FY 2019–2020 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

November 2020

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and Financing

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Background

In 2011, the Colorado Department of Health Care Policy and Financing (the Department) established the Accountable Care Collaborative (ACC) Program as a central part of Colorado's plan for Medicaid reform. Central goals for the program were improvement in health outcomes through a coordinated, client-centered system of care and cost control by reduction of avoidable, duplicative, variable, and inappropriate use of healthcare resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. The RCCOs provided care management for medically and behaviorally complex clients, coordinated care among providers, and provided practice support for a network of primary care fee-for-service (FFS) providers.

Effective July 1, 2018, the Department implemented ACC Phase II and awarded contracts to seven Regional Accountable Entities (RAEs). The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of primary care FFS providers and capitated behavioral health (BH) providers to ensure access to care for Medicaid members through one accountable entity. The goals and objectives of ACC Phase II include improving member health, reducing costs, strengthening coordination of services by advancing team-based care and Health Neighborhoods, promoting member choice and engagement, and rewarding providers through performance incentives. This report includes the results of external quality review (EQR)-related activities conducted in fiscal year (FY) 2019–2020, the second year of RAE operations. Colorado does not exempt any of its RAEs or managed care organizations (MCOs) from EQR.

Scope of External Quality Review Activities for the Regional Accountable Entities

The RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, two RAE regions incorporate into the RAE a limited managed care initiative for capitated physical health (PH) services (MCOs). RAEs were subject to federally mandated EQR activities—monitoring for compliance with federal healthcare regulations, validation of performance improvement projects (PIPs), and performance measure validation (PMV). Health Services Advisory Group, Inc. (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. RAEs and MCOs are collectively referred to as "health plans" throughout this report.

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 and related Department contract requirements. HSAG assessed compliance through review of three standard areas approved by the Department.

- **Validation of performance measures.** HSAG validated BH performance measures to assess the accuracy of performance measures reported by the RAEs. The validation also determined the extent to which performance measures calculated by the RAEs followed specifications required by the Department.
- **HEDIS measure rates and validation—MCO 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 PCMH CAHPS surveys for Colorado Medicaid practices within each RAE. HSAG included adult and child practice results from the survey in this report.
- **CAHPS surveys—MCO capitation initiative.** Each MCO 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 for members who received BH services through the RAEs. HSAG included the RAEs' survey results for both adult and child populations in this report.
- **EDV—RAE 411 audit over-read.** HSAG reviewed a sample of BH encounter data to ensure that medical record documentation supported the RAE's encounter data submissions to the Department. HSAG sampled the records reviewed by each RAE and conducted an over-read to validate the RAEs' EDV results.
- **EDV—MCO 412 audit over-read.** HSAG conducted this activity for Colorado's two MCOs providing services under the MCO capitation initiative within the ACC Program. HSAG reviewed a sample of PH encounters to ensure that medical record documentation supported the MCO's submission of the selected encounter data to the Department. HSAG sampled the records reviewed by each MCO and conducted an over-read to validate the MCOs' EDV results.
- **Validation of network adequacy.** HSAG obtained network information from the RAEs and MCOs and member data from the Department to conduct geoaccess analyses to determine the health plans' compliance with network adequacy contract requirements for provider-to-member ratios and time and distance standards. HSAG also collaborated with the Department and the health plans to develop and implement standardized quarterly network adequacy reporting templates.

Summary of FY 2019–2020 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

In FY 2019–2020, HSAG reviewed three standards as directed by the Department (see Methodology in Section 2).

Table 1-1 displays the statewide average Compliance Monitoring results for the FY 2019–2020 assessment of compliance with regulations activity.

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

Standard	Statewide Average—FY 2019–2020
Standard I—Coverage and Authorization of Services	88%
Standard II—Access and Availability	97%
Standard VI—Grievance and Appeal Systems	79%

For the seven RAEs providing services under Colorado's ACC Program, the health plans demonstrated high performance with Standard II—Access and Availability. Scores ranged from 94 to 100 percent compliance, demonstrating the RAEs' ability to accurately understand requirements and implement procedures to demonstrate compliance. Scores for Standard I—Coverage and Authorization of Services ranged from 80 to 97 percent compliance, reflecting general compliance with regulations. Lastly, Standard VI—Grievance and Appeal Systems scores demonstrated an opportunity to improve RAE understanding of requirements related to this content area. Scores ranged from 71 to 86 percent compliant.

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 2019–2020 standards, see Section 4, Table 4-2.

Table 1-2 displays the statewide average Compliance Monitoring 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 MCO capitation initiative under the ACC Program).

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

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017; 2019–2020)*	**94%**	**94%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**96%**	**94%**
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 Systems (2017–2018, 2019–2020)*	**87%**	**86%**
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%

**Bold text indicates standards that HSAG reviewed during FY 2019–2020.*

The statewide average scores (based on the two MCOs) demonstrated no improvement in scores during the most recent year of review for the three standards reviewed in FY 2019–2020. However, the statewide average score sustained overall high performance (above 90 percent) for Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. For Standard I—Coverage and Authorization of Services, the statewide average score remained stable at 94 percent. The statewide average scores for both Standard II—Access and Availability and Standard VI—Grievance and Appeal Systems decreased slightly (9 percentage points or fewer) when compared to the previous year these standards were reviewed. When compared to previous review cycles, the most significant improvement (16 percentage points) was observed in Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (reviewed last in FY 2018–2019) followed by an increase of 13 percentage points in Standard X—Quality Assessment and Performance Improvement. A slight increase (9 percentage points or fewer) was noted in Standard IV—Member Rights and Protections and Standard VIII—Credentialing and Recredentialing. Statewide MCO average performance declined in four standards (Standard III—Coordination and Continuity of Care, Standard V—Member Information,

Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation) when compared to the previous review for those standards. The reader should consider these changes in performance between review cycles with caution as changes in federal regulations or in State contract requirements, and design of the compliance monitoring tool may have impacted comparability of the Compliance Monitoring results.

For individual health plan scores and findings for the MCOs, see Section 3 of this report. For the health plan comparison of scores for FY 2019–2020 standards, see Section 4, Table 4-1.

Table 1-3 displays the statewide average Compliance Monitoring results for the most recent year that each standard area was reviewed. As FY 2019–2020 was the second year of RAE operations, no comparative statewide averages are available for the standards that will be reviewed in FY 2020–2021, the third year of compliance standard rotation for the RAEs.

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 (2019–2020)*	**88%**
Standard II—Access and Availability (2019–2020)*	**97%**
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 Systems (2019–2020)	**79%**
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%

**Bold text indicates standards that HSAG reviewed during FY 2019–2020.*

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

In the second year of RAE operations, HSAG reviewed three standard areas. The statewide average score in one of the three areas was over 90 percent compliant (Standard II—Access and Availability), indicating an understanding by the RAEs of most federal regulations related to this standard, and organizational processes sufficient to implement those requirements. For Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems, scores indicate 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

While most health plans demonstrated high performance in Standard II—Access and Availability, one common area of opportunity was for health plans to improve provider monitoring and corrective actions, when needed to ensure provider compliance with access standards (time, distance, and provider ratio). In terms of Standard I—Coverage and Authorization of Services, overall scores were widely varied (80 to 97 percent), and many health plans were required to improve the accuracy of information sent to members and providers, as well as ensure member-specific communications are easy to read. Lastly, Standard VI—Grievance and Appeal Systems compliance scores were the lowest across Medicaid health plans during the most recent review, with common opportunities surrounding accurate definitions, member and provider information, and member-friendly correspondence.

Validation of Performance Measures—RAEs

Information Systems Standards Review

HSAG evaluated the RAEs' 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 seven RAEs followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

Performance Measure Results

Table 1-4 shows the FY 2019–2020 performance measure results for the statewide average and the corresponding incentive performance targets for the RAEs. Cells shaded green indicate the statewide average's performance met or exceeded the FY 2019–2020 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 1-4—Statewide Averages for the RAEs

Performance Measure	FY 2019–2020 Rate	Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment		
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.64%	51.22%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition		
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	65.43%	81.51%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)		
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	34.98%	49.69%

Performance Measure	FY 2019–2020 Rate	Performance Target
Follow-Up After a Positive Depression Screen		
Follow-Up After a Positive Depression Screen	50.16%	54.40%
Behavioral Health Screening or Assessment for Children in the Foster Care System		
Behavioral Health Screening or Assessment for Children in the Foster Care System	16.86%	37.96%

Statewide Strengths Related to Behavioral Health Performance Measures

For performance measure validation, all RAEs had adequate processes in place regarding their eligibility and enrollment of members, how they processed claims and encounters, and how they integrated their data for the measures being calculated. Although the statewide average met none of the performance targets, four out of seven (57.1 percent) RAEs exceeded the statewide average for *Engagement in Outpatient Substance Use Disorder (SUD) Treatment*, three out of seven (42.9 percent) exceeded the statewide average for *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*, and five out of seven (71.4 percent) exceeded the statewide average for *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD).*

Statewide Opportunities for Improvement and Recommendations Related to Behavioral Health Performance Measures

While there are no recommendations for improvement related to the RAEs' information systems (IS) standards review, there are opportunities for improvement in performance. Due to the statewide averages for the RAEs falling below the performance targets in all performance measures, HSAG recommends that the RAEs work with the Department to identify interdependencies across the measures (e.g., access to timely outpatient services, etc.), in order to target a specific intervention for the next year that could positively impact rates for multiple measures. Furthermore, the Department could consider convening a forum in which the higher performing RAEs could share best practice while all RAEs collaborate on programwide solutions to common barriers. The Department could consider supporting these efforts by monitoring the RAEs' progress through routine meetings and informal written updates as the Department determines to be most effective and appropriate.

HEDIS Measure Rates and Validation—MCO Capitation Initiative

Information Systems Standards Review

HSAG reviewed the HEDIS Final Audit Reports (FARs) 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 performance measure validation performed by the MCOs' licensed HEDIS auditor. 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 are valid, reliable, and accurate.

Performance Measure Results

Table 1-5 and Table 1-6 display the Medicaid statewide weighted averages for HEDIS 2018 through HEDIS 2020, along with the percentile ranking for each HEDIS 2020 rate for the high- and low-performing measure rates for the MCO capitation initiative health plans (Denver Health Medical Plan [DHMP] and Rocky Mountain Health Plans Medicaid Prime [RMHP Prime]). Statewide performance measure results for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019 when available. Additionally, rates for HEDIS 2020 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for HEDIS 2020 shaded red with two carets (^^) indicate statistically significant decline in performance from the previous year.[1-1] Additional Medicaid statewide weighted average measure rates are found in Section 4.

Statewide Strengths Related to HEDIS Rates and Validation

Table 1-5—MCO Capitation Initiative Statewide Weighted Averages— HEDIS 2020 High Performers

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 6	43.32%	45.20%	47.85%	75th–89th
Combination 8	42.47%	45.14%	47.85%	75th–89th
Combination 9	39.44%	40.76%	42.68%	75th–89th
Combination 10	38.74%	40.70%	42.68%	75th–89th
Immunizations for Adolescents				
Combination 2 (Meningococcal, Tdap, HPV)	47.11%	48.70%	50.04%	≥90th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.34%	0.23%	0.30%	75th–89th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	53.45%	53.24%	65.91%^	75th–89th
Effective Continuation Phase Treatment	34.05%	33.91%	52.03%^	≥90th

[1-1] Performance comparisons are based on the Chi-square test of statistical significance with a p value < 0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2019 rates may be understated or overstated.

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Living With Illness				
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%[1]	58.63%	60.40%	74.16%^	≥90th
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total[1]	64.22%	64.89%	77.24%^	≥90th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	57.27%	60.91%	69.66%^	75th–89th
Medication Compliance 75%—Total	31.54%	35.00%	47.47%^	75th–89th
Opioids				
Use of Opioids From Multiple Providers*				
Multiple Pharmacies	—	8.23%	3.73%^	75th–89th

**For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered with caution.
— Indicates that NCQA recommended a break in trending for HEDIS 2019; therefore, the HEDIS 2018 rate is not displayed.

The HEDIS 2020 statewide weighted averages for measures within the Pediatric Care and Preventive Screening domains were 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 human papillomavirus (HPV) vaccine series. Additionally, DHMP's rate for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure exceeded the 90th percentile. Conversely, RMHP Prime's rate for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure fell below the 25th percentile.

In the Mental/Behavioral Health domain, the HEDIS 2020 statewide weighted average for the *Antidepressant Medication Management* measure indicators exceeded the 75th percentile, with RMHP Prime's rates exceeding the 90th percentile for both measure indicators. Conversely, DHMP's rates exceeded the 75th percentile and 50th percentile, respectively, for the *Effective Acute Phase Treatment* indicator and *Effective Continuation Phase Treatment* indicator. Although the HEDIS 2020 statewide weighted average for the *Medication Management for People With Asthma* indicators exceeded the 75th percentile, DHMP's rates did not exceed the 75th percentile while RMHP Prime's rates exceeded the 90th percentile.

The HEDIS 2020 statewide weighted average for measures within the Living With Illness domain demonstrated strong performance, with adherence to statin therapies for patients with diabetes and cardiovascular disease exceeding the 90th percentile. DHMP and RMHP Prime exhibited statistically significant increases in rates for *Statin Therapy for Patients With Diabetes—Statin Adherence 80%* and RMHP Prime's rate for *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* also was a statistically significant increase.

The HEDIS 2020 statewide weighted average for the measure *Use of Opioids From Multiple Providers—Multiple Pharmacies* measure in the Opioids domain exceeded the 75th percentile, demonstrating a strength related to members receiving opioids from four or more pharmacies throughout the measurement period.

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

Table 1-6—MCO Capitation Initiative Statewide Weighted Averages— HEDIS 2020 Low Performers

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	9.12%	7.08%	4.83%	<10th
Six or More Visits	4.39%	52.28%	55.51%	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	60.89%	63.57%	64.49%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	34.29%	39.36%	38.21%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	16.52%	21.62%	24.76%^	<10th
Counseling for Nutrition—Total	6.14%	7.57%	9.36%	<10th
Counseling for Physical Activity—Total	1.35%	5.81%	7.96%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	86.85%	88.52%	89.12%	<10th
Ages 25 Months to 6 Years	72.27%	75.14%	74.56%	<10th
Ages 7 to 11 Years	75.68%	80.16%	80.17%	<10th
Ages 12 to 19 Years	75.68%	80.50%	79.40%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	62.88%	61.75%	63.01%	<10th
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	50.53%	48.53%	47.09%	<10th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	43.12%	42.52%	42.52%	<10th
Adult BMI Assessment				
Adult BMI Assessment	47.08%	52.30%	59.16%^	<10th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	66.18%	50.98%	70.21%	10th–24th
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.03%	83.24%	83.74%	10th–24th
*HbA1c Poor Control (>9.0%)**	56.53%	56.98%	56.95%	10th–24th
HbA1c Control (<8.0%)	35.51%	34.71%	35.37%	10th–24th
Eye Exam (Retinal) Performed	27.40%	47.83%	47.75%	10th–24th
Medical Attention for Nephropathy	82.72%	82.30%	83.50%	<10th
Blood Pressure Control (<140/90 mm Hg)	32.61%	37.14%	38.27%	<10th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	49.60%	52.77%	53.27%	<10th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	73.19%	68.18%	66.31%	<10th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	50.53%	47.02%	50.88%	10th–24th
Bronchodilator	61.10%	67.02%	66.43%	<10th
Asthma Medication Ratio				
Total	59.69%	49.08%	47.31%	<10th
Opioids				
Use of Opioids From Multiple Providers*				
Multiple Prescribers	—	22.10%	**39.96%^^**	<10th

**For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered with caution.
— Indicates that NCQA recommended a break in trending for HEDIS 2019; therefore, the HEDIS 2018 rate is not displayed.

For HEDIS 2020, 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 within the Access to Care domain were below the 10th percentile. The measures related to preventive screenings for women (*Breast Cancer Screening* and *Cervical Cancer Screening*) for DHMP also fell below the 10th percentile. RMHP Prime's rates for measures within the Access to Care domain were below the 50th percentile and were below the 25th percentile for measures related to preventive screenings for women.

[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: Sept 14, 2020.

Six of 12 (50 percent) measure rates within the Living With Illness domain that were determined to be low performers for HEDIS 2020 were related to the appropriate prescribing of and/or monitoring of members prescribed long-term medications. Further, all measures within this domain fell below the 25th percentile.

The HEDIS 2020 statewide weighted average for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure in the Opioids domain fell below the 10th percentile and was a statistically significant decline in performance from the previous year, demonstrating an opportunity related to members receiving opioids from four or more different prescribers throughout the measurement period.

The MCOs' HEDIS compliance FARs 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 the IS standards review.

Based on performance measure results, HSAG recommends that the Department and the MCOs conduct a root cause analysis of the barriers to achieving improved performance in measures in the Pediatric Care and Access to Care domains. 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 consider identifying an intervention with the ability to reach and impact the highest number of members (i.e., high impact area), then work with providers and members, as applicable to the intervention, to improve member access, which will subsequently increase performance in these measure rates.

Related to substantially low performance in the Living With Illness domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to perform root cause analysis to determine the reason these measures continue to have low rates (e.g., is there a focus or a dedicated intervention approach to identifying and resolving potential barriers to filling prescriptions, or the need for community outreach and education on side effects or alternatives to certain medication therapies) and implement strategies that focus on improving the care for members related to these measures.

Related to low statewide scores in the *Breast Cancer Screening* and *Cervical Cancer Screening* measures, HSAG continues to recommend 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]

Related to low statewide scores in the Opioids domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to identify and monitor prescribing practices for opioids to treat

[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: Sept 14, 2020.

chronic pain. Guidelines for prescribing opioids for chronic pain include improving communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improving the safety and effectiveness of pain treatment, and reducing the risks associated with long-term opioid therapy.[1-4]

Validation of Performance Improvement Projects

Table 1-7 displays the results of the FY 2019–2020 PIP validations and summarizes how far through the five modules of the rapid-cycle PIP process each RAE progressed.

Table 1-7—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 3 and Initiated Module 4*	NA*
	BH	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
Region 2—Northeast Health Partners				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 3—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*

[1-4] *Guideline for Prescribing Opioids for Chronic Pain.* Available at: https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf. Accessed on: Sept 14, 2020.

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 4—Health Colorado, Inc.				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 5—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
Region 6—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 7—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2019–2020 validation cycle.*

During this validation cycle, the health plans completed Module 3–*Intervention Determination* and initiated intervention testing for Module 4–*Plan-Do-Study-Act.* In Module 3, each health plan used process mapping and a failure modes and effects analysis (FMEA) to identify opportunities for improving the process or processes related to the SMART (specific, measurable, attainable, relevant, and time-bound) Aim for the PIP. Module 3 also included identification of interventions to address the identified opportunities for process improvement. The initiation of Module 4 included selecting one or

more interventions to test through Plan-Do-Study-Act (PDSA) cycles and developing an intervention evaluation plan.

After each health plan submitted Module 3 for validation, HSAG provided feedback in the Module 3 validation tool. If any Module 3 validation criteria were not achieved, the health plan had the opportunity to seek technical assistance from HSAG. Each health plan resubmitted Module 3, and received feedback and technical assistance, until all validation criteria were achieved. While the health plans initiated intervention testing for Module 4 during FY 2019–2020, this module can take up to 12 months or more and can span more than one FY; therefore, HSAG did not validate the health plans' performance on Module 4 during FY 2019–2020. Due to the coronavirus disease 2019 (COVID-19) pandemic, the Department decided to close out the PIPs at the end of FY 2019–2020, prior to the completion of Module 4 and Module 5. The RAEs were instructed to submit a PIP close-out report and will initiate a new round of PIPs in FY 2020–2021.

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

The health plans achieved all validation criteria for Module 3 of the PIPs; therefore, there were no identified opportunities for improvement, based on the FY 2019–2020 PIP validation findings. Although the PIPs were closed out early, due to the COVID-19 pandemic, the RAEs will have lessons learned from working on Colorado's first round of rapid-cycle PIPs. In order to capture knowledge gained and lessons learned from the RAEs' FY 2019–2020 PIP activities, HSAG recommended to the Department that the RAEs' PIP close-out reports include intervention testing summaries, challenges encountered, successes achieved, and lessons learned. Common challenges, successes, and lessons learned reported in the PIP close-out reports were shared with the Department and RAEs at the September 2020 Colorado PIP Summit. Based on common themes included in the close-out reports, HSAG recommended the following to facilitate success in the next round of rapid-cycle PIPs:

- Foster understanding and commitment among external partners that are an integral part of intervention testing and data collection for the rapid-cycle PIPs.
- Allow sufficient time to develop interventions and address data collection issues. Consider the end date of the project and develop project management dates accordingly.
- Ensure adequate and consistent staffing for PIP activities. Develop a transition plan to sustain PIP activities in the event of staff turnover within the RAE or external partner organization.

PCMH CAHPS Surveys—RAEs

Table 1-8 shows the FY 2018–2019 and FY 2019–2020 Colorado RAE Aggregate (i.e., statewide average) PCMH CAHPS survey results for PCMH practices serving adults within the seven RAEs.

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

Measure	FY 2018–2019 Colorado RAE Aggregate	FY 2019–2020 Colorado RAE Aggregate
Rating of Provider	63.6%	59.1%
Rating of Specialist Seen Most Often	62.3%	63.7%
Rating of All Health Care	59.1%	55.8%
Rating of Health Plan	60.3%	61.3%
Getting Timely Appointments, Care, and Information	47.7%	44.6%
How Well Providers Communicate with Patients	73.9%	71.4%
Providers' Use of Information to Coordinate Patient Care	61.8%	58.7%
Talking with You About Taking Care of Your Own Health	48.9%	48.0%
Comprehensiveness	52.8%	51.0%
Helpful, Courteous, and Respectful Office Staff	69.1%	68.6%
Health First Colorado Customer Service	62.6%	63.5%
Received Care from Provider Office During Evenings, Weekends, or Holidays	27.3%	23.2%
Reminders about Care from Provider Office	71.6%	71.0%
Saw Provider Within 15 Minutes of Appointment	38.4%	38.0%
Receive Health Care and Mental Health Care at Same Place	57.6%	60.4%

**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.*

Due to differences in selected practices, the FY 2019–2020 Colorado RAE Aggregate results presented in this report are not comparable to the FY 2018–2019 Colorado RAE Aggregate results.

Table 1-9 shows the FY 2018–2019 and FY 2019–2020 Colorado RAE Aggregate (i.e., statewide average) PCMH CAHPS survey results for PCMH practices serving children within the seven RAEs.

Table 1-9—Child Statewide PCMH CAHPS Results for RAEs*

Measure	FY 2018–2019 Colorado RAE Aggregate	FY 2019–2020 Colorado RAE Aggregate
Rating of Provider	76.0%	71.8%
Rating of Specialist Seen Most Often	74.0%	78.0%
Rating of All Health Care	74.3%	72.0%
Getting Timely Appointments, Care, and Information	66.2%	57.3%
How Well Providers Communicate with Child	80.6%	79.3%
How Well Providers Communicate with Parents or Caretakers	81.9%	78.3%
Providers' Use of Information to Coordinate Patient Care	74.7%	70.7%
Comprehensiveness—Child Development	65.7%	65.5%
Comprehensiveness—Child Safety and Healthy Lifestyles	58.2%	61.0%
Helpful, Courteous, and Respectful Office Staff	69.3%	65.0%
Received Information on Evening, Weekend, or Holiday Care	80.9%	78.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	32.1%	33.1%
Saw Provider Within 15 Minutes of Appointment	42.1%	36.6%
Reminders about Child's Care from Provider Office	67.9%	69.1%

**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.*

Due to differences in selected practices, the FY 2019–2020 Colorado RAE Aggregate results presented in this report are not comparable to the FY 2018–2019 Colorado RAE Aggregate results.

