comprehensiveness: Child Development*
- *Comprehensiveness: Child Safety and Healthy Lifestyles*
- *Received Information on Evening, Weekend, or Holiday Care for Child*

For the child Medicaid population, COA (Region 5) did not have any measure rates that were substantially lower than the statewide averages.

The remaining one measure rate was lower than the statewide average.

For the child Medicaid population, CCHA (Region 6) had five measure rates that were substantially higher than the statewide averages:

- *Rating of Provider* (5.2 percentage points)
- *Getting Timely Appointments, Care, and Information* (6.1 percentage points)
- *Helpful, Courteous, and Respectful Office Staff* (11.5 percentage points)
- *Received Information on Evening, Weekend, or Holiday Care for Child* (5.2 percentage points)
- *Saw Provider Within 15 Minutes of Appointment* (12.7 percentage points)

Five of CCHA (Region 6)'s measure rates were higher than the statewide averages:

- *Rating of All Health Care*
- *How Well Providers Communicate with Parents or Caretakers*

- *Providers' Use of Information to Coordinate Patient Care*
- *Comprehensiveness: Child Development*
- *Reminders about Child's Care from Provider Office*

One of CCHA (Region 6)'s child Medicaid population measure rates was substantially lower than the statewide average:

- *Rating of Specialist Seen Most Often* (7.9 percentage points)

The remaining three measure rates were lower than the statewide averages.

For the child Medicaid population, CCHA (Region 7) had two measure rates that were substantially higher than the statewide averages:

- *Getting Timely Appointments, Care, and Information* (7.2 percentage points)
- *Child Received Care from Provider Office During Evenings, Weekends, or Holidays* (10.9 percentage points)

Eight of CCHA (Region 7)'s measure rates were higher than the statewide averages:

- *Rating of Provider*
- *Rating of All Health Care*
- *How Well Providers Communicate with Child*
- *How Well Providers Communicate with Parents or Caretakers*
- *Helpful, Courteous, and Respectful Office Staff*
- *Received Information on Evening, Weekend, or Holiday Care for Child*
- *Saw Provider Within 15 Minutes of Appointment*
- *Reminders about Child's Care from Provider Office*

For the child Medicaid population, CCHA (Region 7) did not have any measure rates that were substantially lower than the statewide averages.

The remaining four measure rates were lower than the statewide averages.

Based on statewide comparisons, HSAG had the following observations related to child PCMH CAHPS. For three measures (*Rating of Specialist See Most Often*; *Comprehensiveness: Child Safety and Healthy Lifestyles*; and *Child Received Care from Provider Office During Evenings, Weekends, or Holidays*), four RAE regions had rates that were lower than the statewide averages. In addition, there were two measure rates *(How Well Providers Communicate with Child* and *Providers' Use of Information to Coordinate Patient Care)* in which five RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions related to these measures.

Of note, there was one region (RAE Region 5) that had only one child measure rate below the statewide average and two RAE regions (RAE Regions 1 and 4) that had the greatest number of measure rates that were lower than the statewide averages (13 and 14 measure rates, respectively). HSAG determined no particular trend or pattern related to this.

CAHPS Surveys—Limited Managed Care Capitation Initiative

Statewide Results

Table 5-8 shows the adult Medicaid results achieved by DHMP and RMHP Prime for FY 2018–2019.

Table 5-8—2019 Adult Results for MCOs

Measure	DHMP	RMHP Prime
Getting Needed Care	71.8%	84.2%
Getting Care Quickly	74.7%	82.6%
How Well Doctors Communicate	92.0%	95.1%
Customer Service	90.0%+	93.8%+
Shared Decision Making	84.5%+	85.8%
Rating of Personal Doctor	66.0%	74.4%
Rating of Specialist Seen Most Often	70.7%+	69.6%
Rating of All Health Care	50.3%	64.3%
Rating of Health Plan	56.4%	69.1%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Table 5-9 shows the child Medicaid results achieved by DHMP and RMHP Prime for FY 2018–2019.[5-1]

Table 5-9—2019 Child Results for MCOs

Measure	DHMP	RMHP Prime
Getting Needed Care	78.2%	91.5%+
Getting Care Quickly	87.2%	88.4%+
How Well Doctors Communicate	95.5%	89.6%+
Customer Service	86.1%+	85.7%+
Shared Decision Making	77.8%+	93.2%+
Rating of Personal Doctor	85.9%	71.7%+
Rating of Specialist Seen Most Often	75.7%+	75.0%+
Rating of All Health Care	73.5%	68.8%+
Rating of Health Plan	73.2%	71.4%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Statewide Conclusions and Recommendations Related to MCO CAHPS

HSAG identified several possible interventions that could be applied by the health plans as appropriate to the plans' populations and organizational structures. Although none of RMHP Prime's measure rates were lower than the 2018 national average for the adult population, the following two measure rates were substantially lower than the 2018 national average for DHMP's adult population:

- *Getting Needed Care*
- *Getting Care Quickly*

The following measure rate was substantially lower than the 2018 national average across health plans for the child population:

- *Getting Care Quickly*

To impact member perception related to getting care quickly, HSAG recommends that the two health plans consider having providers work with other practices in the area to collaborate on providing and covering extended hours of operation if the individual provider is solely unable to do so. The MCOs should also ensure their members have information about the provider's recommended urgent care centers in the area, including hours of operation, as well as telephone numbers for nurse advice lines.

[5-1] HSAG did not combine DHMP's and RMHP Prime's CAHPS results into a statewide average due to the differences between the plans' Medicaid populations. Therefore, a statewide average is not presented in the table.

ECHO Surveys

Statewide Results

Adult

Table 5-10 shows the adult ECHO survey results achieved by the seven RAEs and the statewide average for FY 2018–2019.