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

Adult

For the adult population, the following three measures had the lowest FY 2019–2020 scores compared to the other measures' scores:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (23.2 percent)
- *Saw Provider Within 15 Minutes of Appointment* (38.0 percent)
- *Getting Timely Appointments, Care, and Information* (44.6 percent)

Child

For the child population, the following three measures had the lowest FY 2019–2020 scores compared to the other measures' scores:

- *Received Care from Provider Office During Evenings, Weekends, or Holidays* (33.1 percent)
- *Saw Provider Within 15 Minutes of Appointment* (36.6 percent)
- *Getting Timely Appointments, Care, and Information* (57.3 percent)

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

CAHPS Surveys—MCO Capitation Initiative

Table 1-10 shows the adult statewide CAHPS results for FY 2017–2018, FY 2018–2019, and FY 2019–2020.

Table 1-10—Adult Statewide CAHPS Results for MCOs

Measure	FY 2017–2018 Statewide Aggregate	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate
Getting Needed Care	79.6%	76.9%	78.4%
Getting Care Quickly	81.2%	77.9%	77.2% ↓
How Well Doctors Communicate	92.3%	93.3%	93.9%
Customer Service	87.1%	91.6%	91.3%
Rating of Personal Doctor	70.0%	69.5%	71.7%
Rating of Specialist Seen Most Often	62.7%	70.2%	71.2%
Rating of All Health Care	56.0%	56.0%	56.7%
Rating of Health Plan	58.0%	61.6%	63.4%

↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

Table 1-11 shows the child statewide CAHPS results for FY 2017–2018, FY 2018–2019, and FY 2019–2020.

Table 1-11—Child Statewide CAHPS Results for MCOs

Measure	FY 2017–2018 Statewide Aggregate	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate
Getting Needed Care	84.8%	78.3%	75.1%+
Getting Care Quickly	86.2%	87.2%	80.5%+ ↓
How Well Doctors Communicate	94.7%	95.4%	94.9%+
Customer Service	91.2%	86.1%	89.0%+
Rating of Personal Doctor	86.1%	85.8%	78.8%
Rating of Specialist Seen Most Often	75.0%+	75.7%+	60.9%+
Rating of All Health Care	76.7%	73.5%	66.0%+
Rating of Health Plan	76.9%	73.2%	67.4%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

RMHP Prime was not required to submit child Medicaid CAHPS data for reporting purposes in FY 2019–2020; therefore, the FY 2019–2020 Statewide Aggregate only includes CAHPS results for DHMP and is not comparable to the FY 2017–2018 and FY 2018–2019 Statewide Aggregates.

Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys—MCO Capitation Initiative

For the adult statewide Medicaid population, overall, member experience scores 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 scores) for the *How Well Doctors Communicate*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan* measures and a downward trend (i.e., lower scores) for the *Getting Care Quickly* measure, which also scored statistically significantly below the 2019 NCQA adult Medicaid national average. HSAG recommends that the Department work with the MCOs to develop initiatives designed to improve timeliness of care.

For the child statewide Medicaid population, overall, member experience scores for the MCOs' child population have fluctuated, either increasing or decreasing slightly, across the years; however, there appears to be a downward trend for the *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan* measures. HSAG recommends that the Department work with the MCOs to develop initiatives designed to improve timeliness of and access to care, communication, and coordination of care.

ECHO Surveys

Table 1-12 presents the adult ECHO results for the Colorado RAE Program (i.e., Statewide Aggregate) for FY 2019–2020 compared to FY 2018–2019.[1-5]

Table 1-12—Adult ECHO Statewide Results for RAEs*

Measure	FY 2018–2019 Colorado RAE Program	FY 2019–2020 Colorado RAE Program
Rating of All Counseling or Treatment	45.9%	46.4%
Getting Treatment Quickly	66.3%	68.8%
How Well Clinicians Communicate	89.0%	89.8%
Perceived Improvement	58.0%	59.9%
Amount Helped	80.5%	82.5%
Cultural Competency	66.5%+	69.2%+
Including Family	42.0%	43.9%
Information About Self-Help or Support Groups	52.6%	53.7%
Information to Manage Condition	76.3%	77.0%
Office Wait	81.5%	84.5%
Patient Feels He or She Could Refuse Treatment	82.8%	78.8%
Privacy	92.5%	94.7%
Support from Family and Friends	67.2%	62.5% ▼
Told About Medication Side Effects	74.8%	74.6%
Improved Functioning	54.9%	52.0%

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

▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

[1-5] Some of the questions that compose *How Well Clinicians Communicate*, *Information About Treatment Options* (re-named as *Information About Self-Help or Support Groups*), and *Social Connectedness* (re-named as *Support from Family and Friends*) were removed from the 2020 survey instruments. For comparison purposes, HSAG re-calculated the 2019 results for these measures with these questions removed; therefore, the results for these measures will be different than the results presented in the 2019 Colorado Behavioral Health Member Experience Report.

Table 1-13 presents the child ECHO results for the Colorado RAE Program (i.e., Statewide Aggregate) for FY 2019–2020 compared to FY 2018–2019.[1-6]

Table 1-13—Child ECHO Statewide Results for the RAEs

Measure	FY 2018–2019 Colorado RAE Program	FY 2019–2020 Colorado RAE Program
Rating of All Counseling or Treatment	46.5%	44.7%
Getting Treatment Quickly	69.8%	66.2%
How Well Clinicians Communicate	87.9%	88.1%
Perceived Improvement	70.7%	68.6%
Amount Helped	78.1%	75.2%
Child Had Someone to Talk To	77.3%	73.4%
Cultural Competency	60.8%+	71.8%+
Information to Manage Condition	70.8%	70.9%
Office Wait	84.9%	89.7% ▲
Privacy	94.0%	94.7%
Respondent Feels He or She Could Refuse Treatment	85.3%	88.8%
Support from Family and Friends	80.7%	69.7% ▼
Told About Medication Side Effects	85.2%	84.3%
Improved Functioning	63.0%	60.3%

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

▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

Statewide Opportunities for Improvement and Recommendations Related to ECHO Surveys

For the child population, the Colorado RAE Program scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 for one measure, *Office Wait*. For the adult and child populations, the Colorado RAE Program scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for one measure, *Support from Family and Friends*. HSAG recommends that the Department work with the RAEs to explore what may be driving a statistically significantly lower experience score for this measure and to develop statewide initiatives for improvement, where appropriate.

[1-6] Some of the questions that compose *How Well Clinicians Communicate*, *Information About Treatment Options* (re-named as *Child Had Someone to Talk To*), and *Social Connectedness* (re-named as *Support from Family and Friends*) were removed from the 2020 survey instruments. For comparison purposes, HSAG re-calculated the 2019 results for these measures with these questions removed; therefore, the results for these measures will be different than the results presented in the 2019 Colorado Behavioral Health Member Experience Report.

Encounter Data Validation—RAE 411 Audit Over-Read

HSAG conducted the EDV for seven RAE regions providing capitated BH services within the ACC Program. Each RAE used guidelines from the Department to validate a sample of BH encounter data from three service categories against medical record documentation. Each RAE then submitted a data file to HSAG and the Department containing EDV findings for each validated record and data element. Table 1-14 presents the RAEs' self-reported encounter data service coding accuracy results by RAE and validated data element.

Table 1-14—Aggregated, Self-Reported EDV Results Reported by RAEs for All Service Categories*

Data Element	RAE 411 Internal EDV Results Aggregate EDV Results for All Service Categories							Aggregate
	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	
Procedure Code	41.1%	10.5%	57.7%	93.7%	61.6%	69.8%	92.9%	61.0%
Diagnosis Code	41.8%	64.7%	92.2%	97.1%	98.3%	78.6%	97.8%	81.5%
Place of Service	36.0%	62.3%	83.2%	98.3%	90.8%	89.8%	95.1%	79.4%
Service Program Category	35.3%	63.5%	51.3%	98.8%	58.4%	88.3%	90.8%	69.5%
Units	42.1%	66.2%	89.1%	97.1%	93.9%	85.4%	85.9%	79.9%
Start Date	42.1%	66.4%	96.4%	99.0%	99.0%	90.3%	93.7%	83.8%
End Date	42.1%	66.4%	96.1%	99.0%	99.0%	91.2%	91.0%	83.6%
Appropriate Population	42.1%	66.7%	96.4%	99.0%	99.0%	95.4%	98.3%	85.3%
Duration	42.1%	66.4%	94.4%	98.8%	96.1%	94.4%	97.6%	84.3%
Allow Mode of Delivery	42.1%	66.7%	91.0%	98.5%	98.1%	94.2%	97.6%	84.0%
Staff Requirement	42.1%	66.7%	94.2%	99.0%	97.3%	92.2%	92.2%	83.4%

Note: RAEs 2, 3, 5, 6, and 7 submitted service coding accuracy calculations displaying two decimal places; HSAG re-calculated these results to show one decimal place for consistency across all RAEs.
** All results have a denominator of 411 total cases per RAE.*

HSAG overread a sample of each RAE's EDV findings and tabulated agreement results that could range from 0.0 percent to 100.0 percent, where 100.0 percent represents perfect agreement between the RAE's EDV results and HSAG's over-read results, and 0.0 percent represents complete disagreement. To determine the percentage of cases in agreement for key validation elements, HSAG generated a composite measure, *Validation Elements*, that included results for the *Procedure Code*, *Diagnosis Code*, and *Units* data elements. Table 1-15 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with the RAEs' EDV results for the *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with the RAEs' EDV results for each of the validated data elements. Each data element was overread for 70 cases total (i.e., 10 cases from each RAE) for each service category.

Table 1-15—Statewide Aggregated RAE BH EDV Over-Read Agreement Results by BH Service Category

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	64	91.4%	733	95.2%
Club House or Drop-In Center Services	63	90.0%	729	94.7%
Residential Services	65	92.9%	757	98.3%
Total	**192**	**91.4%**	**2,219**	**96.1%**

* *HSAG overread 10 cases from each RAE for each BH service category (i.e., a denominator of 70 cases per service category).*

** *HSAG overread 11 individual data elements for each case, resulting in 110 data elements per RAE and a denominator of 770 data elements per service category.*

Statewide Opportunities for Improvement and Recommendations Related to RAE 411 Audit Over-Read

FY 2019–2020 is the first year in which the RAEs have used a medical record review (MRR) to validate BH encounter data under the Department's guidance, and the EDV results provide a baseline from which the RAEs and the Department can monitor quality improvement within the RAEs' BH encounter data. The RAEs' 411 EDV results and HSAG's subsequent over-read findings support opportunities for improvement in the RAEs' oversight of data submissions from their BH providers. HSAG's over-read results suggest a high level of confidence that the RAEs' independent validation findings accurately reflect their encounter data quality. However, the RAEs' independent validation findings reflect targeted opportunities for RAEs to implement provider education and training on the Uniform Service Coding Standards (USCS) manuals and service coding accuracy, especially pertaining to coding accuracy for BH procedure codes. Additionally, given the resource-intensive nature of MRR, the RAEs should consider internal processes for ongoing encounter data monitoring and use the annual EDV study with the Department as a focused mechanism for measuring quality improvement.

Encounter Data Validation—MCO 412 Audit Over-Read

HSAG conducted this EDV for Colorado's two MCOs (DHMP and RMHP Prime) providing services under the MCO Capitation Initiative within the ACC Program. Each MCO used guidelines from the Department to validate a sample of encounter data from four encounter service categories against medical record documentation. Each MCO then submitted a data file to HSAG and the Department containing EDV findings for each validated record and data element.

Table 1-16—MCOs' Aggregated, Self-Reported EDV Results by Data Element and Service Category*

Data Element	Inpatient Encounters	Outpatient Encounters	Professional Encounters	FQHC Encounters	Aggregate Results
Date of Service	89.3%	80.1%	83.0%	86.9%	84.8%
Through Date	89.8%	NA	NA	NA	89.8%
Primary Diagnosis Code	85.0%	70.4%	68.3%	76.2%	75.0%
Primary Surgical Procedure Code	87.7%	NA	NA	NA	87.7%
Discharge Status	90.3%	NA	NA	NA	90.3%
Procedure Code	NA	61.9%	70.9%	68.9%	67.3%
Procedure Code Modifier	NA	74.3%	79.6%	83.4%	79.3%
Units	NA	64.5%	82.5%	84.4%	77.3%

** Each service category has a modified denominator based on the MCO's 412 Service Coding Accuracy Report Summary.*

HSAG overread a sample of each MCO's EDV findings and tabulated agreement results that could range from 0.0 percent to 100.0 percent, where 100.0 percent represents perfect agreement between the MCO's EDV results and HSAG's over-read results, and 0.0 percent represents complete disagreement. Table 1-17 presents aggregated statewide over-read results with the percentage of over-read cases in which HSAG's reviewers agreed with the MCOs' EDV results by encounter service category.

Table 1-17—Statewide Aggregated Encounter Over-Read Agreement Results for MCOs by Service Category

Service Category	Case-Level Accuracy—Total Number of Cases Overread*	Case-Level Accuracy—Percent of Cases With Complete Agreement	Element-Level Accuracy—Total Number of Elements Overread	Element-Level Accuracy—Percent of Elements With Complete Agreement
Inpatient	42	100.0%	252	100.0%
Outpatient	38	84.2%	190	93.7%
Professional	40	97.5%	200	97.5%
FQHC	40	85.0%	200	96.0%
Total	**160**	**91.9%**	**842**	**97.0%**

** HSAG sampled 20 cases per MCO from each service category (i.e., 40 cases total per service category), and the MCOs' EDV determined that two over-read cases originally sampled as Outpatient services had medical record documentation to support Inpatient Services; these cases were validated by the MCO and overread by HSAG as Inpatient cases.*

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

The MCOs' 412 EDV results and HSAG's subsequent over-read demonstrate targeted 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. The current over-read results show improved agreement between HSAG's over-read findings and EDV results from both MCOs compared to the

previous year. Additionally, HSAG's over-read results suggest a high level of confidence that the MCOs' independent validation findings accurately reflect their encounter data quality. However, recommendations from the FY 2018–2019 study are still relevant, as the MCOs' self-reported EDV results reflect specific data elements and service types that were not consistently supported by 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

HSAG collaborated with the Department and the health plans to develop quarterly network adequacy reporting templates that were implemented by the health plans beginning in January 2020. HSAG updated the templates in June 2020 for the health plans' use in FY 2020–2021 quarterly network adequacy reporting. Additionally, HSAG conducted baseline network adequacy validation (NAV) analyses of the Medicaid provider networks among the following network domains for the seven RAEs and two MCOs:

- RAEs: Primary Care, Prenatal Care, Women's Health Services, Behavioral Health, Hospitals
- MCOs: Primary Care, Prenatal Care, Women's Health Services, Physical Health Specialists, Hospitals, Pharmacies, Imaging Services, Laboratories, and Ancillary Physical Health Services

Overall, no RAE met all ratio and time/distance network standards across all counties in each county designation. In general, failure to meet the contract standards was largely attributable to the closest network locations being outside the required standard(s), combined with the requirement for 100 percent of the RAE's members to reside within the contract standard. Except for RMHP, no RAE reported contracting mid-level pediatric primary care practitioners (i.e., physicians assistants) attributable to the Pediatric Primary Care (Mid-Level) network category. Similarly, all RAEs reported contracting no Gynecology (Mid-Level) practitioners across the county designations, with the exception of CCHA in urban counties. Across county types, however, RAEs reported adequate numbers of primary care practitioners (e.g., practitioners attributed to network standards for Adult and Pediatric Primary Care Provider, Family Practitioner) and behavioral health practitioners (e.g., practitioners attributed to network standards for Adult and Pediatric Mental Health Provider, Adult and Pediatric Substance Use Disorder Provider).

In addition, neither MCO met all ratio and time/distance network standards across all counties in each county designation (i.e., urban, rural, or frontier). In general, failure to meet the contract standards was largely attributable to the closest network locations being outside the required standard(s), combined with the requirement for 100 percent of the MCO's members to reside within the contract standard. However, both MCOs were responsible for fewer than 30 members residing in counties in which the network standards were not met. Of note, RMHP Prime reported having no contracted Mid-Level Gynecology Practitioners (i.e., physicians assistants) or Pediatric Ophthalmology Practitioners. Across each county, however, both MCOs reported an adequate number of primary care practitioners (e.g.,

practitioners attributed to network standards for Adult and Pediatric Primary Care Provider, Gynecology, Family Practitioner) and physical health specialists for adults (e.g., practitioners attributed to network standards for Adult General Surgery, Adult Cardiology).

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

Based on the first standardized calculations of the health plans' compliance with network adequacy geoaccess standards, HSAG offers the following recommendations to improve network adequacy data and oversight:

- The Department made significant progress during FY 2019–2020 in developing and implementing quarterly network adequacy reporting materials that are standardized within and across health plan types (e.g., MCOs and RAEs). The Department should continue to refine and automate the quarterly network adequacy reporting process to reduce duplication of reporting and oversight efforts for the Department and the health plans, and to facilitate routine NAV by an external entity.
- HSAG's network data review identified varying levels of missingness by health plan for network category assignments, as well as spelling variations and/or use of special characters for the health plans' data values for provider type, specialty, and credentials.
  - The health plans should continue to assess available data values in their network data systems and standardize available data value options and network category attribution.
  - The Department should incorporate data verification processes into the quarterly network adequacy report reviews.
- The Department should review the network categories for which the health plans failed to meet the time/distance standards, and request that the health plans confirm whether failure to meet the time/distance network access standard(s) resulted from concerns with the health plan's network category data attributions, a lack of network locations for the specific geographic area, or the health plan's inability to contract with available network locations in the geographic area.
- The Department should consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data supplied to members and used for geoaccess analyses.
- As the time/distance results represent the potential geographic distribution of contracted network locations and may not directly reflect network availability at any point in time, the Department should consider using appointment availability surveys to evaluate the health plans' compliance with contract standards for access to care. HSAG also recommends incorporating encounter data to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate network availability.
- In addition to assessing the number, distribution, and availability of the health plans' network locations, each health plan should review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care and develop quality improvement initiatives to address the findings.

Statewide Conclusions and Recommendations

While Colorado's statewide performance across EQR activities demonstrated both strengths and opportunities for improvement, Colorado's strongest statewide performance was in the quality domain based on the health plans' internal processes. Statewide, health plans demonstrated the ability to accurately audit encounter data; provide reliable, valid, and accurate performance measure calculations; and use quality improvement science methodology accurately for process improvement.

Colorado's most significant opportunities for improvement were in the timeliness and access to care domains. While health plan scores in Standard II—Access and Availability ranged from 94 to 97 percent, indicating that health plans had processes to monitor timely access to care, based on the NAV activity, HSAG found that no health plan met the time and distance standards set forth by the Department. In addition, survey measures that evaluated getting care when needed and timeliness of receiving care demonstrated the lowest statewide scores and downward trends, overall.

HSAG does, however, recognize that several of the EQR-related activities in FY 2019–2020 were conducted during the COVID-19 pandemic; therefore, results, particularly in the access to care domain, should be considered with caution.

Quality Strategy

The Health First Colorado 2020 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 states' 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 Quality Strategy articulates Colorado's timely and thoughtful response to an economic recession and the resultant unprecedented growth in Colorado's Medicaid populations. Health First Colorado builds on the PCCM model to provide care and services to Colorado's most vulnerable population using seven PCCM entities, known in Colorado as RAEs. Colorado's RAEs invest directly in each respective community and local infrastructure to coordinate physical health and mental health/SUD services and provide integrated physical health and behavioral healthcare at a single facility or provider location where possible.

Colorado continues to reward the RAEs and their medical home providers on key indicators of quality and timely access to care. A key feature of the RAEs' success is the ability to address the social determinants of health through this community-based model.

In addition, Colorado continues to leverage its relationship with its external quality review organization (EQRO), HSAG, to conduct all mandatory and several optional EQR-related activities. Over the 19-year relationship, HSAG and the Department have collaborated to design state-specific technical assistance and optional activities and projects developed to provide information needed in real-time to shape the iterative design of the Medicaid program.

2. Reader's Guide

Report Purpose and Overview

States with Medicaid program delivery systems that include managed care entities (MCEs), referred to in this report collectively as "health plans," are required to annually provide to 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 Code of Federal Regulations [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 2019–2020 are listed in Table 2-1 and Table 2-2.

Table 2-1—Colorado Medicaid RAEs

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

Table 2-2—Colorado Medicaid MCOs

Medicaid MCO	Services Provided
Denver Health Medical Plan (DHMP)	PH primary, inpatient, outpatient, specialty, and acute care for a subset of Region 5 RAE members. BH inpatient and outpatient services for a subset of Region 5 RAE members (effective January 2020).
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	PH primary, inpatient, outpatient, specialty, and acute care for a subset of Region 1 RAE members.

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 EQR-related activities. This section also includes a summary description of relevant trends over a three-year period for each EQR activity as applicable (given that the RAEs are in the second year of contracting with the State). The "Executive Summary" also 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 2019–2020. 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—Statewide Comparative Results, Assessment, Conclusions, and Recommendations includes statewide comparative results organized by EQR-related 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 5—Assessment of Health Plans' Follow-Up on FY 2018–2019 Recommendations provides, by EQR activity, an assessment of the extent to which the health plans were able to follow up on and

complete any recommendations or corrective actions required as a result of the prior year's EQR-related activities.

Appendix A—MCO Capitation Initiative Administrative and Hybrid Rates 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, 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

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 health plan—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

[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*.

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 2019–2020 site review process to assess compliance with Medicaid managed care regulations, the Department requested a review of three areas of performance. The standard areas chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievance and Appeal Systems. 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 authorization of services and adverse benefit determinations, grievances, and appeals.

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.

[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.

HSAG HEALTH SERVICES ADVISORY GROUP

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 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[2-4] Table 2-3 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-3—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 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. • In March 2020, due to COVID-19, HSAG and the Department collaboratively determined that the remainder of the compliance reviews would occur via Webex virtual audits. • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed.
Activity 2:	**Perform Preliminary Review**
	• Sixty days prior to the scheduled date of the on-site or virtual audit portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and the review agenda. The document request included instructions for organizing and preparing the documents related to review of the three standards and record reviews. Thirty days prior to each scheduled on-site or virtual review, the health plans provided documents for the pre-audit document review. • Documents submitted for the pre-audit document review and the on-site or virtual 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 service authorization denials, grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit.

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 17, 2020.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the on-site or virtual audit portion of the review and prepared a request for further documentation and an interview guide to use during the on-site or virtual review.
Activity 3:	**Conduct Site Visit**
	• During the on-site or virtual audit portion of the review, HSAG met with the health plan's key staff members to obtain a complete understanding of the health plan's level of compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's organizational performance. • HSAG reviewed a sample of administrative records to evaluate denials, grievances, and appeals. • During the on-site or virtual audit, HSAG collected and reviewed additional documents, as needed. • At the close of the audit, 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 or virtual audit 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 plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report 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 or virtually via Webex

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 2-4 depicts assignment of the standards to the domains of care.

Table 2-4—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	X	X	
Standard II—Access and Availability		X	X
Standard VI—Grievance and Appeal Systems		X	X

HEDIS Measure Rates and Validation—MCO 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 MCOs' 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 or Webex conferences, 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 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 FARs to HSAG. The HEDIS auditor's responsibility was to express an opinion on each MCO's 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.

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

Description of Data Obtained

As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for FY 2019–2020 as part of the validation of performance measures:

1. **FARs:** The FARs, produced by the health plans' LOs, provided information on the health plans' compliance to IS standards and audit findings for each measure required to be reported.
2. **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.
3. **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

Information Systems 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 *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. 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 2018, HEDIS 2019, and HEDIS 2020 measure rates are presented for measures deemed *Reportable* (*R*) by the LO according to NCQA standards. With regard to the final measure rates for HEDIS 2018, HEDIS 2019, and HEDIS 2020, 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 Medicaid benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate statistically significant improvement in performance from HEDIS 2019 to HEDIS 2020. Rates shaded red with two carets (^^) indicate statistically significant declines in performance from HEDIS 2019 to HEDIS 2020. Performance comparisons are based on the Chi-square test of proportions with results deemed statistically significant with a p value < 0.05. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered statistically 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 MCO 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 for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019, when available. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* and *Risk of Continued Opioid Use—At Least 15 Days Covered—Total* and *At Least 31 Days Covered—Total* measure indicators were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2019 since these indicators are not published in Quality Compass. 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 health plans to report this rate for the respective HEDIS submission. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2020 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 national Medicaid 75th percentile without a significant decline in performance from HEDIS 2019.
  - Ranked between the national Medicaid 50th and 74th percentiles with significant improvement in performance from HEDIS 2019.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle 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 2019.

According to the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only. The Department required that all HEDIS 2018, HEDIS 2019, and HEDIS 2020 measures be reported using the administrative methodology only. However, DHMP and 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 2-5 presents the measures in this report that can be reported using the hybrid methodology.

Table 2-5—HEDIS Measures That Can Be Reported Using the Hybrid Methodology

HEDIS Measures
Pediatric Care
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

HEDIS Measures
Access to Care
Prenatal and Postpartum Care
Preventive Screening
Cervical Cancer Screening
Adult BMI Assessment
Living With Illness
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 of care. This assignment to domains of care is depicted in Table 2-6.

Table 2-6—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for MCOs

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Adolescent Well-Care Visits	✓		✓
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	✓		✓
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Prenatal and Postpartum Care	✓	✓	✓
Preventive Screening			
Adult BMI Assessment	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		

Performance Measure	Quality	Timeliness	Access
Mental/Behavioral Health			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Living With Illness			
Asthma Medication Ratio	✓		
Comprehensive Diabetes Care	✓		
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	✓		
Antibiotic Stewardship			
Antibiotic Utilization	NA	NA	NA
Appropriate Testing for Pharyngitis	✓		
Appropriate Treatment for Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓		
Opioids			
Pharmacotherapy for Opioid Use Disorder	✓		
Risk of Continued Opioid Use	✓		
Use of Opioids at High Dosage	✓		
Use of Opioids From Multiple Providers	✓		
Use of Services			
Ambulatory Care	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Plan All-Cause Readmissions	✓		

Validation of Performance Measures for RAEs

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of BH performance measure data collected by the RAE.
- Determine the extent to which the specific performance measures calculated by the RAE (or on behalf of the RAE) 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 and completed the calculation of all measures. 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 RAE's measure rates. The Department required that the measurement year (MY) 2019 (i.e., July 1, 2018–June 30, 2019) performance measures be validated during FY 2019–2020 based on the specifications outlined in the *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2018–2019*, which was written collaboratively by the RAEs 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 2019, several measures were HEDIS-like measures, and several other measures were developed by the Department and the RAEs.

HSAG's process for PMV for each RAE 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 Department's IS, policies, processes, and data needed for the on-site performance of validation activities, as they relate to the RAEs. HSAG included questions to address how encounter data were collected, validated, and submitted to the Department.

[2-6] Colorado Department of Health Care Policy and Financing. *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2018–2019.*

- 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 agenda for the on-site visit, and conducting conference calls with the Department to discuss the on-site visit activities and to address any ISCAT-related questions.

On-Site Review Activities: HSAG conducted a site visit for the Department to validate the processes used for calculating the penetration rate measures. The site review 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 IS 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 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.
- 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 FY 2019–2020 as part of the validation of performance measures:

- **ISCAT:** This was received from the Department. The completed ISCAT provided HSAG with background information on the Department's IS, 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 was used to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports:** These were obtained from the Department 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 RAEs.
- **On-Site Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Department staff members as well as through system demonstrations.

How Conclusions Were Drawn

Information Systems 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 RAE's performance measure results for FY 2019–2020 were compared to the Department's established performance targets and are denoted in Table 2-7.

Table 2-7—Performance Targets

Performance Measure	Performance Target*
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	51.22%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	81.51%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	49.69%
Follow-Up After a Positive Depression Screen	54.40%
Behavioral Health Screening or Assessment for Children in the Foster Care System	37.96%

*Performance targets are specified in the *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2018–2019.*

To draw conclusions about the quality and timeliness of, and access to care provided by the RAEs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains of care. This assignment to domains of care is depicted in Table 2-8.

Table 2-8—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for RAEs

Performance Measure	Quality	Timeliness	Access
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	✓	✓	✓
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	✓	✓	✓
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	✓	✓	✓
Follow-Up After a Positive Depression Screen	✓	✓	✓
Behavioral Health Screening or Assessment for Children in the Foster Care System	✓	✓	✓

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 CMS *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-7]

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.[2-8] 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 framework against CMS *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG presented the crosswalk and

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[2-7] 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 27, 2020.

[2-8] 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: Aug 10, 2020.

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 PDSA cycles in modern PIPs 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 both Global Aims and SMART Aims, 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, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act**: In Module 4, 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 2019–2020, these forms provided detailed information on the PIPs and the activities completed for Module 3 and the activities initiated for Module 4.

Following HSAG's rapid-cycle PIP process, the health plans submitted each module according to the approved timeline. Following the initial validation of each module, HSAG provided feedback in the validation tools. For Module 3, if validation criteria were not achieved, the health plan had the opportunity to seek technical assistance from HSAG. The health plan resubmitted Module 3 until all validation criteria were met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing. For Module 4, the health plans initiated intervention testing in FY 2019–2020 and received pre-validation feedback from HSAG on the intervention testing plan. The rapid-cycle PIPs span more than one FY and intervention testing for Module 4 lasts up to 12 months or more; therefore, the health plans did not submit Module 4 for validation in FY 2019–2020.

How Conclusions Were Drawn

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable were not scored. Once 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 health plan accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the health plan 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. Other domains were assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table 2-9.

Table 2-9—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 of Age*	✓		✓
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 of Age*	✓		✓
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 provider 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 CAHPS Clinician & Group (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 FY 2019–2020 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 composite and the individual item measures 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 2-10.

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

PCMH CAHPS Topic	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 (Child Only)	✓		
Received Care from Provider Office During Evenings, Weekends, or Holidays			✓
Reminders about Care/Child's Care from Provider Office	✓		
Saw Provider Within 15 Minutes of Appointment		✓	
Receive Health Care and Mental Health Care at Same Place	✓		

HSAG HEALTH SERVICES ADVISORY GROUP

CAHPS Surveys—MCO 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 (40 items for the CAHPS 5.0 Adult Medicaid Health Plan Survey and 41 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 the 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 eight measures of satisfaction. These measures included four global ratings and four 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 four 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 were: (1) "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for the composite measures was defined as a response of "Usually" or "Always."

DHMP and RMHP Prime provided HSAG with the data presented in this report. SPH Analytics administered the *CAHPS 5.0 Adult Medicaid Health Plan Survey* and *CAHPS 5.0 Child Medicaid*

Health Plan Survey for DHMP and RMHP Prime. 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 2-11.

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

CAHPS Topic	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
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	✓		

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 RAEs were included in the results.

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 (YSS) and the YSS for Families (YSS-F). HSAG administered the ECHO surveys on behalf of the Department. The surveys included 47 items in the Adult ECHO survey and 53 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 FY 2019–2020 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 experience (adult survey) and 15 measures of experience (child survey). These measures included one global rating, three composite scores, 10 individual item measures in the adult survey and nine individual item measures in the child survey, and one MHSIP/YSS-F domain agreement measure. 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*" and "*Told About Medication Side Effects*"). The MHSIP/YSS-F domains are a series of questions from the surveys that evaluate improved functioning. 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 three composite measures, the percentage of respondents who chose a positive response was calculated. A positive or top-box response for the composite measures was defined as a response of "Usually/Always" or "Much better/A little better." For each individual item measure, 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," "Agree/Strongly agree," "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 average score greater than 2.5 are considered "disagreements" and assigned an agreement score of zero.

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

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 2-12.

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

ECHO Topic	Quality	Timeliness	Access
Rating of All Counseling or Treatment	✓		
Getting Treatment Quickly	✓	✓	
How Well Clinicians Communicate	✓		
Perceived Improvement	✓		
Information About Self-Help or Support Groups (Adult Only)	✓		✓
Child Had Someone to Talk To (Child Only)	✓		✓
Office Wait		✓	✓
Told About Medication Side Effects	✓		
Including Family (Adult Only)	✓		
Information to Manage Condition	✓		✓
Patient/Respondent Feels He or She Could Refuse Treatment	✓		
Privacy	✓		
Cultural Competency	✓		
Amount Helped	✓		
Improved Functioning	✓		✓
Support from Family and Friends	✓		

HSAG HEALTH SERVICES ADVISORY GROUP

Encounter Data Validation—RAE 411 Audit Over-Read

Objectives

The RAE 411 over-read evaluated each RAE's compliance with the Department's BH encounter data submission standards, as well as the consistency and accuracy with which each RAE uses MRR to validate its BH encounter data.

Technical Methods of Data Collection

The Department developed the *Annual RAE BH Encounter Data Quality Review Guidelines* to support the RAEs' BH EDVs, including a specific timeline and file format requirements to guide each RAE in preparing its annual Encounter Data Quality Report. To support the BH EDV, the Department selected a random sample of 137 final, paid encounter lines with dates of service between July 1, 2018, and June 30, 2019, from each RAE region's BH encounter flat file for each of the following BH service categories: Prevention/Early Intervention Services, Club House or Drop-In Center Services, and Residential Services. The RAEs reviewed medical records for the sampled cases to evaluate the quality of the BH encounter data submitted to the Department.

HSAG reviewed the RAEs' internal audit documentation and overread each RAE's EDV results using MRR among a random sample of the RAE's 411 EDV cases. HSAG randomly selected 10 encounter lines in each of the three service categories, resulting in an over-read sample of 30 cases per RAE.

Description of Data Obtained

The Department used BH encounter data submitted by each RAE to generate the 411 sample lists, and HSAG sampled the over-read cases from the 411 sample lists. Each RAE was responsible for procuring medical records and supporting documentation for each sampled case, and the RAEs used these materials to conduct their internal validation. Following their validation activities, each RAE submitted a data file containing its EDV results to HSAG and the Department and supplied HSAG with medical records and supporting documentation used to validate each over-read case.

How Conclusions Were Drawn

HSAG's over-read evaluated whether the RAEs' internal validation results were consistent with Colorado's USCS manuals specific to the study period. HSAG entered all over-read results into a standardized data collection tool that aligned with the Department's *Annual RAE BH Encounter Data Quality Review Guidelines*. HSAG tabulated the over-read results by service category to determine the percentage of over-read cases and encounter data elements for which HSAG agreed with the RAEs' EDV responses.

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 each MCO uses MRR to validate its encounter data.

Technical Methods of Data Collection

The Department developed the *Annual MCO Encounter Data Quality Review Guidelines* to support the MCOs' EDVs, including a specific timeline and file format requirements to guide each MCO in preparing its annual Encounter Data Quality Report. To support the EDV, the Department selected a random sample of 103 final, adjudicated encounter lines paid between October 1, 2018, and September 30, 2019, from each MCO's encounter data flat file for each of the following PH service categories: Inpatient, Outpatient, Professional, and Federally Qualified Health Center (FQHC). Each MCO procured and reviewed medical records for each sampled case to evaluate the quality of the encounter data submitted to the Department.

HSAG reviewed the MCOs' internal EDV documentation and overread each MCO's EDV results using MRR among a random sample of the MCO's 412 EDV cases. HSAG randomly selected 20 encounter lines in each of the four service categories, resulting in an over-read sample of 80 cases per MCO.

Description of Data Obtained

The Department used encounter data submitted by each MCO to generate the 412 sample lists, and HSAG sampled the over-read cases from the 412 sample lists. Each MCO was responsible for procuring medical records and supporting documentation for each sampled case, and the MCOs used these materials to conduct their internal validation. Following their validation activities, each MCO submitted a data file containing its EDV results to HSAG and the Department and supplied HSAG with medical records and supporting documentation used to validate each over-read case.

How Conclusions Were Drawn

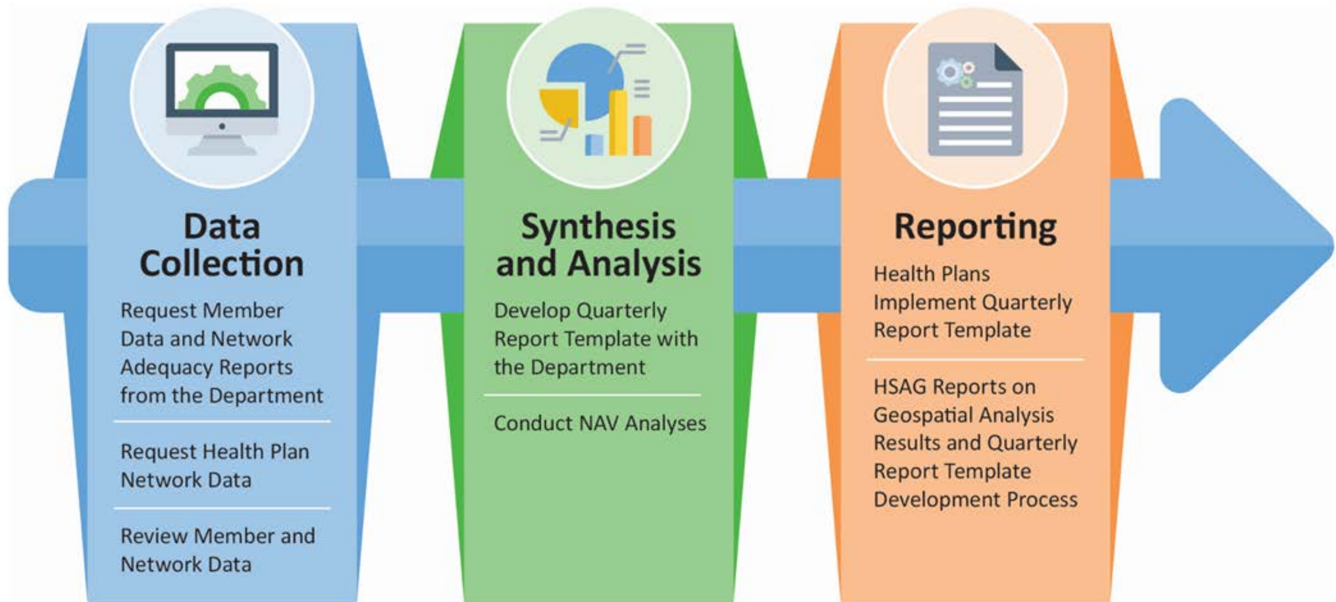
HSAG's over-read evaluated whether the MCOs' internal validation results were accurate based on the review of the encounter data and corresponding medical record documentation. HSAG entered all over-read results into a standardized data collection tool that aligned with the Department's *Annual MCO Encounter Data Quality Review Guidelines*. HSAG tabulated the over-read results by service category to determine the percentage of over-read cases and encounter data elements for which HSAG agreed with the MCOs' EDV responses.

Validation of Network Adequacy

Objectives

Figure 2-1 describes HSAG's three main phases for the FY 2019–2020 NAV tasks.

Figure 2-1—Summary of FY 2019–2020 Network Adequacy Validation Tasks



HSAG used a desk review approach to collect and review the data used to develop the quarterly network adequacy report templates and conduct the baseline NAV analyses.

HSAG collaborated with the Department to identify the network categories to be included in each NAV analysis and the quarterly network adequacy report templates. Analyses and templates included, at a minimum, network categories aligned with the Department's FY 2018–2019 managed care network crosswalk and the minimum network categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.[2-10,2-11] Table 2-13 presents the network domains applicable to MCOs and RAEs; within each domain, network categories included in the FY 2019–2020 NAV analyses were limited to categories corresponding to the health plans' contract standards.

[2-10] Network Adequacy Standards, 42 CFR §438.68. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=d748c4b2039bd7ac516211b8a68e5636&mc=true&node=se42.4.438_168&rgn=div8. Accessed on: Aug 28, 2020.

[2-11] The federal network adequacy standard lists the following provider categories that represent common types or specialties of healthcare providers generally needed within a Medicaid population: primary care, adult and pediatric; obstetrics/gynecology (OB/GYN); behavioral health (mental health and substance abuse disorder), adult and pediatric; specialist, adult and pediatric; hospital; pharmacy; and pediatric dental.

Table 2-13—Network Domains by Health Plan Type

Network Domain	MCO	RAE
Primary Care, Prenatal Care, and Women's Health Services	X	X
Physical Health Specialists	X	
Behavioral Health		X
Facilities (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X*
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	

* *Facilities for RAEs include hospitals and exclude pharmacies, imaging services, or laboratories.*

Technical Methods of Data Collection

The Department provided HSAG with model contracts unique to MCOs and RAEs to identify network adequacy requirements. To conduct the NAV geoaccess analyses, HSAG requested Medicaid member data from the Department for members actively enrolled with an MCO or RAE as of October 1, 2019. HSAG also submitted a detailed network data requirements document to the MCOs and RAEs to request data for practitioners, practice sites, and entities actively enrolled with each health plan as of October 1, 2019.

Description of Data Obtained

Quantitative data for the study included member-level data from the Department and provider-level network data from each MCO and RAE, including data values with provider attributes for type (e.g., nurse practitioner), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code. HSAG used these data to calculate time/distance and ratio results for each MCO and RAE for each county in which the health plan had at least one member identified in the Department's member data file. HSAG used the health plans' provider data and the Department's member data to conduct baseline NAV analyses for each MCO and RAE used to evaluate two dimensions of access and availability: network capacity analysis (i.e., provider-to-member ratios) and geographic network distribution analysis (i.e., time and distance metrics).

How Conclusions Were Drawn

HSAG reviewed the current health plan contracts and existing quarterly network adequacy reports for each health plan type (e.g., RAEs and Medicaid MCOs), then collaborated with the Department to develop a standardized quarterly network adequacy reporting template and data layout for the health plans. HSAG maintained an iterative process with the Department and the health plans to ensure health plans could collect network adequacy data in a standardized manner.

HSAG used the health plans' provider data and the Department's member data to conduct baseline geoaccess analyses specific to each health plan.

Aggregating and Analyzing Statewide Data

For each health plan, 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.

Region 1—Rocky Mountain Health Plans

Assessment of Compliance With Medicaid Managed Care Regulations

Rocky Mountain Health Plans (RMHP) 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*; and the overall compliance score for FY 2019–2020.

Table 3-1—Summary of RMHP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	27	3	0	4	90%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Standard VI—Grievance and Appeal Systems	35	35	30	5	0	0	86%
Totals	**85**	**81**	**73**	**8**	**0**	**4**	**90%***

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

Table 3-2 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-2—Summary of RMHP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	58	54	4	32	93%
Grievances	60	48	46	2	12	96%
Appeals	60	55	50	5	5	91%
Totals	**210**	**161**	**150**	**11**	**49**	**93%***

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

RMHP: Strengths

RMHP submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, work plans, tools, manuals, directories, and sample documents. Documents illustrated a thorough and comprehensive approach to meeting requirements.

Within the Coverage and Authorization of Services standard, RMHP delegated utilization management (UM) functions to Optum, but demonstrated strategic oversight as required, evidenced by a delegation oversight scoring tool and regular joint operations meetings. Staff members both mailed a notice of adverse benefit determination (NABD) letter and placed calls to members to ensure member understanding of the denial decision and appeals process. RMHP's member and provider informational documents accurately defined emergency conditions and emergency and post-stabilization services; and desktop procedures provided staff members with the information needed to process claims according to regulations.

HSAG found that, based on documentation provided, RMHP maintained a network of providers that was sufficient to cover services to its RAE members. RMHP further demonstrated that it had a process to monitor and maintain the required ratio of physicians to members as well as time and distance standards for primary care, behavioral health, and specialist providers. Access was further enhanced by telemedicine services. RMHP's documents supported compliance with requirements regarding family planning, second opinions, women's healthcare, hours of operation, timely access, and cultural competency. Notably, RMHP's provider trainings included cultural competency topics to better understand and serve member populations such as those living in poverty, veterans, and Latino.

Staff members engaged in a supportive process to ensure members' understanding of the grievance and appeal process. In addition to comprehensive policies, procedures, and a detailed provider manual, staff members were thoroughly knowledgeable and able to assist with designated representative forms and followed up in five days via telephone calls to members to ensure processing the grievance or the appeal in a timely manner. Staff members described assisting with walk-in requests to file grievances or appeals and coordinating well between departments to resolve the grievance or appeal. During the on-site grievance and appeal record reviews, HSAG found full compliance for timeliness and clinical review requirements.

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

Standard I—Coverage and Authorization of Services

RMHP policies included inaccurate information regarding time frames for standard and extended prior authorization decisions. During the on-site denials record review, one record did not meet timeliness standards, and three of the 10 denial records reviewed contained clinical terminology and criteria resulting in communication that was potentially not easily understood by the member. RMHP was required to:

- Update policies to reflect accurate information regarding standard and extended pre-authorization decisions.

- Develop a mechanism to ensure NABD mailing time frames are met.
- Ensure NABDs are easy for the member to understand.

Standard VI—Grievance and Appeal Systems

Although RMHP policies and procedures reflected an overall strong comprehension of grievance and appeal regulations, HSAG noted some issues regarding the grievance and appeal processes and supporting documentation. RMHP was required to ensure that:

- Any grievance regarding clinical issues is reviewed and resolved by an RMHP clinician with appropriate clinical expertise in treating the member's condition.
- Each member grievance is thoroughly addressed.
- Appeal resolution letters are written in a language that is easy for the member to understand.
- Policies and procedures are updated to:
  - Accurately reflect that the member must request continuation of benefits within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable; however, the member has the full 60 days to file the appeal.
  - Clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during a State fair hearing (SFH).
  - Remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.