Table 5-10—2019 Adult Statewide Results for ECHO

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Rating of All Counseling or Treatment	38.5%	56.1%	50.7%	44.1%	45.1%	44.3%	45.7%	45.9%
Getting Treatment Quickly	65.5%+	70.9%+	62.7%	70.5%+	68.9%+	66.3%	61.7%+	66.3%
How Well Clinicians Communicate	89.3%	87.6%	86.7%	87.7%	89.9%	88.7%	85.0%	88.0%
Perceived Improvement	63.5%	59.4%	54.3%	62.7%	53.7%	59.9%	49.6%	58.0%
Information About Treatment Options	63.3%	59.6%	55.4%	53.0%	47.3%	66.1%	54.2%	57.3%
Office Wait	84.1%	80.7%	80.0%	84.9%	82.5%	83.0%	73.0%	81.5%
Told About Medication Side Effects	73.6%+	78.9%+	76.5%	65.2%+	78.8%+	76.6%	73.4%+	74.8%
Including Family	45.9%	44.4%	44.5%	37.4%	34.0%	38.0%	47.9%	42.0%
Information to Manage Condition	75.9%	76.9%	78.3%	77.6%	81.7%	71.8%	71.3%	76.3%
Patient Rights Information	92.5%	86.8%	88.5%	83.5%	88.3%	91.3%	87.5%	88.8%
Patient Feels He or She Could Refuse Treatment	86.1%	83.7%	82.3%	75.4%	82.6%	85.6%	80.0%	82.8%
Privacy	94.1%	87.9%	91.6%	94.8%	95.8%	91.8%	89.8%	92.5%
Cultural Competency	NA	NA	NA	NA	NA	NA	NA	66.5%+
Amount Helped	80.5%	78.7%	79.5%	80.1%	88.4%	77.3%	78.3%	80.5%
Improved Functioning	59.2%	52.5%	53.8%	62.3%	52.8%	53.6%	45.9%	54.9%
Social Connectedness	72.9%	60.0%	63.6%	67.9%	68.6%	64.5%	55.3%	65.4%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

Child

Table 5-11 shows the child ECHO Survey results achieved by the seven RAEs and the statewide average for FY 2018–2019.

Table 5-11—2019 Child Statewide Results for ECHO

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Rating of All Counseling or Treatment	47.4%	51.0%	43.7%	50.9%	53.8%+	46.7%	42.3%	46.5%
Getting Treatment Quickly	71.6%+	68.6%+	68.6%+	73.0%+	70.1%+	66.9%+	73.3%+	69.8%
How Well Clinicians Communicate	85.7%	87.9%	87.6%	86.4%	85.4%+	86.5%	87.2%	86.8%
Perceived Improvement	70.9%	67.3%	73.4%	67.4%	72.9%	70.1%	72.5%	70.7%
Information About Treatment Options	69.2%	70.7%	74.1%	72.9%	72.0%+	72.9%	72.8%	72.1%
Office Wait	84.1%	83.8%	84.2%	85.4%	77.8%+	89.2%	87.3%	84.9%
Told About Medication Side Effects	83.3%+	88.9%+	85.1%+	78.0%+	89.7%+	81.6%+	90.0%+	85.2%
Information to Manage Condition	68.8%	70.9%	70.1%	74.0%	72.5%+	67.0%	76.0%	70.8%
Patient Rights Information	87.1%	89.5%	86.5%	91.0%	87.3%+	91.5%	88.8%	88.4%
Respondent Feels He or She Could Refuse Treatment for Their Child	87.1%	85.3%	79.8%	86.8%	85.9%+	89.1%	87.6%	85.3%
Privacy	95.2%	96.9%	90.1%	96.8%	92.1%+	94.2%	96.0%	94.0%
Cultural Competency	NA	NA	NA	NA	NA	NA	NA	60.8%+
Amount Helped	75.3%	75.7%	78.8%	81.4%	72.1%	78.3%	84.2%	78.1%
Improved Functioning	64.6%	62.5%	62.4%	63.4%	67.9%	66.9%	58.9%	63.0%
Social Connectedness	85.3%	81.0%	83.7%	84.8%	80.8%	86.0%	81.8%	83.4%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).

Statewide Conclusions and Recommendations Related to ECHO Surveys

All measures within the adult and child ECHO survey addressed quality. In addition, *Information About Treatment Options*, *Information to Manage Condition*, and *Improved Functioning* addressed access; *Getting Treatment Quickly* addressed timeliness; and *Office Wait* addressed both access and timeliness.

A substantial increase is noted when a RAE's measure rate was 5 percentage points or more above the statewide average. A substantial decrease is noted when a RAE's measure rate was 5 percentage points

or more below the statewide average. The adult and child statewide averages are calculated as weighted averages, with each RAE's eligible population acting as the weight.

RAE Adult Survey

For the adult Medicaid population, RMHP (Region 1) had three measure rates that were substantially higher than the statewide averages:

- *Perceived Improvement* (5.5 percentage points)
- *Information About Treatment Options* (6.0 percentage points)
- *Social Connectedness* (7.5 percentage points)

Seven of RMHP (Region 1)'s measure rates were higher than the statewide averages:

- *How Well Clinicians Communicate*
- *Office Wait*
- *Including Family*
- *Patient Rights Information*
- *Respondent Feels He or She Could Refuse Treatment*
- *Privacy*
- *Improved Functioning*

In addition, one measure for RMHP (Region 1) had the same rate as the statewide average:

- *Amount Helped*

One of RMHP (Region 1)'s adult Medicaid population measure rates was substantially lower than the statewide average:

- *Rating of All Counseling or Treatment* (7.4 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining three measure rates were lower than the statewide averages.

For the adult Medicaid population, NHP (Region 2) had one measure rate that was substantially higher than the statewide average:

- *Rating of All Counseling or Treatment* (10.2 percentage points)

Seven of NHP (Region 2)'s measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *Perceived Improvement*
- *Information About Treatment Options*
- *Told About Medication Side Effects*

- *Including Family*
- *Information to Manage Condition*
- *Patient Feels He or She Could Refuse Treatment*

One of NHP (Region 2)'s adult Medicaid population measure rates was substantially lower than the statewide average:

- *Social Connectedness* (5.4 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining six measure rates were lower than the statewide averages.

For the adult Medicaid population, COA (Region 3) did not have any measure rates that were substantially higher or lower than the statewide averages. Four of COA (Region 3)'s measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Told About Medication Side Effects*
- *Including Family*
- *Information to Manage Condition*

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining 11 measure rates were lower than the statewide averages.

For the adult Medicaid population, HCI (Region 4) had one measure rate that was substantially higher than the statewide average:

- *Improved Functioning* (7.4 percentage points)

Six of HCI (Region 4)'s measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *Perceived Improvement*
- *Office Wait*
- *Information to Manage Condition*
- *Privacy*
- *Social Connectedness*

Three of HCI (Region 4)'s adult Medicaid population measure rates were substantially lower than the statewide averages:

- *Told About Medication Side Effects* (9.6 percentage points)
- *Patient Rights Information* (5.3 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (7.4 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were lower than the statewide averages.

For the adult Medicaid population, COA (Region 5) had two measure rates that were substantially higher than the statewide averages:

- *Information to Manage Condition* (5.4 percentage points)
- *Amount Helped* (7.9 percentage points)

Six of COA (Region 5)'s measure rates were slightly higher than the statewide averages:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Office Wait*
- *Told About Medication Side Effects*
- *Privacy*
- *Social Connectedness*

Two of COA (Region 5)'s adult Medicaid population measure rates were substantially lower than the statewide averages:

- *Information About Treatment Options* (10.0 percentage points)
- *Including Family* (8.0 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were slightly lower than the statewide averages.

For the adult Medicaid population, CCHA (Region 6) had one measure rate that was substantially higher than the statewide average:

- *Information About Treatment Options* (8.8 percentage points)

Six of CCHA (Region 6)'s measure rates were slightly higher than the statewide averages:

- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Office Wait*
- *Told About Medication Side Effects*
- *Patient Rights Information*
- *Patient Feels He or She Could Refuse Treatment*

In addition, one measure for CCHA (Region 6) had the same rate as the statewide average:

- *Getting Treatment Quickly*

For the adult Medicaid population, CCHA (Region 6) did not have any measure rates that were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining seven measure rates were slightly lower than the statewide averages.

For the adult Medicaid population, CCHA (Region 7) had one measure rate that was substantially higher than the statewide average:

- *Including Family* (5.9 percentage points)

Five of CCHA (Region 7)'s adult Medicaid population measure rates were substantially lower than the statewide averages:

- *Perceived Improvement* (8.4 percentage points)
- *Office Wait* (8.5 percentage points)
- *Information to Manage Condition* (5.0 percentage points)
- *Improved Functioning* (9.0 percentage points)
- *Social Connectedness* (10.1 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining nine measure rates were lower than the statewide averages.

Based on statewide comparisons related to adult ECHO results, for five measures (*How Well Clinicians Communicate*, *Information About Treatment Options*, *Patient Feels He or She Could Refuse Treatment*, *Privacy*, and *Social Connectedness*), four RAE regions had rates lower than the statewide averages. In addition, for four measures (*Rating of All Counseling or Treatment*, *Patient Rights Information*, *Amount Helped*, and *Improved Functioning*), five RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve member perceptions related to these measures.

Of note, RAE Region 1 had the fewest amount of measure rates (four) that were lower than the statewide averages for adult measures, while RAE Region 7 had the greatest amount of measure rates (14) that were lower than the statewide averages. Most of the other RAE regions experienced seven or eight measure rates lower than the statewide averages, except for RAE Region 3, which had 11 measure rates that were lower than the statewide averages. HSAG determined no particular trend or pattern related to this.

RAE Child Survey

For the child Medicaid population, RMHP (Region 1) did not have any measure rates that were substantially higher or lower than the statewide averages.

Seven of RMHP (Region 1)'s measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Getting Treatment Quickly*
- *Perceived Improvement*
- *Respondent Feels He or She Could Refuse Treatment for Their Child*
- *Privacy*
- *Improved Functioning*
- *Social Connectedness*

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining seven measure rates were lower than the statewide averages.

For the child Medicaid population, NHP (Region 2) did not have any measure rates that were substantially higher or lower than the statewide averages.

Six of NHP (Region 2)'s measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *How Well Clinicians Communicate*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Privacy*

In addition, one measure for NHP (Region 2) had the same rate as the statewide average:

- *Respondent Feels He or She Could Refuse Treatment for Their Child*

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining seven measure rates were lower than the statewide averages.

For the child Medicaid population, COA (Region 3) did not have any measure rates that were substantially higher than the statewide averages.

Five of COA (Region 3)'s measure rates were slightly higher than the statewide averages:

- *How Well Clinicians Communicate*

- *Perceived Improvement*
- *Information About Treatment Options*
- *Amount Helped*
- *Social Connectedness*

One of COA (Region 3)'s child Medicaid population measure rates was substantially lower than the statewide average:

- *Respondent Feels He or She Could Refuse Treatment for Their Child* (5.5 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining eight measure rates were lower than the statewide averages.

For the child Medicaid population, HCI (Region 4) did not have any measure rates that were substantially higher than the statewide averages. Eleven of HCI (Region 4)'s measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Getting Treatment Quickly*
- *Information About Treatment Options*
- *Office Wait*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Respondent Feels He or She Could Refuse Treatment for Their Child*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*
- *Social Connectedness*

One of HCI (Region 4)'s child Medicaid population measure rates was substantially lower than the statewide average:

- *Told About Medication Side Effects* (7.2 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining two measure rates were slightly lower than the statewide averages.