Performance Measure Rates and Validation

Table 3-3 shows the performance measure results for RMHP PMV FY 2019–2020.

Table 3-3—Performance Measure Results for RMHP

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	49.58%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.18%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	27.75%
Follow-Up After a Positive Depression Screen	44.87%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.29%

RMHP: Strengths

For the performance measure validation, RMHP had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

RMHP was above the statewide average for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* measure.

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

RMHP fell below the statewide average for four out of the five measures being calculated. RMHP reported the lowest rate for the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* and *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* measures. HSAG recommends that RMHP integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

RMHP: Accountable Care PIP

Table 3-4 and Table 3-5 display the FY 2019–2020 validation findings for RMHP's *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP. During FY 2019–2020, RMHP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by RMHP are summarized in Table 3-4.

Table 3-4—Intervention Determination Summary for the *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18* PIP

Failure Modes	Potential Interventions
Member attends an appointment, but the care team does not identify the needed WCV services	Ongoing compliance program including staff education and follow-up to ensure that pre-visit planning (PVP) is consistently performed and communicated to the care team
Dental or behavioral health team does not identify member due for WCV services	• Dental and behavioral health PVP development with a whole-person approach and connection to all service lines • Inclusion in ongoing compliance program (described above)
No registry for tracking WCV services available	• Registry development • Use of registry to track targeted text message WCV reminders, incentives, and education for members

RMHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-5 summarizes the intervention RMHP selected for testing.

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

Intervention Description	Key Driver	Failure Mode
Registry-based outreach campaign to identify members due for well visits, send and track text message WCV reminders, and track scheduled and completed well visits	Ensure member knowledge of recommended annual well visit and the importance of preventative healthcare	No registry currently available to identify members due for a WCV

RMHP: Strengths

RMHP continued work on an accountable care PIP focused on increasing the rate of well-child visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving

the process for members to obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, RMHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

RMHP: Behavioral Health PIP

Table 3-6 and Table 3-7 display the FY 2019–2020 validation findings for RMHP's *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP. During FY 2019–2020, RMHP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by RMHP are summarized in Table 3-6.

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

Failure Modes	Potential Interventions
Member unaware of the need for a wellness visit, which would provide an opportunity to receive a depression screening	Member outreach campaign using the *Relatient* system, to identify RAE members due for a wellness visit, send reminders, track scheduled and completed wellness visits, and track completed depression screenings for targeted members
Member noncompliance with wellness visit; missed opportunity for depression screening	*Relatient* outreach campaign implementation to send wellness visit reminder alerts to members through text message, email, and phone
Current data collection process for capturing completed depression screens is unreliable and subject to delays	*Relatient* implementation to provide more reliable direct interface with the electronic health record; the system will use newly acquired tablet technology in the provider office; and patients will be able to remotely check-in and complete screenings prior to arriving for the appointment

RMHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-7 summarizes the intervention RMHP selected for testing.

Table 3-7—Planned Intervention for the *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older* PIP

Intervention Description	Key Driver	Failure Modes
Member outreach campaign using the *Relatient* system, to identify RAE members due for a wellness visit, track scheduled and completed wellness visits, and track completed depression screenings for targeted members. The intervention will also include workflow review with providers to reinforce offering depression screenings during wellness visits and proper coding of completed depression screenings.	Member awareness of the importance and benefits of preventive care and services	• Member unaware of the need for a wellness visit, which would provide an opportunity to receive a depression screening • Member noncompliance with annual wellness visit; missed opportunity for depression screening • Current data collection process for capturing completed depression screens is unreliable and subject to delays

RMHP: Strengths

RMHP continued work on a behavioral health PIP focused on increasing the percentage of members 11 years of age and older who received a depression screening as part of a well visit. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a depression screening and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who received a depression screening. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, RMHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on access to depression screening. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

RMHP: Adult PCMH CAHPS

Table 3-8 shows the adult PCMH CAHPS results for RMHP for FY 2018–2019 and FY 2019–2020.

Table 3-8—Adult PCMH CAHPS Top-Box Scores for RMHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	66.8%	61.1%
Rating of Specialist Seen Most Often	63.9%	64.5%
Rating of All Health Care	60.2%	58.8%
Rating of Health Plan	58.2%	58.0%
Getting Timely Appointments, Care, and Information	48.3%	43.8% ↓
How Well Providers Communicate with Patients	76.7%	74.9%
Providers' Use of Information to Coordinate Patient Care	66.4%	59.5%
Talking with You About Taking Care of Your Own Health	47.5%	48.7%
Comprehensiveness	55.7%	53.1%
Helpful, Courteous, and Respectful Office Staff	71.8%	69.8%
Health First Colorado Customer Service	65.5%	56.4%+
Received Care from Provider Office During Evenings, Weekends, or Holidays	34.8%	32.6%+
Reminders about Care from Provider Office	73.4%	70.3%
Saw Provider Within 15 Minutes of Appointment	43.5%	35.8%
Receive Health Care and Mental Health Care at Same Place	52.9%	56.0%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, RMHP's FY 2019–2020 results presented in this report are not comparable to RMHP's FY 2018–2019 results.

RMHP: Strengths

For the adult population, HSAG found no measures in which RMHP scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020.

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

For the adult population, RMHP scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Getting Timely Appointments, Care, and Information*. HSAG recommends that RMHP develop initiatives designed to improve timeliness of services provided. In addition, HSAG recommends that RMHP explore areas that may be contributing to low experience scores for the *Getting Timely Appointments, Care, and Information* measure and develop initiatives designed to improve performance for this measure.

RMHP: Child PCMH CAHPS

Table 3-9 shows the child PCMH CAHPS results for RMHP for FY 2018–2019 and FY 2019–2020.

Table 3-9—Child PCMH CAHPS Top-Box Scores for RMHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	75.1%	79.0%
Rating of Specialist Seen Most Often	67.0%+	74.3%+
Rating of All Health Care	67.9%	78.8% ↑
Getting Timely Appointments, Care, and Information	61.7%	70.3% ↑
How Well Providers Communicate with Child	77.7%	81.9%
How Well Providers Communicate with Parents or Caretakers	81.0%	82.4%
Providers' Use of Information to Coordinate Patient Care	71.1%	78.5% ↑
Comprehensiveness—Child Development	61.7%	73.5% ↑
Comprehensiveness—Child Safety and Healthy Lifestyles	54.5%	66.1% ↑
Helpful, Courteous, and Respectful Office Staff	67.1%	72.6% ↑
Received Information on Evening, Weekend, or Holiday Care	80.3%	82.9%
Received Care from Provider Office During Evenings, Weekends, or Holidays	40.4%+	49.7%+ ↑
Saw Provider Within 15 Minutes of Appointment	39.6%	40.8%
Reminders about Child's Care from Provider Office	58.7%	74.5% ↑

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, RMHP's FY 2019–2020 results presented in this report are not comparable to RMHP's FY 2018–2019 results.

RMHP: Strengths

For the child population, RMHP scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on eight measures: *Rating of All Health Care*; *Getting Timely Appointments, Care, and Information*; *Providers' Use of Information to Coordinate Patient Care*; *Comprehensiveness—Child Development*; *Comprehensiveness—Child Safety and Healthy Lifestyles*; *Helpful, Courteous, and Respectful Office Staff*; *Received Care from Provider Office During Evenings, Weekends, or Holidays*; and *Reminders about Child's Care from Provider Office*.

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

For the child population, HSAG found no measures in which RMHP scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 and, therefore, found no opportunities for improvement.

ECHO Survey

RMHP: Adult ECHO Survey

Table 3-10 shows the adult ECHO survey results achieved by RMHP for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-10—Adult ECHO Top-Box Scores for RMHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	38.7%	40.2%
Getting Treatment Quickly	65.6%+	65.7%
How Well Clinicians Communicate	91.0%	89.8%
Perceived Improvement	65.4%	60.0%
Amount Helped	81.1%	81.2%
Cultural Competency	NA	NA
Including Family	46.8%	39.1%
Information About Self-Help or Support Groups	55.0%	54.8%
Information to Manage Condition	76.4%	74.4%
Office Wait	85.2%	83.9%
Patient Feels He or She Could Refuse Treatment	87.4%	87.9%
Privacy	94.4%	94.7%
Support from Family and Friends	74.6%	66.4%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Told About Medication Side Effects	73.5%+	72.0%+
Improved Functioning	60.9%	52.6%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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 adult population, HSAG found no measures in which RMHP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the adult population, RMHP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, RMHP did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on four measures: *Perceived Improvement*, *Including Family*, *Support from Family and Friends*, and *Improved Functioning*. HSAG recommends that RMHP explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., promote self-empowerment, communication regarding the importance of family support), where appropriate.

RMHP: Child ECHO Survey

Table 3-11 shows the child ECHO survey results achieved by RMHP for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-11—Child ECHO Top-Box Scores for RMHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	45.8%	45.2%
Getting Treatment Quickly	70.0%+	64.8%
How Well Clinicians Communicate	86.3%	89.7%
Perceived Improvement	69.7%	70.4%
Amount Helped	74.5%	77.8%
Child Had Someone to Talk To	72.5%	76.6%
Cultural Competency	NA	NA
Information to Manage Condition	67.8%	75.0%
Office Wait	83.6%	90.6%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Privacy	95.0%	96.9%
Respondent Feels He or She Could Refuse Treatment	86.8%	91.2%
Support from Family and Friends	78.0%	69.7%
Told About Medication Side Effects	83.6%+	93.1%+
Improved Functioning	63.1%	61.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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 child population, HSAG found no measures in which RMHP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the child population, RMHP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, RMHP did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on two measures: *Getting Treatment Quickly* and *Support from Family and Friends*. HSAG recommends that RMHP explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., communication regarding importance of family support, identify barriers to providing timely care), where appropriate.

Encounter Data Validation—RAE 411-Audit Over-Read

Table 3-12 presents RMHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-12—Self-Reported EDV Results by Data Element and BH Service Category for RMHP*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	38.0%	16.1%	70.1%	41.1%
Diagnosis Code	39.4%	16.8%	70.1%	41.8%
Place of Service	40.1%	16.8%	51.8%	36.0%
Service Program Category	37.2%	16.8%	52.6%	35.3%
Units	40.1%	16.8%	70.1%	42.1%
Start Date	40.1%	16.8%	70.1%	42.1%

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
End Date	40.1%	16.8%	70.1%	42.1%
Appropriate Population	40.1%	16.8%	70.1%	42.1%
Duration	40.1%	16.8%	70.1%	42.1%
Allow Mode of Delivery	40.1%	16.8%	70.1%	42.1%
Staff Requirement	40.1%	16.8%	70.1%	42.1%

** Each service category has a denominator of 137 total cases.*

Table 3-13 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with RMHP's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with RMHP's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-13—BH EDV Over-Read Agreement Results by BH Service Category for RMHP

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	6	60.0%	87	79.1%
Club House or Drop-In Center Services	10	100.0%	110	100.0%
Residential Services	10	100.0%	110	100.0%
Total	**26**	**86.7%**	**307**	**93.0%**

* *HSAG overread 10 cases for each BH service category.*
** *HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

RMHP: Strengths

RMHP's EDV documentation described the development of its EDV tools, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, HSAG's over-read results agreed completely with RMHP's EDV results for the Club House or Drop-In Center Services and Residential Services.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that RMHP's EDV results accurately reflect its encounter data quality. However, RMHP's self-reported EDV results demonstrated a low level of encounter data accuracy when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for RMHP to consider internal processes

for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers. RMHP's EDV documentation did not confirm whether or not RMHP implemented corrective action plans (CAPs), training, or education for low-scoring providers to address deficiencies identified during the EDV.

Validation of Network Adequacy

RMHP: Strengths

During FY 2019–2020, RMHP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used RMHP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-14 summarizes HSAG's geoaccess analysis results by county classification for RMHP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-14—RMHP's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	13	92.9%	14	10	71.4%	14	13	92.9%
Primary Care Time/Distance	14	8	33.0%	26	8	45.2%	23	8	45.6%
Behavioral Health Time/Distance	14	6	70.2%	26	6	87.8%	23	6	95.5%
Facilities Time/Distance	14	3	7.1%	26	3	0.0%	23	3	1.4%

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

RMHP's network included no practitioners attributed to the Gynecology (Mid-Level) network category. Further, RMHP reported no facilities for the Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals network categories. Consequently, RMHP failed to meet the time/distance network standards for those network categories and standards. Failure to meet the urban county network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for members residing in urban counties. Failure to meet the rural and frontier

county network category access standards was largely attributable to the closest network locations being outside the required standard for RMHP's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for RMHP's data values for provider type, specialty, and credentials. As such, HSAG recommends that RMHP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Region 2—Northeast Health Partners

Assessment of Compliance With Medicaid Managed Care Regulations

Northeast Health Partners (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*; and the overall compliance score for FY 2019–2020.

Table 3-15—Summary of NHP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	29	1	0	4	97%
Standard II—Access and Availability	16	16	15	1	0	0	94%
Standard VI—Grievance and Appeal Systems	35	35	27	8	0	0	77%
Totals	**85**	**81**	**71**	**10**	**0**	**4**	**88%***

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

Table 3-16 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-16—Summary of NHP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	60	53	7	30	88%
Grievances	60	49	48	1	11	98%
Appeals	36	35	28	7	1	80%
Totals	**186**	**144**	**129**	**15**	**42**	**90%***

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

NHP: Strengths

NHP substantiated compliance with each standard through submission of policies, procedures, reports, work plans, tools, manuals, reports, committee minutes, and sample documentation. HSAG found that NHP illustrated a thorough and comprehensive approach for adhering to regulations. BH UM functions, provider network monitoring, and grievance and appeal responsibilities were all delegated to NHP's delegate organization, Beacon Health Options (Beacon).

NABD records reviewed during the audit demonstrated required content and expeditious processing of all authorization requests. HSAG found that authorizations were reviewed by staff members with various credentials, depending on the request. Notably NHP's clinical care managers (CCMs) were typically licensed Master's level professional counselors or licensed social workers. Any service beyond the CCM's scope was reviewed by a medical director. NHP described a strong working relationship with contracted providers, facilities, community mental health centers (CMHCs), and community stakeholders, which enhanced the ability to render decisions in a timely manner.

Single case agreements (SCAs) were commonly used to ensure the provision of service through an out-of-network provider, especially in instances where specialty treatment or alternative languages were needed. However, as evidenced by monthly reports, these instances had decreased more recently as NHP had been able to credential more providers qualified to meet members' specialty service and language needs. NHP staff members described unique cultural competency outreach approaches, such as partnering with farming supply companies to outreach workers in agricultural communities regarding mental health needs and challenges.

During the audit, staff members demonstrated thorough understanding of all grievance and appeal requirements and associated procedures. During the grievance and appeal record reviews, HSAG found that grievance and appeal resolution letters included taglines and alternative format offerings for members with special needs. Beacon's electronic documentation system allowed for accurate time stamping and tracking of grievances and appeals.

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

Standard I—Coverage and Authorization of Services

While all NHP's denial records included all required content and was available in prevalent non-English languages and alternative formats for persons with special needs, HSAG found that many denial records included complex terminology and did not meet general language requirements. NHP was required to ensure the NABD letters, in their entirety, are written in a language that is easy for a member to understand.

Standard II—Access and Availability

Although NHP used a phone survey to monitor provider access standards, many of these providers did not meet standards. NHP was required to develop a more robust mechanism to monitor/survey providers to ensure timely appointment standards and implement CAPs when providers are not in compliance with access to care standards.

Standard VI—Grievance and Appeal Systems

Although NHP's grievance and appeal policies and procedures were aligned with most regulations, HSAG found a few issues regarding the readability of member-specific communications, timeliness of resolution notification, and clarity of member and provider informational documents. NHP was required to:

- Ensure member grievance resolution letters are written in language that is easy for the member to understand.
- Ensure that appeal decisions and notification occur within 10 working days and ensure that member resolution letters are easy for the member to understand.
- Develop a mechanism to ensure that expedited appeal notifications are sent in writing within 72 hours of receipt in addition to making best efforts to notify the member verbally.
- Update appeal resolution letters and the provider handbook to include accurate information regarding continuation of benefits during a SFH and associated filing time frames.
- Clarify that a member may request a SFH only when the appeal is not resolved in favor of the member (i.e., the denial is upheld) and remove references to SFH when the appeal is overturned.
- Correct the SFH Guide to clarify that a member must file an appeal and complete that process prior to being eligible for the process of requesting a SFH, even when NHP does not meet appeal resolution time frame requirements (i.e., clarify the process of deemed exhaustion of the internal appeals process).
- Ensure that continuation of benefit information is only included in appeal resolution letters when the member is eligible (has previously been receiving the services).

Performance Measure Rates and Validation

Table 3-17 shows the performance measure results for NHP PMV FY 2019–2020.

Table 3-17—Performance Measure Results for NHP

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	46.40%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	64.31%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	38.33%
Follow-Up After a Positive Depression Screen	50.00%
Behavioral Health Screening or Assessment for Children in the Foster Care System	15.76%

NHP: Strengths

For the performance measure validation, NHP had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

NHP was above the statewide average for the *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* measure.

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

NHP fell below the statewide average for four out of the five indicators. HSAG recommends that NHP integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

NHP: Accountable Care PIP

Table 3-18 and Table 3-19 display the FY 2019–2020 validation findings for NHP's *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP. NHP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by NHP are summarized in Table 3-18.

Table 3-18—Intervention Determination Summary for the *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP

Failure Modes	Potential Interventions
Member does not want an annual well check	• Pull well check claims and create a monthly well check registry that can be shared with the narrowed focus provider (Salud) for purposes of reaching out to members to schedule well check appointments. – Care coordinators will receive a well check registry list that shows which members attributed to Salud have not had a well check and those who are coming due for a well check. This list will then be used to outreach to members to make them aware of the importance of a well check and help them to schedule the appointment. – Care coordinators from Salud will educate the member on the importance of a well check. – Care coordinators will track their contacts on a spreadsheet and the provider will track appointments scheduled and attended on a spreadsheet that will be compared to real-time data. Spreadsheets will be returned and reconciled monthly to determine the impact of the intervention.
Member may not be aware that he or she needs an annual well check	• Use of the Well Pass texting campaign to inform the member about their need for an annual well check. – Care coordinators can follow up with members who have received the text messages in order to assist with providing the member information regarding, but not limited to, the member's benefit package, the need for a well check, the importance of a well check, and what to expect at the well check appointment. – Care coordinators will track their contacts on a spreadsheet and the provider will track appointments scheduled and attended on a spreadsheet that will be compared to real-time data. Spreadsheets will be returned and reconciled monthly to determine the impact of the intervention.

Failure Modes	Potential Interventions
Member does not value the appointment	Care coordinators from Salud contact members to reschedule a missed appointment and address the importance of a well check. Care coordinators will track their contacts on a spreadsheet and the provider will track appointments scheduled and attended on a spreadsheet that will be compared to real-time data. Spreadsheets will be returned and reconciled monthly to determine the impact of the intervention.

NHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-19 summarizes the intervention NHP selected for testing.

Table 3-19—Planned Intervention for the *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP

Intervention Description	Key Drivers	Failure Mode
Outreach to inform members about well checks	• Member knowledge and understanding about the importance of well check visits • Members may not understand the difference between annual well checks and regular doctor visits	Member does not want an annual well check

NHP: Strengths

NHP continued work on an accountable care PIP focused on increasing the rate of well visits among members 21 to 64 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, NHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.

- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

NHP: Behavioral Health PIP

Table 3-20 and Table 3-21 display the FY 2019–2020 validation findings for NHP's *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP. During FY 2019–2020, NHP completed Module 3–Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by NHP are summarized in Table 3-20.

Table 3-20—Intervention Determination Summary for the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Failure Modes	Potential Interventions
Positive depression screen is not coded accurately on the claim	One-on-one discussion with the providers about the roadblocks they experience that keep them from submitting claims for positive depression screens: • Review claims to see how many (positive and negative) are submitted. • Education for the provider on how to code a depression screen on the claim and then in turn bill the service provided. • Provider town halls could be a venue for the education. • Chart audits conducted to confirm if the screen took place and if the screen was billed as well as if the depression screen was discussed with the member.
Depression screen combined with other services	Provider education around the purpose of itemizing out a depression screen and an implementation timeline for ensuring practitioners and billing staff members are aware of the changes.
Member is diagnosed with other comorbid conditions and depression not seen as critical to treating	Member education on symptoms of depression and impact of depression on other conditions. Collaboration with provider to ensure the resources are usable and relevant to their clinical teams and specific member demographics.

NHP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-21 summarizes the intervention NHP selected for testing.

Table 3-21—Planned Intervention for the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Intervention Description	Key Driver	Failure Modes
Provider contact and education to facilitate the need to submit a claim for completed depression screening with correct billing codes	Billing inconsistency	• Positive depression screen is not coded accurately on the claim • Depression screen combined with other services

NHP: Strengths

NHP continued work on a behavioral health PIP focused on increasing the percentage of members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, NHP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on access to follow-up services after a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.

- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

NHP: Adult PCMH CAHPS

Table 3-22 shows the adult PCMH CAHPS results for NHP for FY 2018–2019 and FY 2019–2020.

Table 3-22—Adult PCMH CAHPS Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	72.1%	67.0% ↑
Rating of Specialist Seen Most Often	69.7%	57.9%
Rating of All Health Care	64.3%	61.2%
Rating of Health Plan	64.4%	63.7%
Getting Timely Appointments, Care, and Information	58.8%	52.0%
How Well Providers Communicate with Patients	79.2%	77.9% ↑
Providers' Use of Information to Coordinate Patient Care	67.0%	66.9% ↑
Talking with You About Taking Care of Your Own Health	47.1%	49.7%
Comprehensiveness	54.9%	50.9%
Helpful, Courteous, and Respectful Office Staff	74.3%	66.7%
Health First Colorado Customer Service	59.7%+	57.0%+
Received Care from Provider Office During Evenings, Weekends, or Holidays	24.7%+	31.9%+
Reminders about Care from Provider Office	63.1%	67.2%
Saw Provider Within 15 Minutes of Appointment	52.7%	45.2%
Receive Health Care and Mental Health Care at Same Place	54.5%	63.5%

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.

↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, NHP's FY 2019–2020 results presented in this report are not comparable to NHP's FY 2018–2019 results.

NHP: Strengths

For the adult population, NHP scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on three measures: *Rating of Provider*; *How Well Providers Communicate with Patients*; and *Providers' Use of Information to Coordinate Patient Care*.

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

For the adult population, HSAG found no measures in which NHP scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 and, therefore, found no opportunities for improvement.

NHP: Child PCMH CAHPS

Table 3-23 shows the child PCMH CAHPS results for NHP for FY 2018–2019 and FY 2019–2020.

Table 3-23—Child PCMH CAHPS Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	83.3%	80.5%
Rating of Specialist Seen Most Often	76.4%+	84.3%+
Rating of All Health Care	75.8%	76.7%
Getting Timely Appointments, Care, and Information	73.7%+	57.9%+
How Well Providers Communicate with Child	79.0%+	82.7%+
How Well Providers Communicate with Parents or Caretakers	84.1%	78.2%
Providers' Use of Information to Coordinate Patient Care	80.0%+	69.8%
Comprehensiveness—Child Development	68.3%	64.9%
Comprehensiveness—Child Safety and Healthy Lifestyles	59.3%	60.8%
Helpful, Courteous, and Respectful Office Staff	70.3%	63.6%
Received Information on Evening, Weekend, or Holiday Care	70.1%	76.4%
Received Care from Provider Office During Evenings, Weekends, or Holidays	20.9%+	9.1%+ ↓
Saw Provider Within 15 Minutes of Appointment	48.1%	37.6%
Reminders about Child's Care from Provider Office	54.7%	61.3% ↓

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, NHP's FY 2019–2020 results presented in this report are not comparable to NHP's FY 2018–2019 results.

NHP: Strengths

For the child population, HSAG found no measures in which NHP scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020.

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

For the child population, NHP scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on two measures: *Received Care from Provider Office During Evenings, Weekends, or Holidays* and *Reminders about Child's Care from Provider Office*.

HSAG recommends that NHP develop initiatives designed to improve the quality and access of services provided. In addition, HSAG recommends that NHP explore areas that may be contributing to low experience scores for the *Received Care from Provider Office During Evenings, Weekends, or Holidays* and *Reminders about Child's Care from Provider Office* measures and develop initiatives designed to improve the scores for these measures.

ECHO Survey

NHP: Adult ECHO Survey

Table 3-24 shows the adult ECHO survey results achieved by NHP for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-24—Adult ECHO Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	55.7%	49.5%
Getting Treatment Quickly	70.2%$^{+}$	63.9%
How Well Clinicians Communicate	88.2%	86.7%
Perceived Improvement	57.2%	58.5%
Amount Helped	78.0%	82.1%
Cultural Competency	NA	NA
Including Family	44.3%	45.4%
Information About Self-Help or Support Groups	54.7%	49.5%
Information to Manage Condition	76.6%	65.1%
Office Wait	80.0%	79.6%
Patient Feels He or She Could Refuse Treatment	83.0%	76.1%
Privacy	87.7%	94.4%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Support from Family and Friends	62.1%	60.4%
Told About Medication Side Effects	79.1%+	71.6%+
Improved Functioning	50.4%	49.6%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the adult population, HSAG found no measures in which NHP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the adult population, NHP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, NHP did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on six measures: *Rating of All Counseling or Treatment*, *Getting Treatment Quickly*, *Information About Self-Help or Support Groups*, *Information to Manage Condition*, *Patient Feels He or She Could Refuse Treatment*, and *Told About Medication Side Effects*. HSAG recommends that RMHP explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., continuing education on various counseling approaches, communication skills training for providers, training focused on listening to patients' needs), where appropriate.

NHP: Child ECHO Survey

Table 3-25 shows the child ECHO survey results achieved by NHP for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-25—Child ECHO Top-Box Scores for NHP

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	52.9%	39.0%+
Getting Treatment Quickly	68.8%+	62.9%+
How Well Clinicians Communicate	88.3%	83.5%+
Perceived Improvement	68.7%	68.6%
Amount Helped	76.6%	72.3%+
Child Had Someone to Talk To	80.2%	75.6%+

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Cultural Competency	NA	NA
Information to Manage Condition	72.0%	72.6%+
Office Wait	84.3%	84.3%+
Privacy	97.1%	100.0%+
Respondent Feels He or She Could Refuse Treatment	85.4%	85.4%+
Support from Family and Friends	77.7%	75.5%
Told About Medication Side Effects	88.9%+	87.5%+
Improved Functioning	63.9%	56.6%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the child population, HSAG found no measures in which NHP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the child population, NHP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, NHP did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on three measures: *Rating of All Counseling or Treatment*, *Getting Treatment Quickly*, and *Improved Functioning*. HSAG recommends that NHP explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., continuing education on various counseling approaches), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-26 presents NHP's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-26—Self-Reported EDV Results by Data Element and BH Service Category for NHP*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	16.8%	0.0%	14.6%	10.5%
Diagnosis Code	51.8%	47.4%	94.9%	64.7%
Place of Service	53.3%	47.4%	86.1%	62.3%

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Service Program Category	49.6%	46.0%	94.9%	63.5%
Units	56.9%	46.7%	94.9%	66.2%
Start Date	57.7%	46.7%	94.9%	66.4%
End Date	57.7%	46.7%	94.9%	66.4%
Appropriate Population	57.7%	47.4%	94.9%	66.7%
Duration	57.7%	46.7%	94.9%	66.4%
Allow Mode of Delivery	57.7%	47.4%	94.9%	66.7%
Staff Requirement	57.7%	47.4%	94.9%	66.7%

** Each service category has a denominator of 137 total cases.*

Table 3-27 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with NHP's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with NHP's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-27—BH EDV Over-Read Agreement Results by BH Service Category for NHP

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	10	100.0%	110	100.0%
Club House or Drop-In Center Services	10	100.0%	110	100.0%
Residential Services	9	90.0%	101	91.8%
Total	**29**	**96.7%**	**321**	**97.3%**

** HSAG overread 10 cases for each BH service category.*
*** HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

NHP: Strengths

NHP's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, NHP described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed completely with NHP's EDV results for the Prevention/Early Intervention Services and Club House or Drop-In Center Services.

NHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that NHP's EDV results accurately reflect its encounter data quality. However, NHP's self-reported EDV results demonstrated a low level of encounter data accuracy when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for NHP to consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Validation of Network Adequacy

NHP: Strengths

During FY 2019–2020, NHP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used NHP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-28 summarizes HSAG's geoaccess analysis results by county classification for NHP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-28—NHP's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	8	57.1%	14	12	85.7%	14	12	85.7%
Primary Care Time/Distance	14	8	8.0%	25	8	6.6%	18	8	22.2%
Behavioral Health Time/Distance	14	6	9.5%	25	6	17.0%	18	6	47.1%
Facilities Time/Distance	14	3	0.0%	25	3	0.0%	18	3	0.0%

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

NHP's network included no practitioners attributed to the Gynecology (Mid-Level) or the Pediatric Primary Care Provider (Mid-Level) network categories. Further, NHP reported no facilities for the Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals, or the Acute Care Hospitals network categories. Consequently, NHP failed to meet the time/distance network standards for those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required standard for NHP's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for NHP's data values for provider type, specialty, and credentials. As such, HSAG recommends that NHP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Region 3—Colorado Access

Assessment of Compliance With Medicaid Managed Care Regulations

Colorado Access (COA) Region 3 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*; and the overall compliance score for FY 2019–2020.

Table 3-29—Summary of COA Region 3 Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	24	6	0	4	80%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Standard VI—Grievance and Appeal Systems	35	35	28	7	0	0	80%
Totals	**85**	**81**	**68**	**13**	**0**	**4**	**84%***

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

Table 3-30 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-30—Summary of COA Region 3 Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	56	28	28	34	50%
Grievances	60	45	25	20	15	56%
Appeals	54	50	38	12	4	76%
Totals	**204**	**151**	**91**	**60**	**53**	**60%***

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

COA Region 3: Strengths

HSAG found that COA's UM program staff members reviewed and authorized services using InterQual criteria to ensure regulatory guidelines were consistently followed and that BH medical reviewers routinely offered a peer review consultation prior to making determinations. Furthermore, denial records reviewed demonstrated 100 percent compliance with the use of qualified reviewers. NABD content was easy to read and included all required information. HSAG also found 100 percent compliance with timelines for making authorization decisions. In COA's policies and procedures, definitions of "emergency condition," "emergency services," and "post-stabilization services" were consistent with regulatory definitions and COA staff members reported that the claims processing systems auto-paid these services. Furthermore, policies clarified financial responsibilities regarding post-stabilization, out-of-network services, UM determinations, and requests for authorization and consultations, as applicable.

COA monitored access and availability using geoaccess reports for time, distance, and caseload ratios as well as quarterly secret shopper calls, which assessed compliance with appointment standards. COA used SCAs with out-of-network providers to ensure timely service for members. COA also monitored HEDIS and CAHPS data to determine if additional initiatives were needed to improve access to care. In addition to CAHPS, COA planned to implement a two-question customer service phone survey regarding access. COA used both in-person and language line translation services to support members' translation needs. The COA website supported nearly 100 languages, member letters included required tag lines, and cultural competency training was required for staff members as well as available on the website for the provider network. COA staff members described a plan for CY 2020 to develop the capability to track providers' access to online training.

The grievance and appeal department staff members used a software system that captured all required reporting elements. Based on grievance and appeal record reviews, HSAG found that COA ensured staff members who had been involved in previous levels of review were not involved in decisions on grievances and appeals and that resolutions were sent to members within required time frames, both expedited and standard.

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

Standard I—Coverage and Authorization of Services

While NABDs were sent to members for service authorization denials, members were not being mailed NABDs regarding claims denials. HSAG also noted that, while policies described post-stabilization services correctly in general terms, specific procedures for post-stabilization service claim payments were not well defined. COA was required to:

- Ensure NABDs for claims denials (both whole and partial) are sent to the member (other than claims denials related to provider procedural issues). This corrective action related to multiple NABD findings such as content, timeliness, and language requirement failures found during the record reviews.

- Update policies to more clearly outline required time frames for mailing NABDs to members and exceptions to those time frames.
- Develop or enhance UM and claims payment procedures for applying the criteria outlined in 42 CFR §422.113(c)(3) to determine when COA's financial responsibility ends for payment of post-stabilization services that were not pre-approved.

Standard VI—Grievance and Appeal Systems

Although COA maintained general policies and procedures in alignment with regulations, HSAG noted the following procedural and informational issues. COA was required to:

- Develop mechanisms to ensure that:
  - Grievances that are clinical in nature are reviewed by a staff member with appropriate clinical expertise.
  - Acknowledgement letters are mailed within two working days.
  - Resolution letters are sent within required time frames.
  - Both grievance and appeal resolution letters are written in member-friendly language.
- Revise documents to clarify that:
  - Grievance extension letters include the member's right to file a grievance.
  - Appeal resolution letters not in favor of the member should include only SFH information, not additional appeal information as the appeal has, at this point, been exhausted.
  - A member's right to request continuation of benefits is within 10 days following the date of the NABD, or before the intended effective date of the action, and if continued, must be requested again within 10 days following the appeal resolution that is adverse to the member.

Performance Measure Rates and Validation

Table 3-31 shows the performance measure results for COA Region 3 PMV FY 2019–2020.

Table 3-31—Performance Measure Results for COA Region 3

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.75%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.76%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	27.83%
Follow-Up After a Positive Depression Screen	43.51%
Behavioral Health Screening or Assessment for Children in the Foster Care System	12.05%

COA Region 3: Strengths

For performance measure validation, COA had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

COA was above the statewide average for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* measure.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

COA fell below the statewide average for four out of the five indicators. It reported the lowest rate for the *Behavioral Health Screening or Assessment for Children in the Foster Care System* measure. HSAG recommends that COA integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

COA Region 3: Accountable Care PIP

Table 3-32 and Table 3-33 display the FY 2019–2020 validation findings for COA Region 3's *Well-Child Visits for Members 10–14 Years of Age* PIP. During FY 2019–2020, COA Region 3 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by COA Region 3 are summarized in Table 3-32.

Table 3-32—Intervention Determination Summary for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Physicians are performing qualifying well visit services during a sick visit but are not billing appropriately	Face-to-face and/or virtual training on appropriate billing practices for well visit services for providers and billing staff members. Training would be accompanied by ongoing support from COA Region 3 as needed.
Sick visit appointment times cannot be extended to incorporate well visit services	Adding an additional step in the sick visit process flow to ensure that a follow-up well visit appointment is scheduled for members who could not have their sick visit appointment time extended for well visit services. The process change would eventually incorporate digital appointment reminders and provider outreach activities.

COA Region 3 also initiated Module 4 in FY 2019–2020, selecting interventions to test and developing the plan for testing through PDSA cycles. Table 3-33 summarizes the interventions COA Region 3 selected for testing.

Table 3-33—Planned Intervention for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Intervention Description	Key Drivers	Failure Modes
Conduct targeted telephonic outreach to members ages 10–14 who are due or overdue for their annual well visit	Providers have information and processes needed to conduct member outreach to encourage members to schedule an annual well visit	• Members and/or their parents may not receive the mailings or text reminders • Mailings or text reminders may not be sufficient to encourage members and/or their parents to schedule a well visit appointment
Provider and staff training to ensure well visit services are itemized in the billing process, particularly if these services are added on to other types of appointments	Coding consistencies for well visits across clinic settings	Services are occurring but not being accurately billed or documented

COA Region 3: Strengths

COA Region 3 continued work on an accountable care PIP focused on increasing the rate of well-child visits among members 10 to 14 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well-child visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well-child visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, COA Region 3 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

COA Region 3: Behavioral Health PIP

Table 3-34 and Table 3-35 display the FY 2019–2020 validation findings for COA Region 3's *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP. COA Region 3 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by COA Region 3 are summarized in Table 3-34.

Table 3-34—Intervention Determination Summary for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services	Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done
Behavioral health specialists are not performing qualifying follow-up services after a positive depression screen for members ages 10–14	Educate providers at integrated primary health/behavioral health practices regarding appropriate follow-up services for members who screen positive for depression
Limited availability of behavioral health providers to provide follow-up service to members within 30 days of a positive depression screen	Collaborate with primary care pediatric practices to offer virtual behavioral health consultation and clinical services to their patients via COA Region 3's telehealth program, with a focus on members ages 10–14 who screened positive for depression to ensure timely access to qualifying behavioral health follow-up services

COA Region 3 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-35 summarizes the intervention COA Region 3 selected for testing.

Table 3-35—Planned Intervention for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done	Availability and timeliness of applicable behavioral health services following a positive depression screening in primary care	Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services

COA Region 3: Strengths

COA Region 3 continued work on a behavioral health PIP focused on increasing the percentage of adolescent members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, COA Region 3 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on access to timely behavioral health services following a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

COA Region 3: Adult PCMH CAHPS

Table 3-36 shows the adult PCMH CAHPS results for COA Region 3 for FY 2018–2019 and FY 2019–2020.

Table 3-36—Adult PCMH CAHPS Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	62.5%	56.6% ↓
Rating of Specialist Seen Most Often	68.6%	65.0%
Rating of All Health Care	59.8%	55.0%
Rating of Health Plan	61.5%	61.3%
Getting Timely Appointments, Care, and Information	44.9%	45.7%
How Well Providers Communicate with Patients	73.4%	69.0% ↓
Providers' Use of Information to Coordinate Patient Care	62.6%	57.6% ↓
Talking with You About Taking Care of Your Own Health	49.8%	46.9%
Comprehensiveness	54.4%	53.6%
Helpful, Courteous, and Respectful Office Staff	64.9%	60.4% ↓
Health First Colorado Customer Service	61.8%	59.7%
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.8%	26.7%+
Reminders about Care from Provider Office	70.7%	70.7%
Saw Provider Within 15 Minutes of Appointment	40.9%	38.8%
Receive Health Care and Mental Health Care at Same Place	58.0%	52.5%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, COA's FY 2019–2020 results presented in this report are not comparable to COA's FY 2018–2019 results.

COA Region 3: Strengths

For the adult population, HSAG found no measures in which COA Region 3 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020.

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

For the adult population, COA Region 3 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on four measures: *Rating of Provider*; *How Well Providers Communicate with Patients*; *Providers' Use of Information to Coordinate Patient Care*; and *Helpful, Courteous, and Respectful Office Staff*. HSAG recommends that COA Region 3 develop initiatives designed to improve the quality of services provided. In addition, HSAG recommends that COA Region 3 focus on improving providers' communication skills with patients, care coordination, and customer service training.

COA Region 3: Child PCMH CAHPS

Table 3-37 shows the child PCMH CAHPS results for COA Region 3 for FY 2018–2019 and FY 2019–2020.

Table 3-37—Child PCMH CAHPS Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	74.9%	71.2% ↓
Rating of Specialist Seen Most Often	77.2%	75.3%
Rating of All Health Care	74.1%	73.1%
Getting Timely Appointments, Care, and Information	68.4%	48.4% ↓
How Well Providers Communicate with Child	80.0%	78.5%
How Well Providers Communicate with Parents or Caretakers	81.7%	78.1%
Providers' Use of Information to Coordinate Patient Care	73.9%	69.4% ↓
Comprehensiveness—Child Development	66.8%	70.4% ↑
Comprehensiveness—Child Safety and Healthy Lifestyles	59.6%	68.3% ↑
Helpful, Courteous, and Respectful Office Staff	66.2%	59.4% ↓
Received Information on Evening, Weekend, or Holiday Care	80.9%	80.4%
Received Care from Provider Office During Evenings, Weekends, or Holidays	25.9%+	25.4% ↓
Saw Provider Within 15 Minutes of Appointment	41.4%	31.5% ↓
Reminders about Child's Care from Provider Office	69.1%	72.2%

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, COA's FY 2019–2020 results presented in this report are not comparable to COA's FY 2018–2019 results.

COA Region 3: Strengths

For the child population, COA Region 3 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on two measures: *Comprehensiveness—Child Development* and *Comprehensiveness—Child Safety and Healthy Lifestyles*.

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

For the child population, COA Region 3 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on six measures: *Rating of Provider*; *Getting Timely Appointments, Care, and Information*; *Providers' Use of Information to Coordinate Patient Care*; *Helpful, Courteous, and Respectful Office Staff*; *Received Care from Provider Office During Evenings, Weekends, or Holidays*; and *Saw Provider Within 15 Minutes of Appointment*.

HSAG recommends that COA Region 3 develop initiatives designed to improve quality, access, and timeliness of services provided. In addition, HSAG recommends that COA Region 3 focus on providing timely care, care coordination, customer service training, and after-hours care.

ECHO Survey

COA Region 3: Adult ECHO Survey

Table 3-38 shows the adult ECHO survey results achieved by COA Region 3 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-38—Adult ECHO Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	51.9%	40.4%
Getting Treatment Quickly	64.1%	69.4%
How Well Clinicians Communicate	88.2%	90.1%
Perceived Improvement	56.2%	53.1%
Amount Helped	80.3%	78.1%
Cultural Competency	NA	NA
Including Family	44.7%	50.9%
Information About Self-Help or Support Groups	50.8%	59.3%
Information to Manage Condition	78.9%	73.7%
Office Wait	80.7%	87.7%
Patient Feels He or She Could Refuse Treatment	82.8%	78.9%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Privacy	91.7%	96.4%
Support from Family and Friends	65.2%	62.3%
Told About Medication Side Effects	76.2%	75.5%+
Improved Functioning	56.5%	50.8%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the adult population, HSAG found no measures in which COA Region 3 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the adult population, COA Region 3 did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, COA Region 3 did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on three measures: *Rating of All Counseling or Treatment*, *Information to Manage Condition*, and *Improved Functioning*. HSAG recommends that COA Region 3 explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., continuing education on various counseling approaches, promote self-empowerment), where appropriate.

COA Region 3: Child ECHO Survey

Table 3-39 shows the child ECHO survey results achieved by COA Region 3 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-39—Child ECHO Top-Box Scores for COA Region 3

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	41.5%	44.0%
Getting Treatment Quickly	67.8%+	59.7%
How Well Clinicians Communicate	88.8%	89.0%
Perceived Improvement	71.2%	64.4%
Amount Helped	77.4%	69.7%
Child Had Someone to Talk To	76.2%	63.9% ▼

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Cultural Competency	NA	NA
Information to Manage Condition	68.9%	68.8%
Office Wait	83.7%	87.2%
Privacy	89.9%	91.7%
Respondent Feels He or She Could Refuse Treatment	79.8%	85.0%
Support from Family and Friends	83.0%	69.4% ▼
Told About Medication Side Effects	85.3%+	81.3%+
Improved Functioning	60.0%	59.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

COA Region 3: Strengths

For the child population, HSAG found no measures in which COA Region 3 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the child population, COA Region 3 scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for two measures: *Child Had Someone to Talk To* and *Support from Family and Friends*. HSAG recommends that COA Region 3 work with the Department to explore areas that may be contributing to statistically significantly lower experience scores for these measures and to develop initiatives for improvement (e.g., communication regarding the importance of family support), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-40 presents COA Region 3's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-40—Self-Reported EDV Results by Data Element and BH Service Category for COA Region 3*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	67.2%	24.8%	81.0%	57.7%
Diagnosis Code	98.5%	87.6%	90.5%	92.2%
Place of Service	73.7%	97.8%	78.1%	83.2%

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Service Program Category	67.2%	5.8%	81.0%	51.3%
Units	98.5%	93.4%	75.2%	89.1%
Start Date	99.3%	100.0%	89.8%	96.4%
End Date	99.3%	100.0%	89.1%	96.1%
Appropriate Population	99.3%	100.0%	89.8%	96.4%
Duration	98.5%	100.0%	84.7%	94.4%
Allow Mode of Delivery	83.2%	100.0%	89.8%	91.0%
Staff Requirement	98.5%	97.8%	86.1%	94.2%

** Each service category has a denominator of 137 total cases.*

Table 3-41 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with COA Region 3's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with COA Region 3's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-41—BH EDV Over-Read Agreement Results by BH Service Category for COA Region 3

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	9	90.0%	107	97.3%
Club House or Drop-In Center Services	8	80.0%	101	91.8%
Residential Services	9	90.0%	109	99.1%
Total	**26**	**86.7%**	**317**	**96.1%**

** HSAG overread 10 cases for each BH service category.*
*** HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

COA Region 3: Strengths

COA Region 3's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, COA Region 3 described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed with 96.1 percent of COA Region 3's validation results for individual data elements.

COA Region 3: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that COA Region 3's EDV results accurately reflect its encounter data quality. However, COA Region 3's self-reported EDV results demonstrated a low level of encounter data accuracy for the *Procedure Code* data element when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for COA Region 3 to consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Validation of Network Adequacy

COA Region 3: Strengths

During FY 2019–2020, COA participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used COA's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-42 summarizes HSAG's geoaccess analysis results by county classification for COA, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-42—COA Region 3's Provider Ratio and Time/Distance Results by County Classification

	Urban			Rural			Frontier		
Measure Results	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	10	71.4%	14	12	85.7%	14	12	85.7%
Primary Care Time/Distance	14	8	42.9%	27	8	59.9%	19	8	50.0%
Behavioral Health Time/Distance	14	6	50.0%	27	6	71.1%	19	6	73.7%
Facilities Time/Distance	14	3	14.3%	27	3	9.9%	19	3	40.4%

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

COA's network included no practitioners attributed to the Gynecology (Mid-Level) or the Pediatric Primary Care Provider (Mid-Level) network categories. Consequently, COA failed to meet the time/distance network standards for those network categories and standards. Failure to meet the urban county network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for members residing in urban counties. Failure to meet the rural and frontier county network category access standards was largely attributable to the closest network locations being outside the required standard for COA's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for COA's data values for provider type, specialty, and credentials. As such, HSAG recommends that COA continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Region 4—Health Colorado, Inc.

Assessment of Compliance With Medicaid Managed Care Regulations

Health Colorado, Inc. (HCI) Overall Evaluation

Table 3-43 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 2019–2020.