For the child Medicaid population, COA (Region 5) had one measure rate that was substantially higher than the statewide average:

- *Rating of All Counseling or Treatment* (7.3 percentage points)

Six of COA (Region 5)'s measure rates were slightly higher than the statewide averages:

- *Getting Treatment Quickly*
- *Perceived Improvement*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Respondent Feels He or She Could Refuse Treatment for Their Child*
- *Improved Functioning*

Two of COA (Region 5)'s child Medicaid population measure rates were substantially lower than the statewide averages:

- *Office Wait* (7.1 percentage points)
- *Amount Helped* (6.0 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were lower than the statewide averages.

For the child Medicaid population, CCHA (Region 6) did not have any measure rates that were substantially higher or lower than the statewide averages.

Nine of CCHA (Region 6)'s measure rates were slightly higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Information About Treatment Options*
- *Office Wait*
- *Patient Rights Information*
- *Respondent Feels He or She Could Refuse Treatment for Their Child*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*
- *Social Connectedness*

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were slightly lower than the statewide averages.

For the child Medicaid population, CCHA (Region 7) had two measure rates that were substantially higher than the statewide averages:

- *Information to Manage Condition* (5.2 percentage points)
- *Amount Helped* (6.1 percentage points)

Nine of CCHA (Region 7)'s measure rates were slightly higher than the statewide averages:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Information About Treatment Options*
- *Office Wait*
- *Told About Medication Side Effects*
- *Patient Rights Information*
- *Respondent Feels He or She Could Refuse Treatment for Their Child*
- *Privacy*

For the child Medicaid population, CCHA (Region 7) did not have any measure rates that were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining three measure rates were lower than the statewide averages.

Based on statewide comparisons, HSAG had the following observations for the child ECHO results. For three measures (*How Well Clinicians Communicate*, *Office Wait*, and *Told About Medication Side Effects*), four RAE regions had rates lower than the statewide averages. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions related to these measures.

Of note, there were two RAE regions (RAE Regions 4 and 7) that had only three measure rates lower than the statewide averages for the child survey. The rest of the RAE regions had between five and nine measure rates that were lower than the statewide averages. HSAG determined no particular trend or pattern related to this.

Encounter Data Validation—RAE Behavioral Health Information Systems Review

Statewide Results

The Department and each RAE participated in the BH IS review and documentation supplied to HSAG suggested that each entity maintains policies and procedures to process BH claims and encounters. The RAEs' questionnaire responses and supporting documentation indicated that each RAE has robust encounter data systems that can be adapted to meet the Department's encounter data submission specifications through the transition to X12 transaction file submissions.

Prior to implementation of ACC Phase II, BHOs submitted BH encounter data to the Department in a flat file format. The Department permitted each RAE, or its ASO, to submit BH encounter data using the legacy flat file format while building infrastructure capable of generating and submitting X12 transaction files to interChange through DXC, with the understanding that all RAEs would begin submitting X12 transaction files by September 2018. The Department's questionnaire responses indicated that it provides the RAEs with regularly updated legacy flat file specifications and X12 transaction companion guides to facilitate production and submission of compliant encounter data in both formats. RAEs with pre-existing contractual relationships to the Department (e.g., as BHOs or for other lines of business) have continued to use historic policies and procedures to produce legacy encounter flat files. Additionally, all RAEs reported using the Department's monthly "stat" reports to make updates or modifications to the processing systems used to generate encounter flat files. Consequently, no RAEs reported file acceptance issues for legacy flat file submissions.

The Department required each RAE to complete a series of general steps to enroll as a trading partner and initiate the X12 transmission process for BH encounter data files. All RAEs' questionnaire responses suggested that minimal modification of existing data management infrastructure and policies and procedures was required to facilitate the transition to X12 transaction file submission. However, as of March 2019, only three RAEs were continuing to submit X12 transaction files beyond their September 2018 test submissions. As of March 2019, two RAEs reported making ongoing significant modifications of processing software to accommodate compliance errors listed in test submission response files. Three RAEs listed extensive compliance issues with the X12 transaction requirements, and the RAEs partially attributed the issues to the Department's conflicting data quality standards between the legacy and X12 formats. Generally, all RAEs reported experiencing the following issues when submitting X12 transaction files:

- Encounters are rejected due to conflicts between coding standards included in DXC's business editing assessment and BH coding standards in the Department's Uniform Service Coding Standards (USCS) Manuals.
- Encounters are rejected for members with dual Medicare and Medicaid coverage and no Medicare payment denial information.

- Encounters are rejected when provider data do not mirror the corresponding provider information in interChange.

The Department's questionnaire responses indicated that it conducts separate data quality monitoring activities for BH encounters in the legacy encounter data system and the data warehouse holding the X12 transaction data. The Department reported the following differences in the scope of validation checks between the data formats:

- Flat file validation considers the presence and accuracy of key data elements for professional encounters (e.g., rendering provider ID and first procedure code modifier) and institutional encounters (e.g., attending provider ID), as well as duplication within the submitted file and against data previously submitted and stored in the Department's flat file data warehouse.
- X12 transaction file validation considers the presence and validity of multiple data elements. Edits assess compliance with coding standards for data elements such as procedure code, units, and place of service. Edits also assess the presence and accuracy of billing provider information and applicable payor information (e.g., when members have TPL or Medicare crossover benefits).

The Department stated that business rules within the DXC claims processor were originally developed to support FFS claims processing rather than encounter data processing; consequently, a large percentage of BH encounters submitted in X12 transaction files are incorrectly denied (i.e., per the Department's BH payment rules, these encounters should not have been denied). Additionally, discrepancies with provider information included in reports sent to RAEs have contributed to incurred denials: RAEs have encountered issues identifying which of their providers are appropriately enrolled in interChange and which provider information must be included in X12 submissions. Table 5-12 displays the RAE-specific X12 transaction file rejection rates reported by the Department for each encounter type.