Table 3-43—Summary of HCI Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	29	1	0	4	97%
Standard II—Access and Availability	16	16	15	1	0	0	94%
Standard VI—Grievance and Appeal Systems	35	35	29	6	0	0	83%
Totals	**85**	**81**	**73**	**8**	**0**	**4**	**90%***

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

Table 3-44 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-44—Summary of HCI Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	60	52	8	30	87%
Grievances	62	51	49	2	9	96%
Appeals	24	23	19	4	1	83%
Totals	**174**	**134**	**120**	**14**	**40**	**90%***

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

HCI: Strengths

HCI submitted a large body of evidence to substantiate compliance with the Coverage and Authorization, Access and Availability, and Grievance and Appeal Systems standard requirements. HCI delegated ensuring access and availability of services, UM functions for all BH services, and processing grievances and appeals to Beacon.

HCI's submission illustrated a thorough and comprehensive approach for review, authorization, and denial of RAE-covered BH services. Authorizations were documented and processed in HCI's electronic documentation system, *Connect*. HSAG found that the NABDs reviewed included the required content and policies, demonstrated all timeline requirements were clearly articulated and adhered to, and the *Connect* system was capable of monitoring time stamps for expedited reviews. HCI used InterQual to ensure clinical criteria were applied consistently. HCI also ensured that staff members with appropriate clinical experience were utilized to make decisions. HCI staff members highlighted close working relationships with providers, which enhanced HCI's ability to process timely decisions.

Geoaccess reporting, policies, procedures, SCAs, and committee meeting minutes demonstrated compliance with access and availability requirements. HCI used SCAs to ensure no disruptions in continuity of care while contracting processes were finalized with providers. Through the use of SCAs, HCI was able to ensure that providers were available to offer services in a specific language or that specialized care/treatment was available. HCI analyzed monthly internal reports to identify network needs. HCI provided outreach and education initiatives designed to address cultural competency and provide topics specific to the rural needs and challenges of its members. For example, topics included providing mental health resources to migrant workers, farmers, and the agricultural communities within the region to decrease suicide rates among this population.

Beacon delegated processing of grievances to five FQHC and CMHC entities and maintained oversight of these activities. HCI's policies contained accurate descriptions and definitions related to grievances and appeals and staff members assisted members in exercising their rights to file grievances or appeals. Appropriate clinical staff members reviewed and made decisions for both grievances and appeals and all records reviewed demonstrated compliance with resolution time frames requirements. Resolution letters included all required information.

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

Standard I—Coverage and Authorization of Services

While HCI included all required content and alternative language formats were present, the NABD letters were not all easy to understand for members. HCI was required to ensure that NABDs, in their entirety, are easy for members to understand.

Standard II—Access and Availability

Although HCI submitted a provider manual, policies, and hosted a webpage demonstrating required appointment standards, a phone survey of a small sample of the BH network demonstrated that standards were not met by all providers surveyed. HCI was required to develop a more robust mechanism for monitoring and surveying providers to ensure timely access to services, such as implementing CAPs for providers not in compliance.

Standard VI—Grievance and Appeal Systems

While HCI's policies and procedures were largely aligned with regulations, HSAG found one issue with grievance letters and a few issues with general member informational materials. HCI was required to:

- Develop a mechanism to ensure grievance resolution descriptions are written in member-friendly language.
- Correct documentation and member and provider informational materials related to the SFH to clarify that:
  - A SFH may be requested if HCI does not follow appeal processing timelines and the timeline has expired (not before an appeal is filed).
  - The member may request continuation of services during a SFH (within 10 days of receiving an adverse appeal resolution).
  - Removing the reference "the time period for the authorization must not yet be over" from the SFH information (which applies to appeals, not the SFH).
  - A SFH may be requested within 120 days from the appeal resolution date, but continuation of services must be requested within 10 days of the appeal resolution (and remove indication that the SFH must be requested within 10 days of the appeal resolution).
  - The SFH Guide included the description, "you do not request a SFH and continued services within 10 days of an appeal decision not in your favor" as a criterion for how long benefits will continue during a SFH (this applies to continued benefits during the appeal but not during a SFH).
- Revise member and provider materials to correct other inaccuracies such as:
  - Information within the appeal (upheld) resolution letter describing procedures and circumstances for requesting continuation of services during a SFH.
  - The overturned appeal decision letter must have information removed regarding the member's right to a SFH (as it would not apply).

Performance Measure Rates and Validation

Table 3-45 shows the performance measure results for HCI PMV FY 2019–2020.

Table 3-45—Performance Measure Results for HCI

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.93%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	74.36%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	46.03%
Follow-Up After a Positive Depression Screen	42.98%
Behavioral Health Screening or Assessment for Children in the Foster Care System	24.93%

HCI: Strengths

For performance measure validation, HCI had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

HCI was above the statewide average for four out of the five indicators. Additionally, HCI reported the highest rates for the *Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*, *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)*, and *Behavioral Health Screening or Assessment for Children in the Foster Care System* measures.

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

HCI fell below the statewide average for the *Follow-Up After a Positive Depression Screen* measure. HSAG recommends that HCI integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

HCI: Accountable Care PIP

Table 3-46 and Table 3-47 display the FY 2019–2020 validation findings for HCI's *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP. During FY 2019–2020, HCI completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by HCI are summarized in Table 3-46.

Table 3-46—Intervention Determination Summary for the *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP

Failure Modes	Potential Interventions
Member does not see that there is a need for a well check	• Pull well check claims and create a monthly well check registry that can be shared with the provider for purposes of reaching out to members to schedule well check appointments. • Claims data can be used to see if members on the well check registry list who were contacted completed an appointment.
Member may be fearful of well check results	Care coordinators from Health Solutions contact member and address the importance of a well check. Care coordinators may receive a well check registry list that shows which members attributed to Castillo Primary Care have not had a well check and those who are coming due for a well check. • Help the member to understand that the results of various tests may or may not show a need for further medical care. • Claims data can be used to see if members contacted by care coordinators completed an appointment.
Member does not want an annual well check	The use of the Well Pass texting campaign is another option that can be used to educate the member about his or her benefits package and the importance of a well check.

HCI also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-47 summarizes the intervention HCI selected for testing.

Table 3-47—Planned Intervention for the *Increasing Well Checks for Adult Members 21–64 Years of Age* PIP

Intervention Description	Key Drivers	Failure Mode
Care coordinators will reach out to members to address the importance of a well check and assist them in scheduling a well check appointment	• Member knowledge and understanding about the importance of well check visits • Members may not understand the difference between annual well checks and regular doctor visits	Member does not see a need for a well check visit

HCI: Strengths

HCI continued work on an accountable care PIP focused on increasing the rate of well visits among male members 21 to 64 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, HCI had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on well visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

HCI: Behavioral Health PIP

Table 3-48 and Table 3-49 display the FY 2019–2020 validation findings for HCI's *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP. During FY 2019–2020, HCI completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by HCI are summarized in Table 3-48.

Table 3-48—Intervention Determination Summary for the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Failure Modes	Potential Interventions
Member does not want to engage in treatment	• Give provider documentation to give members who receive a positive depression screen that will start the conversation on the importance of mental health (MH) treatment. Documentation and conversations will also address privacy, confidentiality and discreteness of MH treatment. • Provider will review documentation with member in case there is a literacy issue. • Provider will review documentation with member to ensure that the member understands the benefits package. • Provider education on the importance of MH follow-up in terms of clinical data and how they affect the performance of the RAE. In addition, education of medical providers in integrated medicine.
Member decides that attending the appointment is not worthwhile	• Education provided to member and member understands that MH services are provided at no charge. This can be done though the development of a brochure (provider can discuss with member), and member services will conduct education through one-on-one communication and in group meetings. • Care coordinator can reach out to members by phone to address the benefits package, cost, transportation issues, etc. on follow-up calls. • Provide education to the provider on the member's benefit package.
Member does not know how to schedule the appointment	• Care coordinator outreach to address scheduling and attending the appointment. • Walk-in appointment availability for the initial appointment. Identify same-day access.

HCI also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-49 summarizes the intervention HCI selected for testing.

Table 3-49—Planned Intervention for the *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP

Intervention Description	Key Driver	Failure Modes
Telephone outreach to members who have not scheduled their follow-up appointment within 7 days after their positive depression screen	Member education	• Member does not want to engage in treatment • Member decides that attending the appointment is not worthwhile • Member does not know how to schedule the appointment

HCI: Strengths

HCI continued work on a behavioral health PIP focused on increasing the percentage of members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, HCI had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on access to behavioral health services following a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.

- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

HCI: Adult PCMH CAHPS

Table 3-50 shows the adult PCMH CAHPS results for HCI for FY 2018–2019 and FY 2019–2020.

Table 3-50—Adult PCMH CAHPS Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	63.3%	68.5% ↑
Rating of Specialist Seen Most Often	62.6%	61.4%
Rating of All Health Care	61.0%	61.5%
Rating of Health Plan	60.5%	66.6% ↑
Getting Timely Appointments, Care, and Information	51.9%	56.8% ↑
How Well Providers Communicate with Patients	75.0%	76.4%
Providers' Use of Information to Coordinate Patient Care	61.1%	66.0% ↑
Talking with You About Taking Care of Your Own Health	44.6%	51.8%
Comprehensiveness	43.2%	49.3%
Helpful, Courteous, and Respectful Office Staff	72.3%	69.5%
Health First Colorado Customer Service	66.9%	62.1%
Received Care from Provider Office During Evenings, Weekends, or Holidays	38.5%+	34.1%
Reminders about Care from Provider Office	73.0%	71.5%
Saw Provider Within 15 Minutes of Appointment	35.9%	38.1%
Receive Health Care and Mental Health Care at Same Place	57.8%	52.4%

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.

↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, HCI's FY 2019–2020 results presented in this report are not comparable to HCI's FY 2018–2019 results.

HCI: Strengths

For the adult population, HCI scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on four measures: *Rating of Provider*; *Rating of Health Plan*; *Getting Timely Appointments, Care, and Information*; and *Providers' Use of Information to Coordinate Patient Care*.

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

For the adult population, HSAG found no measures in which HCI scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 and, therefore, found no opportunities for improvement.

HCI: Child PCMH CAHPS

Table 3-51 shows the child PCMH CAHPS results for HCI for FY 2018–2019 and FY 2019–2020.

Table 3-51—Child PCMH CAHPS Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	65.3%	65.1% ↓
Rating of Specialist Seen Most Often	69.5%+	73.6%+
Rating of All Health Care	69.9%	62.7% ↓
Getting Timely Appointments, Care, and Information	60.6%	56.8% ↓
How Well Providers Communicate with Child	78.1%	75.3%
How Well Providers Communicate with Parents or Caretakers	78.1%	75.8% ↓
Providers' Use of Information to Coordinate Patient Care	72.3%	69.6%
Comprehensiveness—Child Development	56.8%	51.6% ↓
Comprehensiveness—Child Safety and Healthy Lifestyles	49.0%	49.0% ↓
Helpful, Courteous, and Respectful Office Staff	63.5%	64.1%
Received Information on Evening, Weekend, or Holiday Care	79.6%	75.3% ↓
Received Care from Provider Office During Evenings, Weekends, or Holidays	20.8%+	37.9%+
Saw Provider Within 15 Minutes of Appointment	29.6%	30.7% ↓
Reminders about Child's Care from Provider Office	59.9%	53.6% ↓

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, HCI's FY 2019–2020 results presented in this report are not comparable to HCI's FY 2018–2019 results.

HCI: Strengths

For the child population, HSAG found no measures in which HCI scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020.

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

For the child population, HCI scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on nine measures: *Rating of Provider*; *Rating of All Health Care*; *Getting Timely Appointments, Care, and Information*; *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*; *Saw Provider Within 15 Minutes of Appointment*; and *Reminders about Child's Care from Provider Office*.

HSAG recommends that HCI develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that HCI focus on improving providers' communication skills, provider training on child development, child safety, and healthy lifestyles, providing timely care and reminders, and after-hours care.

ECHO Survey

HCI: Adult ECHO Survey

Table 3-52 shows the adult ECHO survey results achieved by HCI for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-52—Adult ECHO Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	44.6%	54.8%
Getting Treatment Quickly	70.3%+	74.2%
How Well Clinicians Communicate	88.8%	93.7%
Perceived Improvement	62.6%	57.8%
Amount Helped	80.2%	86.7%
Cultural Competency	NA	NA
Including Family	36.6%	40.5%
Information About Self-Help or Support Groups	50.4%	57.9%
Information to Manage Condition	77.7%	82.6%
Office Wait	84.1%	82.6%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Patient Feels He or She Could Refuse Treatment	74.3%	74.1%
Privacy	94.5%	94.7%
Support from Family and Friends	63.5%	57.1%
Told About Medication Side Effects	64.8%+	70.9%+
Improved Functioning	63.0%	47.6% ▼

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

HCI: Strengths

For the adult population, HSAG found no measures in which HCI scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the adult population, HCI scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for one measure, *Improved Functioning*. HSAG recommends that HCI explore areas that may be contributing to a statistically significantly lower experience score for this measure and develop initiatives for improvement (e.g., promote self-empowerment), where appropriate.

HCI: Child ECHO Survey

Table 3-53 shows the child ECHO survey results achieved by HCI for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-53—Child ECHO Top-Box Scores for HCI

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	50.9%	45.5%+
Getting Treatment Quickly	73.8%+	70.2%
How Well Clinicians Communicate	86.6%	83.9%+
Perceived Improvement	66.7%	68.0%
Amount Helped	80.8%	70.5%+
Child Had Someone to Talk To	82.9%	71.6%+
Cultural Competency	NA	NA

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Information to Manage Condition	74.4%	67.8%+
Office Wait	85.7%	85.4%+
Privacy	96.5%	95.5%+
Respondent Feels He or She Could Refuse Treatment	86.2%	81.2%+
Support from Family and Friends	83.2%	74.5%
Told About Medication Side Effects	77.4%+	71.4%+
Improved Functioning	62.2%	56.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the child population, HSAG found no measures in which HCI scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

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

For the child population, HCI did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, HCI did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on eight measures: *Rating of All Counseling or Treatment*, *Amount Helped*, *Child Had Someone to Talk To*, *Information to Manage Condition*, *Respondent Feels He or She Could Refuse Treatment*, *Support From Family and Friends*, *Told About Medication Side Effects*, and *Improved Functioning*. HSAG recommends that HCI explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., training focused on listening to patients' needs, communication regarding the importance of family support, promote self-empowerment), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-54 presents HCI's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-54—Self-Reported EDV Results by Data Element and BH Service Category for HCI*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	86.9%	94.2%	100.0%	93.7%
Diagnosis Code	97.1%	96.4%	97.8%	97.1%

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Place of Service	96.4%	98.5%	100.0%	98.3%
Service Program Category	98.5%	97.8%	100.0%	98.8%
Units	97.1%	94.2%	100.0%	97.1%
Start Date	98.5%	98.5%	100.0%	99.0%
End Date	98.5%	98.5%	100.0%	99.0%
Appropriate Population	98.5%	98.5%	100.0%	99.0%
Duration	98.5%	97.8%	100.0%	98.8%
Allow Mode of Delivery	97.1%	98.5%	100.0%	98.5%
Staff Requirement	98.5%	98.5%	100.0%	99.0%

** Each service category has a denominator of 137 total cases.*

Table 3-55 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with HCI's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with HCI's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-55—BH EDV Over-Read Agreement Results by BH Service Category for HCI

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	10	100.0%	110	100.0%
Club House or Drop-In Center Services	10	100.0%	110	100.0%
Residential Services	10	100.0%	110	100.0%
Total	**30**	**100.0%**	**330**	**100.0%**

** HSAG overread 10 cases for each BH service category.*
*** HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

HCI: Strengths

HCI's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, HCI described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed completely with HCI's EDV results for all service categories.

HCI: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that HCI's EDV results accurately reflect its encounter data quality. Additionally, NCI's self-reported EDV results demonstrated a relatively high level of encounter data accuracy when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read support HCI's maintenance of its existing processes for ongoing encounter data monitoring and assurance of service coding accuracy by BH providers.

Validation of Network Adequacy

HCI: Strengths

During FY 2019–2020, HCI participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used HCI's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-56 summarizes HSAG's geoaccess analysis results by county classification for HCI, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-56—HCI's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	11	78.6%	14	11	78.6%	14	12	85.7%
Primary Care Time/Distance	13	8	0.0%	27	8	25.0%	23	8	31.3%
Behavioral Health Time/Distance	13	6	0.0%	27	6	34.0%	23	6	59.0%
Facilities Time/Distance	13	3	0.0%	27	3	0.0%	23	3	0.0%

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

HCI's network included no practitioners attributed to the Gynecology (Mid-Level) or the Pediatric Primary Care Provider (Mid-Level) network categories. Further, HCI reported no facilities for the Acute Care Hospitals network category. Consequently, HCI failed to meet the time/distance network standards for those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network location being outside the required standard for HCI's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for HCI's data values for provider type, specialty, and credentials. As such, HSAG recommends that HCI continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

HSAG HEALTH SERVICES ADVISORY GROUP

Region 5—Colorado Access

Assessment of Compliance With Medicaid Managed Care Regulations

Colorado Access (COA) Region 5 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*; and the overall compliance score for FY 2019–2020.

Table 3-57—Summary of COA Region 5 Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	24	6	0	4	80%
Standard II—Access and Availability	16	16	16	0	0	0	100%
Standard VI—Grievance and Appeal Systems	35	35	29	6	0	0	83%
Totals	**85**	**81**	**69**	**12**	**0**	**4**	**85%***

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

Table 3-58 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-58—Summary of COA Region 5 Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	96	60	40	20	30	67%
Grievances	60	40	26	14	20	65%
Appeals	60	53	33	20	7	62%
Totals	**210**	**153**	**99**	**54**	**57**	**65%***

**The overall record review 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 UM program staff members reviewed and authorized services, using InterQual criteria to ensure regulatory guidelines were consistently followed. BH medical reviewers routinely offered a peer review consultation prior to making determinations. Furthermore, denial records reviewed demonstrated 100 percent compliance with requirements for qualifications of UM reviewers, NABD content being easy to read, inclusion of all required information, and timelines for making authorization decisions. Policies and procedures contained definitions for "emergency condition," "emergency services," and "post-stabilization services" that were consistent with regulatory definitions, and COA staff members reported that COA's claims processing systems auto-paid these services. Furthermore, COA's policies addressed financial responsibilities regarding post-stabilization services, out-of-network services, described the process for UM determinations regarding post-stabilization services, and outlined 24/7 UM coverage to support timely requests for authorization and consultations, as applicable.

COA effectively monitored access and availability of services using geoaccess reports for time, distance, and caseload ratios. In addition, COA used quarterly secret shopper calls to assess compliance with appointment standards. COA used SCAs with out-of-network providers to ensure timely service for members and HEDIS and CAHPS data to determine if additional initiatives were needed to ensure access to specific services. In addition to the CAHPS survey, COA planned to implement a two-question customer service phone survey regarding access. COA used both in-person and language line translation services to support members' translation needs. The COA website supported nearly 100 languages, member letters included required tag lines, and cultural competency training was required for staff members and was available on the COA website for the provider network. COA described a plan in CY 2020 to develop the capability to track providers' access to online training.

The grievance and appeal department staff members used a software system that captured all required reporting elements. Based on grievance and appeal record reviews, HSAG found that COA ensured staff members who had been involved in previous levels of review were not involved in decisions on grievances and appeals and that resolutions were sent to members within required time frames, both expedited and standard.

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

Standard I—Coverage and Authorization of Services

While NABDs were sent for service authorization denials, members were not being mailed NABDs regarding claims denials. HSAG also noted that, while policies described post-stabilization services correctly in general terms, specific procedures for post-stabilization service claim payments were not well defined. COA was required to:

- Ensure NABDs for claims denials (both whole and partial) are sent to the member (other than claims denials related to provider procedural issues). This action related to multiple NABD findings such as content, timeliness, and language requirement failures found during the record reviews.

- Update policies to more clearly outline required time frames for mailing NABDs to members and exceptions to those time frames.
- Develop or enhance UM and claims payment procedures for applying the criteria outlined in 42 CFR §422.113(c)(3) to determine when COA's financial responsibility ends for payment of post-stabilization services that were not pre-approved.

Standard VI—Grievance and Appeal Systems

Although COA maintained well detailed policies and procedures, during the record reviews, HSAG noted some procedural and informational issues. COA was required to:

- Develop mechanisms to ensure that:
  - Acknowledgement letters are mailed within two working days.
  - If a grievance with limited details is submitted by a member, COA staff members should use both phone and written attempts to contact the member to process the grievance. If the member cannot be reached, the investigation must continue based on information first provided and the grievance processing should proceed to the fullest extent COA is able, including providing a resolution letter.
  - Both grievance and appeal resolution letters are written in member-friendly language.
- Revise documents to clarify that:
  - Grievance extension letters include the member's right to file a grievance if the member is unhappy about the extension.
  - Appeal resolution letters not in favor of the member should include only SFH information, not additional appeal information as the appeal has at this point been exhausted.
  - A member's right to request continuation of benefits is within 10 days following the date of the NABD, or before the intended effective date of the action and, if services have been continued, must be requested again within 10 days following the appeal resolution that is adverse to the member.

Performance Measure Rates and Validation

Table 3-59 shows the performance measure results for COA Region 5 PMV FY 2019–2020.

Table 3-59—Performance Measure Results for COA Region 5

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	43.54%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	63.56%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	37.22%
Follow-Up After a Positive Depression Screen	32.20%
Behavioral Health Screening or Assessment for Children in the Foster Care System	17.20%

COA Region 5: Strengths

For performance measure validation, COA had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

COA was above the statewide average for the *Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)* and *Behavioral Health Screening or Assessment for Children in the Foster Care System* measures.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

COA fell below the statewide average for three out of the five indicators. COA reported the lowest rates for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Follow-Up After a Positive Depression Screen* measures. HSAG recommends that COA integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

COA Region 5: Accountable Care PIP

Table 3-60 and Table 3-61 display the FY 2019–2020 validation findings for COA Region 5's *Well-Child Visits for Members 10–14 Years of Age* PIP. During FY 2019–2020, COA Region 5 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by COA Region 5 are summarized in Table 3-60.

Table 3-60—Intervention Determination Summary for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Physicians are performing qualifying well visit services during a sick visit but are not billing appropriately	Face-to-face and/or virtual training on appropriate billing practices for well visit services for providers and billing staff members. Training would be accompanied by ongoing support from COA Region 5 as needed.
Sick visit appointment times cannot be extended to incorporate well visit services	Adding an additional step in the sick visit process flow to ensure that a follow-up well visit appointment is scheduled for members who could not have their sick visit appointment time extended for well visit services. The process change would eventually incorporate digital appointment reminders and provider outreach activities.
Parent does not schedule a well visit appointment for their child or any other qualifying well visit service	Partner with providers to educate parents about the importance of a well visit for their adolescent. Educational materials would be provided in both English and Spanish.

COA Region 5 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-61 summarizes the intervention COA Region 5 selected for testing.

Table 3-61—Planned Intervention for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Chart audits to identify providers who missed opportunities to bill for well visit services and targeted training for these providers on when and how to bill for well visit services	Coding consistencies for well visits across clinic settings	Physicians are performing qualifying well visit services during a sick but are not billing appropriately

COA Region 5: Strengths

COA Region 5 continued work on an accountable care PIP focused on increasing the rate of well-child visits among members 10 to 14 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well-child visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well-child visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

After initiating Module 4, COA Region 5 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

COA Region 5: Behavioral Health PIP

Table 3-62 and Table 3-63 display the FY 2019–2020 validation findings for COA Region 5's *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP. COA Region 5 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by COA Region 5 are summarized in Table 3-62.

Table 3-62—Intervention Determination Summary for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services	Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done
Behavioral health specialists are not performing qualifying follow-up services after a positive depression screen for members ages 10–14	Educate providers at integrated primary health/behavioral health practices regarding appropriate follow-up services for members who screen positive for depression
Limited availability of behavioral health providers to provide follow-up service to members within 30 days of a positive depression screen	Collaborate with primary care pediatric practices to offer virtual behavioral health consultation and clinical services to their patients via COA Region 5's telehealth program, with a focus on members ages 10–14 who screened positive for depression to ensure timely access to qualifying behavioral health follow-up services

COA Region 5 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-63 summarizes the intervention COA Region 5 selected for testing.

Table 3-63—Planned Intervention for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done	Availability and timeliness of applicable behavioral health services following a positive depression screening in primary care	Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services

COA Region 5: Strengths

COA Region 5 continued work on a behavioral health PIP focused on increasing the percentage of adolescent members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing

interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

After initiating Module 4, COA Region 5 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on access to timely behavioral health services following a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

COA Region 5: Adult PCMH CAHPS

Table 3-64 shows the adult PCMH CAHPS results for COA Region 5 for FY 2018–2019 and FY 2019–2020.

Table 3-64—Adult PCMH CAHPS Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	62.2%	65.0%
Rating of Specialist Seen Most Often	56.7%	68.4%
Rating of All Health Care	55.2%	59.8%
Rating of Health Plan	61.3%	66.1%
Getting Timely Appointments, Care, and Information	53.8%	56.7% ↑

Measure	FY 2018–2019 Score	FY 2019–2020 Score
How Well Providers Communicate with Patients	69.6%	75.7%
Providers' Use of Information to Coordinate Patient Care	58.6%	64.2%
Talking with You About Taking Care of Your Own Health	44.6%	47.5%
Comprehensiveness	43.2%	43.7% ↓
Helpful, Courteous, and Respectful Office Staff	68.3%	73.9% ↑
Health First Colorado Customer Service	59.8%	66.9%+
Received Care from Provider Office During Evenings, Weekends, or Holidays	23.9%	24.6%+
Reminders about Care from Provider Office	65.7%	69.4%
Saw Provider Within 15 Minutes of Appointment	34.5%	39.3%
Receive Health Care and Mental Health Care at Same Place	58.3%	57.4%

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, COA's FY 2019–2020 results presented in this report are not comparable to COA's FY 2018–2019 results.

COA Region 5: Strengths

For the adult population, COA Region 5 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on two measures: *Getting Timely Appointments, Care, and Information* and *Helpful, Courteous, and Respectful Office Staff*.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the adult population, COA Region 5 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Comprehensiveness*. HSAG recommends that COA Region 5 develop initiatives designed to improve the quality of services provided. In addition, HSAG recommends that COA Region 5 focus on improving providers' communication skills with patients.

COA Region 5: Child PCMH CAHPS

Table 3-65 shows the child PCMH CAHPS results for COA Region 5 for FY 2018–2019 and FY 2019–2020.

Table 3-65—Child PCMH CAHPS Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	81.2%	90.1% ↑
Rating of Specialist Seen Most Often	74.8%+	70.4%+
Rating of All Health Care	81.9%	89.7% ↑
Getting Timely Appointments, Care, and Information	75.2%	74.8%+ ↑
How Well Providers Communicate with Child	84.7%	85.4%+
How Well Providers Communicate with Parents or Caretakers	84.8%	86.4% ↑
Providers' Use of Information to Coordinate Patient Care	74.5%	84.2%+ ↑
Comprehensiveness—Child Development	69.8%	75.7% ↑
Comprehensiveness—Child Safety and Healthy Lifestyles	62.8%	67.4% ↑
Helpful, Courteous, and Respectful Office Staff	79.5%	82.5% ↑
Received Information on Evening, Weekend, or Holiday Care	82.4%	85.9% ↑
Received Care from Provider Office During Evenings, Weekends, or Holidays	56.0%+	49.6%+ ↑
Saw Provider Within 15 Minutes of Appointment	51.0%	48.2% ↑
Reminders about Child's Care from Provider Office	75.6%	73.9%

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, COA's FY 2019–2020 results presented in this report are not comparable to COA's FY 2018–2019 results.

COA Region 5: Strengths

For the child population, COA Region 5 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on 11 measures: *Rating of Provider*; *Rating of All Health Care*; *Getting Timely Appointments, Care, and Information*; *How Well Providers Communicate with Parents or Caretakers*; *Providers' Use of Information to Coordinate Patient Care*; *Comprehensiveness—Child Development*; *Comprehensiveness—Child Safety and Healthy Lifestyles*; *Helpful, Courteous, and Respectful Office Staff*; *Received Information on Evening, Weekend, or Holiday Care*; *Received Care from Provider Office During Evenings, Weekends, or Holidays*; and *Saw Provider Within 15 Minutes of Appointment.*

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the child population, HSAG found no measures in which COA Region 5 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 and, therefore, found no opportunities for improvement.

ECHO Survey

COA Region 5: Adult ECHO Survey

Table 3-66 shows the adult ECHO survey results achieved by COA Region 5 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-66—Adult ECHO Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	45.9%	55.9%
Getting Treatment Quickly	69.9%+	71.1%
How Well Clinicians Communicate	90.5%	91.2%
Perceived Improvement	53.8%	63.6%
Amount Helped	88.8%	90.2%
Cultural Competency	NA	NA
Including Family	32.7%	41.6%
Information About Self-Help or Support Groups	41.7%	52.5%
Information to Manage Condition	81.9%	86.3%
Office Wait	81.9%	83.2%
Patient Feels He or She Could Refuse Treatment	81.6%	74.3%
Privacy	95.5%	92.2%
Support from Family and Friends	69.4%	58.8%
Told About Medication Side Effects	78.7%+	77.9%+
Improved Functioning	52.8%	53.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the adult population, HSAG found no measures in which COA Region 5 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the adult population, COA Region 5 did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, COA Region 5 did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on two measures: *Patient Feels He*

or She Could Refuse Treatment and *Support From Family and Friends*. HSAG recommends that COA Region 5 explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., training focused on listening to patients' needs, communication regarding the importance of family support), where appropriate.

COA Region 5: Child ECHO Survey

Table 3-67 shows the child ECHO survey results achieved by COA Region 5 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-67—Child ECHO Top-Box Scores for COA Region 5

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	55.4%+	40.8%+
Getting Treatment Quickly	72.8%+	78.5%+
How Well Clinicians Communicate	85.8%+	90.4%+
Perceived Improvement	75.6%	75.6%+
Amount Helped	73.6%	84.5%+
Child Had Someone to Talk To	72.6%+	81.7%+
Cultural Competency	NA	NA
Information to Manage Condition	74.1%+	78.6%+
Office Wait	76.5%+	91.4%+ ▲
Privacy	91.7%+	91.4%+
Respondent Feels He or She Could Refuse Treatment	84.7%+	83.3%+
Support from Family and Friends	77.7%	75.9%+
Told About Medication Side Effects	88.6%+	85.7%+
Improved Functioning	71.3%	65.1%+

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

COA Region 5: Strengths

For the child population, COA Region 5 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 for one measure, *Office Wait*.

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COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the child population, COA Region 5 did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, COA Region 5 did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on two measures: *Rating of All Counseling or Treatment* and *Improved Functioning*. HSAG recommends that COA Region 5 explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., continuing education on various counseling approaches), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-68 presents COA Region 5's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-68—Self-Reported EDV Results by Data Element and BH Service Category for COA Region 5*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	77.4%	16.1%	91.2%	61.6%
Diagnosis Code	99.3%	97.8%	97.8%	98.3%
Place of Service	79.6%	97.1%	95.6%	90.8%
Service Program Category	77.4%	6.6%	91.2%	58.4%
Units	93.4%	97.1%	91.2%	93.9%
Start Date	99.3%	100.0%	97.8%	99.0%
End Date	99.3%	100.0%	97.8%	99.0%
Appropriate Population	99.3%	100.0%	97.8%	99.0%
Duration	95.6%	100.0%	92.7%	96.1%
Allow Mode of Delivery	96.4%	100.0%	97.8%	98.1%
Staff Requirement	98.5%	97.1%	96.4%	97.3%

** Each service category has a denominator of 137 total cases.*

Table 3-69 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with COA Region 5's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with COA Region 5's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-69—BH EDV Over-Read Agreement Results by BH Service Category for COA Region 5

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	10	100.0%	110	100.0%
Club House or Drop-In Center Services	10	100.0%	110	100.0%
Residential Services	8	80.0%	108	98.2%
Total	**28**	**93.3%**	**328**	**99.4%**

* *HSAG overread 10 cases for each BH service category.*
** *HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

COA Region 5: Strengths

COA Region 5's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, COA Region 5 described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed completely with COA Region 5's EDV results for the Prevention/Early Intervention Services and Club House or Drop-In Center Services.

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that COA Region 5's EDV results accurately reflect its encounter data quality. However, COA Region 5's self-reported EDV results demonstrated a low level of encounter data accuracy for the *Procedure Code* data element when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for COA Region 5 to consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Validation of Network Adequacy

COA Region 5: Strengths

During FY 2019–2020, COA participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used COA's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-70 summarizes HSAG's geoaccess analysis results by county classification for COA, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all

network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-70—COA Region 5's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	10	71.4%	14	12	85.7%	14	12	85.7%
Primary Care Time/Distance	14	8	47.3%	27	8	60.6%	18	8	56.7%
Behavioral Health Time/Distance	14	6	61.9%	27	6	70.4%	18	6	75.8%
Facilities Time/Distance	14	3	19.0%	27	3	17.3%	18	3	46.3%

COA Region 5: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

COA's network included no practitioners attributed to the Gynecology (Mid-Level) or the Pediatric Primary Care Provider (Mid-Level) network categories. Consequently, COA failed to meet the time/distance network standards for those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required standard for COA's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for COA's data values for provider type, specialty, and credentials. As such, HSAG recommends that COA continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Region 6—Colorado Community Health Alliance

Assessment of Compliance With Medicaid Managed Care Regulations

Colorado Community Health Alliance (CCHA) Region 6 Overall Evaluation

Table 3-71 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 2019–2020.

Table 3-71—Summary of CCHA Region 6 Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	25	5	0	4	83%
Standard II—Access and Availability	16	16	15	0	1	0	94%
Standard VI—Grievance and Appeal Systems	35	35	25	10	0	0	71%
Totals	**85**	**81**	**65**	**15**	**1**	**4**	**80%***

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

Table 3-72 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-72—Summary of CCHA Region 6 Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	61	49	12	29	80%
Grievances	60	53	46	7	7	87%
Appeals	48	47	39	8	1	83%
Totals	**198**	**161**	**134**	**27**	**37**	**83%***

**The overall record review 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 effective UM systems, which ensured delivery of medically necessary BH services and treatment, including inpatient, residential, outpatient, transitions of care, assessments, and more. HSAG found that submitted documents substantiated an overall comprehensive approach for review, authorization, and denial of RAE-covered BH services. Policies described clear roles for staff members and appropriate oversight and monitoring of UM functions. Although CCHA used Anthem's corporate-level software and clinical best practices, CCHA did not delegate UM functions. CCHA implemented "daily rounds," which allowed for interdisciplinary communications and making informed decisions. CCHA processed authorization requests according to clear clinical practice guidelines and ensured appropriate clinical review of requests for authorization. CCHA described payment and claims processing procedures for emergency and post-stabilization services to ensure payment in all appropriate circumstances. CCHA had the appropriate flags within the electronic documentation system to ensure post-stabilization services are passed through UM to determine CCHA's financial responsibility.

Policies, procedures, and extensive reporting described CCHA's process for monitoring access and availability requirements. If the RAE determined a gap in its BH or primary care medical provider (PCMP) network, CCHA implemented the procedures from its well-documented strategy for provider recruitment and network development. CCHA described a variety of scenarios in which CCHA was able to identify member needs and enhance delivery of services in a culturally sensitive manner. CCHA also described robust staffing, making it possible to assist members on an individual basis, engaging them in their homes or supporting them at behavioral and physical health appointments, and partnering with community stakeholders to meet members' needs.

CCHA used Anthem staff members and systems to process appeals and employed local staff members to resolve grievances. CCHA maintained processes to accept both verbal and written grievances and appeals from members or their designated representative. Based on record reviews, HSAG found that CCHA ensured persons with appropriate clinical expertise reviewed and resolved grievances and appeals. Policies and member and provider materials accurately described the required time frames for processing grievances, appeals, and requesting a SFH.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

Standard I—Coverage and Authorization of Services

Although CCHA's policies, procedures, and supporting documentation provided an overall understanding of the UM process in accordance with regulations, the following deficiencies were noted. CCHA was required to:

- Update the definition of "medical necessity" to include all aspects of the State definition.
- Enhance documentation to ensure CCHA consistently and proactively outreaches to the requesting provider when additional information is necessary to make a UM decision.

- Develop a mechanism to ensure members are sent a written NABD within required time frames regarding any decision to deny a service authorization request or denial (full or partial) of payment (for claims denials not related to provider procedural issues).
- Ensure that NABDs include member-friendly language and explain the reason for the denial.

Standard II—Access and Availability

While CCHA's policy described efforts to establish an adequate provider network, the associated reports were being transitioned to a new software program and current quarterly reports did not include calculations to demonstrate offering members at least two choices of PCMPs within their ZIP code or compliance with time and distance standards. CCHA was required to implement mechanisms to conduct regular time and distance calculations to measure and monitor network access in accordance with State standards and demonstrate that members have a choice of at least two PCMPs within their ZIP code or required time and distance classifications.

Standard VI—Grievance and Appeal Systems

While most of CCHA's grievances and appeals reviewed by HSAG contained required content and were processed according to regulations, there were a few exceptions. Based on findings in the grievance and appeals record reviews, CCHA was required to ensure that:

- Clinical grievances are reviewed by staff members with the appropriate clinical expertise.
- Grievance resolutions thoroughly address the member's complaint.
- Appeal determinations and member notices are processed within required time frames.
- Both grievance and appeal member resolution letters are mailed timely.
- Both grievance and appeal member resolution letters include member-friendly language.
- Both grievance and appeal extension letters are sent, when applicable, and clearly address all required content, including the reason for the extension and the right to file a grievance if the member is unhappy about the extension.

Various appeal and SFH policies and member and provider materials were found to contain errors. CCHA was required to update these documents to:

- Accurately address all elements of appeal resolution letter content, including resolution dates and that continuation of benefits during a SFH is only in cases of termination, suspension, or reduction of a previously authorized service and the member had requested and received continuation of the services during the appeal.
- Include SFH information only when applicable.
- Inform the member that continuation of services during a SFH must be requested through CCHA, when applicable.
- Clarify the timeline to request continuation of services for appeals (within 10 days following the NABD or before the services are proposed to end) in policy.

- Include information regarding continuation of services filing during a SFH in policy.
- Clarify the timeline to request continuation of services during the SFH (within 10 days following the resolution of the appeal) in policy.
- Remove language from policy, which included modifications to federal language regarding continuation of services for SFH that do not apply once the member has received continued services:
  - "Within 10 days of the Contractor mailing the notice of adverse appeal resolution."
  - "The intended effective date of the proposed adverse benefit determination."
  - "The original period covered by the original authorization has not expired."
  - "The member requests a SFH in accordance with required time frames."
  - That providers will not experience punitive action if assisting a member in an expedited appeal.

Performance Measure Rates and Validation

Table 3-73 shows the performance measure results for CCHA Region 6 PMV FY 2019–2020.

Table 3-73—Performance Measure Results for CCHA Region 6

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	45.81%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	69.45%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	35.25%
Follow-Up After a Positive Depression Screen	52.56%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.59%

CCHA Region 6: Strengths

For performance measure validation, CCHA had adequate processes in place regarding its eligibility and enrollment of members, how it processed claims and encounters, and how it integrated its data for the measures being calculated.

CCHA was above the statewide average for three out of the five indicators.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

CCHA fell below the statewide average for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Behavioral Health Screening or Assessment for Children in the Foster Care System* measures. HSAG recommends that CCHA integrate a more enhanced discharge plan to improve its rates for the follow-up indicators. This includes improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge.

Validation of Performance Improvement Projects

CCHA Region 6: Accountable Care PIP

Table 3-74 and Table 3-75 display the FY 2019–2020 validation findings for CCHA Region 6's *Well-Care Visits for Children Between 15–18 Years of Age* PIP. During FY 2019–2020, CCHA Region 6 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by CCHA Region 6 are summarized in Table 3-74.

Table 3-74—Intervention Determination Summary for *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Not enough schedule availability based on member's time preference	Extend summer clinic hours to have a walk-in clinic every other Saturday
Member unable to receive communication via patient portal	• Having members be required to have a Patient Portal account • More promotion of the Patient Portal; this way, the practice can always be in contact with the patient • Utilizing the Patient Portal to help do recall outreach
Member mailing address and/or phone number are outdated or incorrect	Utilizing multimodal efforts to outreach to members and provide information about how to update their contact information via the Peak App at every appointment and have resources available on the patient portal

CCHA Region 6 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-75 summarizes the intervention CCHA Region 6 selected for testing.

Table 3-75—Planned Intervention for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Intervention Description	Key Driver	Failure Modes
Extended hours, summer walk-in clinic every other Saturday	*Not reported in Module 4*	• Not enough schedule availability based on member's time preference • Member unable to receive communication via the portal

CCHA Region 6: Strengths

CCHA Region 6 continued work on an accountable care PIP focused on increasing the rate of well-care visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well-care visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well-care visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

After initiating Module 4, CCHA Region 6 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CCHA Region 6: Behavioral Health PIP

Table 3-76 and Table 3-77 display the FY 2019–2020 validation findings for CCHA Region 6's *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP. CCHA Region 6 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by CCHA Region 6 are summarized in Table 3-76.

Table 3-76—Intervention Determination Summary for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Failure Modes	Potential Interventions
No current process for when primary care provider (PCP) does not see positive PHQ-9 (depression screen)	Highlight the PHQ-9 to reduce the incidence of the positive screen getting lost in a stack of papers
No current coding standardization process	Optimize use of codes that work effectively in an integrated setting and to support the PIP
No current process with external providers to ensure follow-up visit occurred	Collaborate and strengthen partnership with Mental Health Partners (MHP) to improve sharing of information and closure of feedback loop

CCHA Region 6 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-77 summarizes the intervention CCHA Region 6 selected for testing.

Table 3-77—Planned Intervention for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Intervention Description	Key Driver	Failure Mode
Brightly color the PHQ-9 screening document	Provider engagement	No current process for when PCP does not see positive PHQ-9

CCHA Region 6: Strengths

CCHA Region 6 continued work on a behavioral health PIP focused on increasing the percentage of adolescent members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

After initiating Module 4, CCHA Region 6 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on access to timely behavioral health services following a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

CCHA Region 6: Adult PCMH CAHPS

Table 3-78 shows the adult PCMH CAHPS results for CCHA Region 6 for FY 2018–2019 and FY 2019–2020.

Table 3-78—Adult PCMH CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	61.1%	58.9%
Rating of Specialist Seen Most Often	55.3%	67.9%
Rating of All Health Care	55.8%	55.7%
Rating of Health Plan	57.6%	60.2%
Getting Timely Appointments, Care, and Information	43.4%	42.1% ↓
How Well Providers Communicate with Patients	71.5%	73.5%
Providers' Use of Information to Coordinate Patient Care	58.4%	61.1%

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Talking with You About Taking Care of Your Own Health	51.0%	52.3% ↑
Comprehensiveness	58.3%	56.5% ↑
Helpful, Courteous, and Respectful Office Staff	69.3%	65.1% ↓
Health First Colorado Customer Service	56.4%	64.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	22.2%	13.1% ↓
Reminders about Care from Provider Office	74.5%	74.7%
Saw Provider Within 15 Minutes of Appointment	32.9%	33.9%
Receive Health Care and Mental Health Care at Same Place	58.5%	60.4%

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, CCHA's FY 2019–2020 results presented in this report are not comparable to CCHA's FY 2018–2019 results.

CCHA Region 6: Strengths

For the adult population, CCHA Region 6 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on two measures: *Talking with You About Taking Care of Your Own Health* and *Comprehensiveness*.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the adult population, CCHA Region 6 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on three measures: *Getting Timely Appointments, Care, and Information*; *Helpful, Courteous, and Respectful Office Staff*; and *Received Care from Provider Office During Evenings, Weekends, or Holidays*. HSAG recommends that CCHA Region 6 develop initiatives designed to improve access and timeliness of services provided. In addition, HSAG recommends that CCHA Region 6 focus on providing customer service training for office staff.

CCHA Region 6: Child PCMH CAHPS

Table 3-79 shows the child PCMH CAHPS results for CCHA Region 6 for FY 2018–2019 and FY 2019–2020.

Table 3-79—Child PCMH CAHPS Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	81.2%	68.2% ↓
Rating of Specialist Seen Most Often	66.1%+	82.3%
Rating of All Health Care	76.5%	71.6%
Getting Timely Appointments, Care, and Information	72.3%	61.5%
How Well Providers Communicate with Child	79.5%	78.3%
How Well Providers Communicate with Parents or Caretakers	84.1%	78.0%
Providers' Use of Information to Coordinate Patient Care	78.2%	72.8%
Comprehensiveness—Child Development	67.7%	69.0%
Comprehensiveness—Child Safety and Healthy Lifestyles	58.1%	66.1% ↑
Helpful, Courteous, and Respectful Office Staff	80.8%	65.6%
Received Information on Evening, Weekend, or Holiday Care	86.1%	76.5%
Received Care from Provider Office During Evenings, Weekends, or Holidays	31.7%+	32.5%
Saw Provider Within 15 Minutes of Appointment	54.8%	40.4%
Reminders about Child's Care from Provider Office	72.5%	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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, CCHA's FY 2019–2020 results presented in this report are not comparable to CCHA's FY 2018–2019 results.

CCHA Region 6: Strengths

For the child population, CCHA Region 6 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Comprehensiveness—Child Safety and Healthy Lifestyles*.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the child population, CCHA Region 6 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Rating of Provider*. HSAG recommends that CCHA Region 6 explore areas that may be contributing to low experience scores for the *Rating of Provider* measure and develop initiatives designed to improve the score for this measure.