Table 5-12—Department-Reported X12 Transaction File Rejection Rates by RAE

RAE	Professional Encounter Rejection Rate	Institutional Encounter Rejection Rate
Region 1—RMHP	59.0%	35.0%
Region 2—NHP	95.0%	56.0%
Region 3—COA	90.0%	41.0%
Region 4—HCI	99.0%	31.0%
Region 5—COA	95.0%	30.0%
Region 6—CCHA*	NA	NA
Region 7—CCHA*	NA	NA

** The Department reported an "NA" rejection rate for CCHA because it has not successfully submitted X12 transaction files.*

The Department and RAEs have maintained various lines of communication to facilitate discussion and resolution of issues identified during the implementation of X12 transaction file submissions.

Specifically, the Department facilitates regular meetings with RAEs, CMHCs, and DXC to address structural file rejection issues reported by the RAEs. The Department also maintains and shares a meeting log document to track the discussion date and subsequent actions for concerns discussed during biweekly Health Systems meetings.

Due to data submission challenges identified by the Department and individual RAEs, the transition from flat files to X12 transaction files is ongoing. Consequently, the Department uses BH encounters from the flat file submissions when conducting rate-setting and performance measure calculation.

Statewide Conclusions and Recommendations

The RAEs' questionnaire responses demonstrated their capacity to collect, process, and transmit BH claims and encounter data meeting the Department's quality specifications for legacy flat file submissions. Each RAE reported no issues with flat file acceptance and emphasized its ability to develop adaptable data review processes that can promptly respond to quality issues identified by the Department. However, the Department's current BH encounter data oversight activities are limited and do not assess the extent to which various data elements comply with USCS specifications. While the Department is scheduled to implement annual BH encounter validation activities among the RAEs, the planned validation will only assess USCS compliance among a sample of BH encounter records, compared to a systematic review of data quality among all encounters.

In general, RAEs reported that inconsistent documentation from, and communication with, the Department has impeded their transition from submitting BH encounters in flat files to submitting X12 transaction files. RAEs noted that the documentation of transition challenges is not owned by a Department stakeholder, and modification of DXC's claims processing steps that result in erroneous rejections is slow, allowing for further rejected data files while processing modifications are implemented. Consequently, this IS review was limited in its ability to determine the extent to which RAEs' current X12 transaction file policies and procedures support production of complete and accurate BH encounter data. IS review questionnaire responses from the Department and the RAEs described systematic issues that prevent effective detection of non-compliant X12 records, including the following factors affecting the RAEs' ability to develop BH encounter data policies and procedures and to successfully submit X12 transaction files to the Department:

- Inconsistent X12 transaction file specifications from the Department
- Differences in data quality assessments applied to flat file submissions versus X12 transaction file submissions
- Instances in which RAEs' providers have not enrolled or revalidated their information in interChange and provider records cannot be linked to incoming BH encounters

The Department's questionnaire responses indicated that business rules incorporated into its claims processing system were designed to assess FFS claims; consequently, each RAE reported experiencing file rejections due to noncompliance with billing and reimbursement rules not applicable to BH encounters. Additionally, RAEs reported experiencing X12 file rejection as a result of differential data

quality assessments employed for encounter records submitted in legacy flat files compared to X12 transaction files. Such discrepancies have limited the RAEs' ability to establish uniform data quality standards for BH encounters.

Finally, RAEs' questionnaire responses consistently identified non-compliant provider data as a major contributor to X12 transaction file rejections. RAEs noted that these rejections stem from different reporting requirements: RAEs collect individual-level billing provider data, while the Department requires group-level billing provider data. Furthermore, RAEs need to link provider data to corresponding interChange provider records to meet BH encounter data specifications. However, RAEs reported that many contracted providers have not successfully enrolled in interChange; and the Department did not provide a list of interChange providers for this linkage process to the RAEs until November 2018. Note that provider linkage complications persist; three RAEs noted that the Department's provider list does not consistently include information needed to identify individual providers (e.g., taxonomy codes).

Recommendations

As the first comprehensive EDV activity with the RAEs, the IS review established a foundation from which to improve the quality of BH encounter data submitted by the RAEs to the Department. Therefore, HSAG offers the following recommendations to improve the RAEs' BH encounter data quality:

- As of the March 2019 questionnaire responses, three RAEs indicated that their encounter data policies and procedures were being updated; the Department should verify that the policies and procedures were updated by requesting and reviewing copies of the RAEs' documents.
- Two RAEs reported that they do not include zero payment encounters from sub-capitated providers in their encounter data submissions to the Department. Additionally, the same RAEs reported that they do not include denied encounters from CMHCs in their X12 transaction files; the Department should determine whether this practice is consistent with encounter data submission standards.
- One RAE indicated that the Department was developing a comprehensive, interChange-based provider file to facilitate the RAEs' provider data configuration efforts; the Department should develop a timeline for supplying these routine provider data files to the RAEs.
- While RAEs' responses noted participation in the biweekly Health Plan Systems meetings hosted by the Department, the Department was unable to provide meeting documentation for HSAG's review. As these meetings provide a routine forum for encounter data stakeholders to discuss concerns with X12 transaction file submissions, the Department should publish meeting agendas, meeting minutes or notes, and supporting documents in a location accessible to all stakeholders.
- Each RAE reported monitoring its encounter data quality; the Department should review examples of the RAEs' flat file and X12 encounter data quality monitoring reports. These reports may offer potential best practices or monitoring metrics by which other RAEs may enhance their encounter data oversight. Additionally, these reports will assist the Department in setting standards and expectations for the RAEs and further efforts to achieve consistency in processes across RAEs.

- To support the Department's overall encounter data quality and transition between the legacy flat files and the X12 transaction files, the Department should:
  - Conduct a thorough comparative analysis between the RAEs' flat file submissions and successfully submitted X12 transaction files to identify factors contributing to the Department's rejection of RAEs' X12 transaction files.
    - Based on the comparative analysis findings, the Department should determine which interChange business rules apply to BH encounters and provide the RAEs with a timeline by which the Department will publish updated companion guides, including uniform file formatting specifications.
  - Simplify the X12 transaction file submission specifications, updating all BH encounter data documentation to reflect the business rules specific to BH encounter data.
  - Following the RAEs' successful implementation of X12 transaction file submissions for a minimum of six months, conduct comprehensive EDV activities to assess the timeliness and accuracy of RAEs' BH encounter data maintained in interChange. The EDV should include, at a minimum, a comparative analysis between the Department's electronic encounter data and data extracted from the RAEs' data systems.

Encounter Data Validation—MCO 412 Audit Over-Read

Statewide Results

Overall, results from HSAG's FY 2018–2019 MCO 412 over-read showed that HSAG's reviewers agreed with the MCOs' reviewers for 78.8 percent of over-read cases and 91.5 percent of individual encounter data elements.[5-2] Table 5-13 shows the percentage of cases in which HSAG's reviewers agreed with the health plans' reviewers' results (i.e., case-level and element-level accuracy rates) by service category.

Table 5-13—Statewide Aggregated Encounter Over-Read Agreement Results for MCOs by Service Category

Service Category	Case-Level Accuracy—Total Number of Cases	Case-Level Accuracy—Percent with Complete Agreement	Element-Level Accuracy—Total Number of Elements	Element-Level Accuracy—Percent with Complete Agreement
Inpatient	40	80.0%	240	93.3%
Outpatient	40	90.0%	200	96.0%
Professional	40	77.5%	200	93.5%
FQHC	40	67.5%	200	83.0%
Total	**160**	**78.8%**	**840**	**91.5%**

[5-2] Although results represent those reported by HSAG to the Department, each MCO submitted feedback to the Department indicating disagreement with a number of findings in HSAG's MCO-specific EDV over-read reports.

Statewide Conclusions and Recommendations

As there were clear differences between each MCO's over-read results, HSAG's findings suggest opportunities for both MCOs to improve their encounter data quality, with additional opportunity for RMHP Prime to improve its internal audit processes.

The MCOs' internal audit documentation offered no examples of specific instructions or reviewer training materials, resulting in an opportunity for the MCOs to improve their internal audit documentation. Additionally, HSAG recommends the Department continues to work with its encounter data system vendor to improve the encounter data documentation guiding the MCOs' data submissions.

In nearly all cases in which HSAG's reviewers disagreed with the MCOs' audit results, HSAG's reviewers identified a misalignment between medical record documentation and encounter data, rather than insufficient medical record documentation. To address encounter data deficiencies, HSAG recommends that the MCOs implement robust encounter data quality monitoring procedures, and ensure contracted providers are trained to submit encounters that accurately reflect medical record documentation and services rendered.

Validation of Network Adequacy

Statewide Results

The Department actively participated in the network adequacy activities, supplying network process documentation and provider data from the interChange data system. However, provider data in interChange supports FFS data processes (e.g., processing healthcare claims) and has no mechanism to capture data on a provider's FFS and/or health plan affiliation(s). Additionally, the Department reported that it does not routinely collect the health plans' provider network data files and does not require health plans to use a standardized set of definitions for identifying specific provider categories. Furthermore, the structure in which interChange maintains provider data affects the availability and completeness of provider attributes. Providers' degree, title, and/or credentialing information is required for selected provider types when enrolling in interChange (e.g., providers or facilities must submit documentation confirming that they meet the criteria for the given provider type). Consequently, providers' degree, title, and/or credentialing information is not captured in separate interChange data elements but may be inferred based on the provider type.

Each health plan participated in the network adequacy activities, supplying documentation and provider data to HSAG. While all health plans reported on their approaches for collecting and maintaining their provider data, specific activities varied by health plan. Each health plan reported that it identifies group and/or facility-level providers, though many health plans included no provider type values for facilities (e.g., hospitals or multi-specialty practices), indicating that each health plan handles records differently for these provider categories compared to data for the individual-level providers. Additionally, not every health plan reported that it collects providers' taxonomy code(s), limiting the use of this provider

attribute when creating a standardized crosswalk of provider category definitions. Finally, each health plan's provider data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map the provider data to the Department's provider categories (i.e., generate provider crosswalks). Disparities in provider data elements available from the Department and the health plans also prevented HSAG from reliably identifying the same provider from both the interChange and the health plans' data sets.

Statewide Conclusions and Recommendations

The health plans' data completeness and consistency affected the range of attribute combinations recommended for each provider category in the provider crosswalks. When HSAG determined that a health plan's data was missing provider type values or contained overly broad specialty information (e.g., a specialty of "Nurse Practitioner"), HSAG may have required taxonomy, degree, or credential data to determine whether the provider could be counted in a specific PCA category. Behavioral health provider categories for the RAEs required licensure information (e.g., Licensed Clinical Social Workers), and the applicable health plans generally had sufficient provider attribute data to assign potential providers to the Department's approved provider categories. Many health plans' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., NPs or PAs). While these health plans collected detailed subspecialty information for physicians, similar information was not reported for the non-physician providers.

PCA results illustrated the need for standardized provider category definitions when conducting network adequacy assessments to ensure consistent analytic results across health plans. The PCA results also reinforce the need for the health plans to evaluate the level of specificity available in their provider data systems. Additionally, interChange provider data include hospitals, FQHCs, RHCs, and CMHCs; however, the health plans may not have these providers counted in the PCA due to the way in which these providers are reflected in the health plans' data.

As the first comprehensive investigation into the health plans' provider networks, the current study established a foundation from which to build robust managed care network adequacy expectations and processes for overseeing the health plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the health plan. The Department should also develop standardized quarterly network adequacy reporting templates for each health plan type. To ensure consistent reporting within each health plan type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps

    - Content should allow the health plan to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206[5-3] and reporting requirements under 42 CFR §438.207[5-4]
  - Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the health plan
  - Methodology information for any expected calculations
    - For example, time/distance calculations should be based on driving distances between each member and the nearest applicable provider
  - Templates for any expected data tables, including definitions for each cell that the health plan is expected to populate

- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the health plans and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the health plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. The health plans should assess available data values in their provider data systems and standardize available data value options.

[5-3] Availability of Services, 42 CFR §438.206. Available at: https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8. Accessed on: May 20, 2019.

[5-4] Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at: https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207. Accessed on: May 20, 2019.

6. Assessment of Health Plans' Follow-Up on FY 2017–2018 Recommendations

Colorado's BHOs' contracts ended June 30, 2018. On July 1, 2018, Colorado's seven RAEs began operations to implement the next iteration of Colorado's ACC program. Therefore, this section applies only to Colorado's two MCOs, DHMP and RMHP Prime.

Denver Health Medical Plan

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in 2017–2018 (Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation), DHMP was required to:

- Ensure information presented to the members is easily readable, readily accessible, and includes the most up-to-date information and guidance.
- Improve policies and procedures related to grievances and appeals and to ensure that information pertaining to grievances and appeals is proactively distributed to providers and subcontractors.
- Expand processes in place for identifying potential overpayments, fraud, waste or abuse, and for notifying the Department regarding written disclosures of ownership and control.
- Implement processes for pre-delegation assessment of every subcontractor and performing ongoing monitoring of subcontractors' performance; ensure it has a written agreement with every subcontractor; ensure that written agreements with subcontractors include the subcontractors' agreement to comply with all applicable laws and regulations and provisions for auditing by the State or designated federal entities.

DHMP submitted its initial corrective action plan (CAP) proposal on February 26, 2018. Following Department approval, DHMP successfully completed implementation of all planned interventions on June 5, 2019.

HEDIS Measure Rates and Validation

Information Systems Standards Review Results

There were no recommendations for DHMP in FY 2017–2018 related to IS standards review.

Performance Measure Results

HSAG recommended that DHMP should evaluate access issues and implement procedures to ensure that adequate care is provided and develop mechanisms to ensure that care provided is appropriately documented within administrative data systems. This may also result in improvement of the quality of care provided. Additionally, DHMP has opportunities to improve in areas related to medication management, as evidenced by the following measures performing below the national Medicaid 25th percentile: *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, *Persistence of Beta-Blocker Treatment After a Heart Attack*, *Annual Monitoring for Patients on Persistent Medications*, and *Pharmacotherapy Management of COPD Exacerbation*. DHMP should work to ensure that members receive medications necessary to treat their conditions and that providers appropriately monitor members receiving long-term medications.

To follow-up on these recommendations related to the 2017–2018 PMV, DHMP developed the following initiatives:

- Allowed vaccines to be covered through the Pharmacy benefit, allowing broader access for members to receive them.
- Used quarterly reporting through the appointment center that shows the number of appointments that Medicaid members access for PCPs and specialists. This report helps to identify any potential gaps in services or appointment times.

The performance measure rates for *Childhood Immunization Status* and *Immunizations for Adolescents* remained the same from 2018 to 2019.

Validation of Performance Improvement Projects

In FY 2017–2018, DHMP closed out a PIP focused on improving the follow-up visit rate of asthmatics after they have visited an emergency department, urgent care, or an inpatient facility. At the conclusion of DHMP's PIP, HSAG recommended the following:

- Consider using other quality improvement tools, such as a process map or FMEA, to isolate barriers or gaps within processes that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.
- For improvement strategies that were deemed successful, DHMP should develop a plan for sustaining and spreading the success beyond the life of the PIP.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, DHMP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, DHMP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, DHMP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, DHMP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess DHMP's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Survey

To follow up on recommendations related to FY 2017–2018 CAHPS, DHMP reported engaging in the following quality improvement initiatives:

- DHMP continues to improve their Quality Assurance and training program for staff members. DHMP monitors 10 calls per representative per month and identified trends for team training and individual issues for one-on-one training. Trainings are conducted each month.
- To addresses opportunities for improvement with customer service, DHMP runs a report through Customer Relationship Management (CRM) that documents the reasons for incoming calls and common themes that were captured by customer service representatives. As new trends are identified, DHMP provides additional information, refresher training, or new training for new issues identified to customer service representatives.
- DHMP conducted an Annual Member Experience Survey and asked members specific questions about their communication preferences (e.g., information in the Member Handbook was clear, know where to find and get materials, understand DHMP's policies and procedures). DHMP set a top-box goal of 75 percent for each of the questions and two questions exceeded the goal, while three questions fell short of the goal. DHMP's website offers members options to view the site in different formats to meet their needs (e.g., larger font size, line spacing, color contrast). DHMP's marketing department will evaluate the areas that performed below the target top-box rates during the annual web review process and review opportunities for member education on DHMP's policies and procedures.
- DHMP uses a report generated quarterly through the appointment center that shows the number of appointments that Medicaid members access for specialists. The report helps DHMP identify any potential gaps in services or appointment times. In addition, DHHA began an initiative over a year ago to increase availability for new patient appointments in specialist care clinic visits.
- DHMP's marketing department creates and distributes member newsletters quarterly, which contains content to educate members about various health topics and community and plan resources (e.g., same-day care options, the Denver Health NurseLine, recipes, Denver Public Health).

Rocky Mountain Health Plans Medicaid Prime

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in 2017–2018 (Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation):

- RMHP Prime had no required actions related to Standard V—Member Information and Standard IX—Subcontracts and Delegation.
- RMHP Prime had two required actions to ensure time frames for grievances and appeals were appropriately being implemented and met.
- RMHP Prime had a required action to implement a process to regularly verify that services billed by network providers were actually received by the members.

RMHP Prime submitted its initial CAP proposal on April 2, 2018. Following Department approval, RMHP Prime successfully completed implementation of all planned interventions on January 7, 2019.

HEDIS Measure Rates and Validation

Information Systems Standards Review Results

There were no recommendations for RMHP Prime in FY 2017–2018 related to IS standards review.

Performance Measure Results

For HEDIS 2018, HSAG recommended that RMHP Prime focus efforts on performance measures related to medication management. RMHP Prime should focus on barriers that may exist for adults attempting to access preventive care. RMHP Prime should work to ensure that adult members have access to preventive and ambulatory care. Additionally, HSAG recommended that RMHP Prime should focus efforts on decreasing unnecessary antibiotic prescriptions when patients present with acute bronchitis and improving statin therapy for patients with cardiovascular disease.

To follow-up on recommendations related to the 2017–2018 PMV, RMHP Prime developed the following initiatives:

- RMHP Prime developed member-facing educational materials that direct the member to contact Customer Service at the One-Call phone number if/when there is a question related to benefits or services offered under its plan.

The performance measure rates for *Adults' Access to Preventive/Ambulatory Health Services* remained the same from 2018 to 2019.

Validation of Performance Improvement Projects

In FY 2017–2018, RMHP Prime closed out a PIP focused on improving the transition of care by assisting members who have been paroled with accessing a PCP within 90 days of enrollment into RMHP Prime. At the conclusion of RMHP Prime's PIP, HSAG recommended the following:

- Evaluate the effectiveness of each individual intervention and make changes, as necessary.
- Develop a plan to sustain the improvement achieved through the PIP process.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, RMHP Prime developed the foundation for a project that will address the prior recommendations. In Module 4, RMHP Prime will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, RMHP Prime will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess RMHP Prime's progress toward addressing the prior recommendations in the next FY's PIP validation.

CAHPS Survey

To follow up on recommendations related to FY 2017–2018 CAHPS, RMHP Prime reported engaging in the following quality improvement initiatives:

- RMHP Prime continues to conduct an annual CAHPS survey to capture data on members' experience with timeliness of appointments.
- RMHP Prime is a "Partner in Quality" with NCQA; therefore, RMHP Prime practices that are PCMH have a requirement to offer expanded hours of availability, and RMHP Prime supports practices in PCMH transformation. RMHP Prime incentivizes practices for being a higher tiered practice in the RMHP Value-Based Tiered Payment Model. Tier 1 practices are required to be a PCMH. In addition, the Access Measures under the State Alternative Payment Model (APM) Program are monitored by the RMHP Practice Transformation Team (PTT).
- RMHP Prime conducts a quarterly Provider Attributes survey. Implemented in November 2018, this survey template is sent to all network providers and requests any updates from the provider, including availability of hours. RMHP Prime is developing a database to capture this information more efficiently and allow RMHP Prime to populate the print and online directories. This development should be fully incorporated by the end of August 2019.
- RMHP Prime incentivizes providers through funding additional care coordination, practice transformation activities, and, in some cases, additional Per Member Per Month (PMPM) payments.
- RMHP Prime continually strives to ensure that its provider network is sufficient so that services are provided to members on a timely basis. RMHP Prime uses a variety of means to educate providers about the various BH and PH appointment standards.
- RMHP Prime provides members and providers access to the directory on its website where they can easily search for after-hours care and urgent care providers.

- RMHP Prime is actively working to expand and increase membership on its member advisory councils, particularly the newer Larimer County council. RMHP Prime is partnering with the Department to use member inquiry/interest data from the Statewide MEAC to recruit new members. For example, one identified goal is to develop community-based member committees. In addition, RMHP Prime is exploring implementing member mentorship programs.
- RMHP Prime has contracted with the network of Family Resource Centers across Western Colorado and Larimer County to offer two trainings per year on topics relevant to the community, with special focus on emotional well-being and healthy eating and active living. These trainings are open to the public but tailored for the unique needs of low-income families. In addition, RMHP Prime is partnering closely with Healthy Communities and Nurse Family Partnership to ensure these systems have adequate support from RMHP Prime to ensure members receive the medical care that they require.
- RMHP Prime offers a Disability Competent Care training to providers to ensure that providers understand how to verify members' understanding of information that is being conveyed to them.
- RMHP Prime makes every effort to communicate with members in a clear and effective manner. Typically, RMHP Prime gathers this information via surveys and continually strives to increase how that information is shared and acted upon. RMHP Prime allows members to identify their communication preferences via the member portal.

Appendix A. RMHP Prime Administrative and Hybrid Rates

Appendix A shows RMHP Prime's rates for HEDIS 2019 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2019 hybrid rate.

Table A-1—HEDIS 2019 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	54.29%	62.86%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	14.29%	28.57%	25th–49th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.90%	76.19%	50th–74th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	17.66%	35.77%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	4.37%	87.86%	75th–89th
Counseling for Nutrition—Total	15.53%	80.10%	75th–89th
Counseling for Physical Activity—Total	0.00%	77.67%	75th–89th
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	44.69%	85.79%	50th–74th
Postpartum Care	28.58%	67.63%	50th–74th
Preventive Screening			
Cervical Cancer Screening			
Cervical Cancer Screening	41.93%	59.60%	25th–49th
Adult BMI Assessment			
Adult BMI Assessment	27.74%	93.00%	75th–89th
Living With Illness			
Comprehensive Diabetes Care			
HbA1c Testing	84.59%	91.61%	75th–89th
*HbA1c Poor Control (>9.0%)**	76.08%	25.91%	≥90th
HbA1c Control (<8.0%)	19.55%	58.58%	75th–89th
Eye Exam (Retinal) Performed	50.14%	60.40%	50th–74th
Medical Attention for Nephropathy	83.21%	89.60%	25th–49th
Blood Pressure Control (<140/90 mm Hg)	8.91%	74.82%	75th–89th

**For this measure, a lower rate indicates better performance.*