ECHO Survey

CCHA Region 6: Adult ECHO Survey

Table 3-80 shows the adult ECHO survey results achieved by CCHA Region 6 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-80—Adult ECHO Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	43.8%	48.6%
Getting Treatment Quickly	66.1%	66.8%
How Well Clinicians Communicate	90.1%	92.3%
Perceived Improvement	61.1%	65.7%
Amount Helped	77.6%	83.8%
Cultural Competency	NA	NA
Including Family	38.3%	49.1%
Information About Self-Help or Support Groups	65.7%	62.9%
Information to Manage Condition	71.7%	79.0%
Office Wait	83.7%	86.0%
Patient Feels He or She Could Refuse Treatment	86.4%	79.0%
Privacy	92.0%	97.1%
Support from Family and Friends	66.7%	69.5%
Told About Medication Side Effects	76.6%	75.9%+
Improved Functioning	54.7%	55.4%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a 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

For the adult population, HSAG found no measures in which CCHA Region 6 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the adult population, CCHA Region 6 did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, CCHA Region 6 did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on one measure, *Patient*

Feels He or She Could Refuse Treatment. HSAG recommends that CCHA Region 6 explore areas that may be contributing to a substantially lower experience score for this measure and develop initiatives for improvement (e.g., training focused on listening to patients' needs), where appropriate.

CCHA Region 6: Child ECHO Survey

Table 3-81 shows the child ECHO survey results achieved by CCHA Region 6 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-81—Child ECHO Top-Box Scores for CCHA Region 6

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	46.4%	45.9%
Getting Treatment Quickly	65.7%+	65.4%
How Well Clinicians Communicate	87.9%	88.1%
Perceived Improvement	69.5%	69.4%
Amount Helped	78.1%	75.4%
Child Had Someone to Talk To	79.3%	73.4%
Cultural Competency	NA	NA
Information to Manage Condition	66.4%	68.5%
Office Wait	90.6%	91.1%
Privacy	94.7%	95.2%
Respondent Feels He or She Could Refuse Treatment	90.3%	91.5%
Support from Family and Friends	84.6%	67.6% ▼
Told About Medication Side Effects	82.8%+	84.6%+
Improved Functioning	66.1%	62.2%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

CCHA Region 6: Strengths

For the child population, HSAG found no measures in which CCHA Region 6 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the child population, CCHA Region 6 scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for one measure, *Support from Family and Friends*. HSAG recommends that CCHA Region 6 work with the Department to explore areas that may be contributing to a statistically significantly lower experience score for this measure and to develop initiatives for improvement (e.g., communication regarding the importance of family support), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-82 presents CCHA Region 6's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-82—Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 6*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	68.6%	67.9%	73.0%	69.8%
Diagnosis Code	71.5%	77.4%	86.9%	78.6%
Place of Service	91.2%	91.2%	86.9%	89.8%
Service Program Category	94.2%	85.4%	85.4%	88.3%
Units	89.1%	82.5%	84.7%	85.4%
Start Date	93.4%	92.7%	84.7%	90.3%
End Date	93.4%	92.7%	87.6%	91.2%
Appropriate Population	94.2%	94.2%	97.8%	95.4%
Duration	94.2%	93.4%	95.6%	94.4%
Allow Mode of Delivery	92.7%	92.7%	97.1%	94.2%
Staff Requirement	92.7%	89.8%	94.2%	92.2%

** Each service category has a denominator of 137 total cases.*

Table 3-83 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with CCHA Region 6's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with CCHA Region 6's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-83—BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 6

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	9	90.0%	99	90.0%
Club House or Drop-In Center Services	7	70.0%	90	81.8%
Residential Services	9	90.0%	109	99.1%
Total	**25**	**83.3%**	**298**	**90.3%**

* *HSAG overread 10 cases for each BH service category.*
** *HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

CCHA Region 6: Strengths

CCHA Region 6's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, CCHA Region 6 described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed with 90.3 percent of CCHA Region 6's validation results for individual data elements.

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that CCHA Region 6's EDV results accurately reflect its encounter data quality. However, CCHA Region 6's self-reported EDV results demonstrated a moderately low level of encounter data accuracy for the *Procedure Code* and *Diagnosis Code* data elements when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for CCHA Region 6 to consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Validation of Network Adequacy

CCHA Region 6: Strengths

During FY 2019–2020, CCHA participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used CCHA's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-84 summarizes HSAG's geoaccess analysis results by county classification for CCHA, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-84—CCHA Region 6's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	10	71.4%	14	13	92.9%	14	13	92.9%
Primary Care Time/Distance	14	8	32.1%	27	8	6.3%	20	8	1.4%
Behavioral Health Time/Distance	14	6	52.4%	27	6	62.0%	20	6	65.8%
Facilities Time/Distance	14	3	2.4%	27	3	0.0%	20	3	0.0%

CCHA Region 6: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

CCHA's network included no practitioners attributed to the Pediatric Primary Care Provider (Mid-Level) network category. Further, CCHA reported no facilities for the Acute Care Hospitals network category. Consequently, CCHA failed to meet the time/distance network standards for those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required standard for CCHA's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for CCHA's data values for provider type, specialty, and credentials. As such, HSAG recommends that CCHA continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

Region 7—Colorado Community Health Alliance

Assessment of Compliance With Medicaid Managed Care Regulations

Colorado Community Health Alliance (CCHA) Region 7 Overall Evaluation

Table 3-85 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 2019–2020.

Table 3-85—Summary of CCHA Region 7 Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	26	4	0	4	87%
Standard II—Access and Availability	16	16	15	0	1	0	94%
Standard VI—Grievance and Appeal Systems	35	35	26	9	0	0	74%
Totals	**85**	**81**	**67**	**13**	**1**	**4**	**83%***

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

Table 3-86 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-86—Summary of CCHA Region 7 Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	61	55	6	29	90%
Grievances	60	53	44	9	7	83%
Appeals	60	58	45	13	2	78%
Totals	**210**	**172**	**144**	**28**	**38**	**84%***

**The overall record review 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 effective UM systems, which ensured delivery of medically necessary BH services and treatment, including inpatient, residential, outpatient, transitions of care, assessments, and more. HSAG found that submitted documents substantiated an overall comprehensive approach for review, authorization, and denial of RAE-covered BH services. Policies described clear roles for staff members and appropriate oversight and monitoring of UM functions. Although CCHA used Anthem's corporate-level software and clinical best practices, CCHA did not delegate UM functions. CCHA implemented "daily rounds," which allowed for interdisciplinary communications and making informed decisions. CCHA processed authorization requests according to clear clinical practice guidelines and ensured appropriate clinical review of authorization requests. CCHA described payment and claims processing procedures for emergency and post-stabilization services to ensure payment in all appropriate circumstances. CCHA had the appropriate flags within the electronic documentation system to ensure post-stabilization services are passed through UM to determine CCHA's financial responsibility.

Policies, procedures, and extensive reporting described CCHA's process for monitoring access and availability requirements. If the RAE determined a gap in its BH or PCMP network, CCHA implemented the procedures from its well-documented strategy for provider recruitment and network development. CCHA described a variety of scenarios in which CCHA was able to identify member needs and enhance delivery of services in a culturally sensitive manner. CCHA also described robust staffing, making it possible to assist members on an individual basis, engaging them in their homes, supporting them at behavioral and physical health appointments, and partnering with community stakeholders to meet members' needs.

CCHA used Anthem staff members and systems to process appeals and employed local staff members to resolve grievances. CCHA maintained processes to accept both verbal and written grievances and appeals from members or their designated representative. Based on the record reviews, HSAG found that CCHA ensured persons with appropriate clinical expertise reviewed and resolved grievances and appeals. Policies and member and provider materials accurately described the required time frames for processing grievances and appeals, and for requesting a SFH.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations

Standard I—Coverage and Authorization of Services

Although CCHA's policies, procedures, and supporting documentation provided an overall understanding of the UM process in accordance with regulations, the following deficiencies were noted. CCHA was required to:

- Update the definition of "medical necessity" to include all aspects of the State definition.
- Enhance documentation to ensure CCHA consistently and proactively outreaches to the requesting provider when additional information is necessary to make a UM decision.

- Develop a mechanism to ensure members are sent a written NABD within required time frames regarding any decision to deny a service authorization request or denial (full or partial) of payment (that is not related to provider procedural issues).
- Ensure NABDs include member-friendly language and explain the reason for the denial.

Standard II—Access and Availability

While CCHA's policy described efforts to establish an adequate provider network, the associated reports were being transitioned to a new software program and current quarterly reports did not include calculations to demonstrate offering members at least two choices of PCMPs within their ZIP code or compliance with time and distance standards. CCHA was required to implement mechanisms to conduct regular time and distance calculations to measure and monitor network access in accordance with State standards and demonstrate that members have a choice of at least two PCMPs within their ZIP code or required time and distance classifications.

Standard VI—Grievance and Appeal Systems

While most of CCHA's grievances and appeals reviewed by HSAG contained required content and were processed according to regulations, there were a few exceptions. Based on these findings, CCHA was required to ensure:

- Clinical grievances are reviewed by staff members with the appropriate clinical expertise.
- Grievance resolutions thoroughly address the member's complaint.
- Appeal determinations and member notices are processed within required time frames.
- Both grievance and appeal member letters are mailed timely.
- Both grievance and appeal member letters include member-friendly language.
- Both grievance and appeal extension letters are sent, when applicable, and clearly address all required content, including the reason for the extension and the right to file a grievance.

Various appeal and SFH policies and member and provider documents were found to contain errors. CCHA was required to update these documents to:

- Accurately address all elements of appeal resolution letter content, including resolution dates and that continuation of benefits during a SFH is only in cases of termination, suspension, or reduction of a previously authorized service and the member had requested continuation of benefits during the appeal.
- Include SFH information only when applicable.
- Inform the member that continuation of benefits during a SFH must be requested through CCHA, when applicable.
- Clarify the timeline to file continuation of benefits for appeals (10 days) in policy.
- Include information regarding continuation of benefits filing during a SFH in policy.

- Clarify the timeline to file continuation of benefits for SFH (10 days) in policy.
- Remove language from policy, which included modifications to federal language regarding continuation of services for SFH that do not apply once the member has received continued services:
  - "Within 10 days of the Contractor mailing the notice of adverse appeal resolution."
  - "The intended effective date of the proposed adverse benefit determination."
  - "The original period covered by the original authorization has not expired."
  - "The member requests a SFH in accordance with required time frames."
- Correct policy statements related to the duration of the continuation of benefits of the continued services.
- Clearly state in the PH provider manual that CCHA is available to assist in filing grievances and appeals.
- Clearly state in the BH provider manual:
  - That CCHA is available to assist in filing appeals.
  - The time frames for appeal acknowledgement and resolution.
  - Time frames for requesting continuation of services during the appeal and the SFH.
  - Duration of continued services during appeals and SFHs.
  - That the provider may not request continuation of services during appeals or SFHs on behalf of the member.
  - That outcomes of an appeal should also be addressed, whether the appeal is upheld or reversed (in addition to language already present regarding outcomes of the SFH when a continuation of services has been requested).
  - That providers will not experience punitive action if assisting a member in an expedited appeal.

Performance Measure Rates and Validation

Table 3-87 shows the performance measure results for CCHA Region 7 PMV FY 2019–2020.

Table 3-87—Performance Measure Results for CCHA Region 7

Performance Measure	Performance Measure Results
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	55.01%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	72.90%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	37.01%
Follow-Up After a Positive Depression Screen	59.18%
Behavioral Health Screening or Assessment for Children in the Foster Care System	19.47%

CCHA Region 7: Strengths

For performance measure validation, CCHA had adequate processes in place regarding their eligibility and enrollment of members, how they processed claims and encounters, and how they integrated their data for the measures being calculated.

CCHA was above the statewide average for all five indicators. It reported the highest rates for the *Engagement in Outpatient Substance Use Disorder (SUD) Treatment* and *Follow-Up After a Positive Depression Screen* measures.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

CCHA was above the statewide average for all five indicators. However, to continue to strive toward improvement, CCHA could identify additional interventions related to its lowest performing measure, *Behavioral Health Screening or Assessment for Children in the Foster Care System*, to identify any potential areas for increasing performance as a focus area in the next year.

Validation of Performance Improvement Projects

CCHA Region 7: Accountable Care PIP

Table 3-88 and Table 3-89 display the FY 2019–2020 validation findings for CCHA Region 7's *Well-Care Visits for Children Between 15–18 Years of Age* PIP. During FY 2019–2020, CCHA Region 7 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by CCHA Region 7 are summarized in Table 3-88.

Table 3-88—Intervention Determination Summary for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Not setting "tickler" reminder in electronic health record (EHR)	Updating established member recall workflows including processes to catch missed tickler reminders
Incorrect contact information for member	Utilizing multimodal efforts to outreach to members and provide information about how to update their contact information via the Peak App at every appointment and through mailed resources
Member ineligible for Medicaid on day of service	Established processes to check member eligibility on the day of service and connect ineligible members with CCHA care coordinators

CCHA Region 7 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-89 summarizes the intervention CCHA Region 7 selected for testing.

Table 3-89—Planned Intervention for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Update established member recall workflows including processes to catch missed tickler reminders	*Not reported in Module 4*	Not setting "tickler" reminder in EHR

CCHA Region 7: Strengths

CCHA Region 7 continued work on an accountable care PIP focused on increasing the rate of well-care visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain a well-care visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive a well-care visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health

plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Accountable Care PIP

After initiating Module 4, CCHA Region 7 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CCHA Region 7: Behavioral Health PIP

Table 3-90 and Table 3-91 display the FY 2019–2020 validation findings for CCHA Region 7's *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP. CCHA Region 7 completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by CCHA Region 7 are summarized in Table 3-90.

Table 3-90—Intervention Determination Summary for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Failure Modes	Potential Interventions
Unable to ascertain if patient attended appointment/unclear which behavioral health (BH) provider the member has chosen	**Tracking Mechanism:** CCHA and CenterPointe collaborated to develop a tracking mechanism for all members who screen positive for depression. This will include Medicaid ID, member name, date of screening, date of BH referral, whether member scheduled the appointment, BH referral name/practice, date of reminder call, and date of BH follow-up visit. CenterPointe—Widefield office staff members will outreach to the member after one week to determine which provider he or she plans to see, if the appointment is scheduled, and determine any other barriers to attending the appointment.
Member does not contact BH provider	**Warm Handoff:** Utilizing a warm handoff of member to BH provider of his or her choice, member will be assisted at the primary care provider's office in scheduling the BH follow-up appointment before the member leaves the office.
Long wait time for BH provider appointment	**Collaboration with AspenPointe:** CCHA to establish a Care Compact (to give CenterPointe members priority appointments) with AspenPointe Community Mental Health Center to assist in getting members seen within 30 days of a positive screen.

CCHA Region 7 also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-91 summarizes the intervention CCHA Region 7 selected for testing.

Table 3-91—Planned Intervention for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Intervention Description	Key Driver	Failure Mode
Referral and tracking mechanism for a follow-up visit	Provider standards of care	Unable to ascertain if patient attended appointment/unclear which BH provider the member has chosen

CCHA Region 7: Strengths

CCHA Region 7 continued work on a behavioral health PIP focused on increasing the percentage of adolescent members who received follow-up behavioral health services within 30 days of a positive depression screen. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain follow-up behavioral health services and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive timely follow-up services after a positive depression screen. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Behavioral Health PIP

After initiating Module 4, CCHA Region 7 had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on access to timely behavioral health services following a positive depression screen. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

PCMH CAHPS Survey

CCHA Region 7: Adult PCMH CAHPS

Table 3-92 shows the adult PCMH CAHPS results for CCHA Region 7 for FY 2018–2019 and FY 2019–2020.

Table 3-92—Adult PCMH CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	74.9%	54.6% ↓
Rating of Specialist Seen Most Often	65.0%	61.2%
Rating of All Health Care	67.6%	52.1% ↓
Rating of Health Plan	60.5%	57.6% ↓
Getting Timely Appointments, Care, and Information	54.3%	50.8%
How Well Providers Communicate with Patients	82.4%	68.9% ↓
Providers' Use of Information to Coordinate Patient Care	68.4%	53.4% ↓
Talking with You About Taking Care of Your Own Health	53.5%	43.5% ↓
Comprehensiveness	60.1%	46.9% ↓
Helpful, Courteous, and Respectful Office Staff	71.6%	73.7% ↑
Health First Colorado Customer Service	66.0%+	65.2%
Received Care from Provider Office During Evenings, Weekends, or Holidays	28.8%+	29.2%
Reminders about Care from Provider Office	76.8%	69.4%
Saw Provider Within 15 Minutes of Appointment	44.2%	40.3%
Receive Health Care and Mental Health Care at Same Place	51.2%	53.2%

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices, CCHA's FY 2019–2020 results presented in this report are not comparable to CCHA's FY 2018–2019 results.

CCHA Region 7: Strengths

For the adult population, CCHA Region 7 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Helpful, Courteous, and Respectful Office Staff*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Adult PCMH CAHPS

For the adult population, CCHA scored statistically significantly lower than the Colorado RAE Aggregate on seven measures: *Rating of Provider*; *Rating of All Health Care*; *Rating of Health Plan*; *How Well Providers Communicate with Patients*; *Providers' Use of Information to Coordinate Patient Care*; *Talking with You About Taking Care of Your Own Health*; and *Comprehensiveness.* HSAG recommends that CCHA Region 7 develop initiatives designed to improve the quality of care provided. In addition, HSAG recommends CCHA Region 7 focus on improving providers' communication skills, care coordination, and providing additional provider training.

CCHA Region 7: Child PCMH CAHPS

Table 3-93 shows the child PCMH CAHPS results for CCHA Region 7 for FY 2018–2019 and FY 2019–2020.

Table 3-93—Child PCMH CAHPS Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of Provider	78.3%	74.6%
Rating of Specialist Seen Most Often	71.6%	75.2%
Rating of All Health Care	77.5%	72.8%
Getting Timely Appointments, Care, and Information	73.4%	65.1%
How Well Providers Communicate with Child	83.7%	82.1%
How Well Providers Communicate with Parents or Caretakers	85.3%	81.8%
Providers' Use of Information to Coordinate Patient Care	72.6%	73.1%
Comprehensiveness—Child Development	64.9%	66.0%
Comprehensiveness—Child Safety and Healthy Lifestyles	55.1%	56.7% ↓
Helpful, Courteous, and Respectful Office Staff	71.2%	67.5%
Received Information on Evening, Weekend, or Holiday Care	82.7%	82.4%
Received Care from Provider Office During Evenings, Weekends, or Holidays	43.0%+	36.4%
Saw Provider Within 15 Minutes of Appointment	46.2%	44.5% ↑
Reminders about Child's Care from Provider Office	70.0%	72.9% ↑

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Due to differences in selected practices between survey years, CCHA's FY 2019–2020 results presented in this report are not comparable to CCHA's FY 2018–2019 results.

CCHA Region 7: Strengths

For the child population, CCHA Region 7 scored statistically significantly higher than the Colorado RAE Aggregate in FY 2019–2020 on two measures: *Saw Provider Within 15 Minutes of Appointment* and *Reminders about Child's Care from Provider Office*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to the Child PCMH CAHPS

For the child population, CCHA Region 7 scored statistically significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on one measure, *Comprehensiveness—Child Safety and Healthy Lifestyles*. HSAG recommends that CCHA Region 7 provide additional provider training on child safety and healthy lifestyles.

ECHO Survey

CCHA Region 7: Adult ECHO Survey

Table 3-94 shows the adult ECHO survey results achieved by CCHA Region 7 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-94—Adult ECHO Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	43.8%	40.0%+
Getting Treatment Quickly	60.2%+	71.3%+
How Well Clinicians Communicate	84.5%	86.0%+
Perceived Improvement	46.6%	61.1% ▲
Amount Helped	76.7%	76.8%+
Cultural Competency	NA	NA
Including Family	48.6%	38.3%+
Information About Self-Help or Support Groups	48.2%	40.4%+
Information to Manage Condition	70.3%	77.7%+
Office Wait	72.6%	86.2%+ ▲
Patient Feels He or She Could Refuse Treatment	80.2%	79.8%+
Privacy	89.9%	93.5%+
Support from Family and Friends	64.9%	61.5%
Told About Medication Side Effects	74.2%+	74.7%+
Improved Functioning	41.8%	52.4%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*

CCHA Region 7: Strengths

For the adult population, CCHA Region 7 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 for two measures: *Perceived Improvement* and *Office Wait*.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Adult ECHO Results

For the adult population, CCHA Region 7 did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure; however, CCHA Region 7 did show a substantial decrease (i.e., at least 5 percentage points) in FY 2019–2020 than in FY 2018–2019 on two measures: *Including Family* and *Information About Self-Help or Support Groups*. HSAG recommends that CCHA Region 7 explore areas that may be contributing to substantially lower experience scores for these measures and develop initiatives for improvement (e.g., communication regarding the importance of family support, providing brochures/educational materials for self-help groups), where appropriate.

CCHA Region 7: Child ECHO Survey

Table 3-95 shows the child ECHO survey results achieved by CCHA Region 7 for FY 2019–2020 compared to results for FY 2018–2019.

Table 3-95—Child ECHO Top-Box Scores for CCHA Region 7

Measure	FY 2018–2019 Score	FY 2019–2020 Score
Rating of All Counseling or Treatment	42.7%	48.2%
Getting Treatment Quickly	73.3%+	73.8%
How Well Clinicians Communicate	89.5%	90.0%
Perceived Improvement	73.2%	63.8% ▼
Amount Helped	84.8%	77.7%
Child Had Someone to Talk To	78.4%	77.5%
Cultural Competency	NA	NA
Information to Manage Condition	75.9%	76.6%
Office Wait	87.4%	91.8%
Privacy	96.3%	92.7%
Respondent Feels He or She Could Refuse Treatment	88.3%	90.1%
Support from Family and Friends	77.8%	67.7%
Told About Medication Side Effects	89.8%+	81.9%+
Improved Functioning	59.8%	51.5%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

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CCHA Region 7: Strengths

For the child population, HSAG found no measures in which CCHA Region 7 scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Child ECHO Results

For the child population, CCHA Region 7 scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for one measure, *Perceived Improvement*. HSAG recommends that CCHA work with the Department to explore areas that may be contributing to a statistically significantly lower experience score for this measure and to develop initiatives for improvement (e.g., promote self-empowerment), where appropriate.

Encounter Data Validation—RAE 411 Audit Over-Read

Table 3-96 presents CCHA Region 7's self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 3-96—Self-Reported EDV Results by Data Element and BH Service Category for CCHA Region 7*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	97.1%	92.0%	89.8%	92.9%
Diagnosis Code	98.5%	99.3%	95.6%	97.8%
Place of Service	96.4%	99.3%	89.8%	95.1%
Service Program Category	81.8%	94.9%	95.6%	90.8%
Units	97.1%	81.8%	78.8%	85.9%
Start Date	97.8%	98.5%	84.7%	93.7%
End Date	97.8%	98.5%	76.6%	91.0%
Appropriate Population	97.8%	98.5%	98.5%	98.3%
Duration	97.8%	97.1%	97.8%	97.6%
Allow Mode of Delivery	96.4%	98.5%	97.8%	97.6%
Staff Requirement	93.4%	89.8%	93.4%	92.2%

** Each service category has a denominator of 137 total cases.*

Table 3-97 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with CCHA Region 7's EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with CCHA Region 7's EDV results for each of the validated data elements. Each data element was overread for 10 cases for each service category.

Table 3-97—BH EDV Over-Read Agreement Results by BH Service Category for CCHA Region 7

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	10	100.0%	110	100.0%
Club House or Drop-In Center Services	8	80.0%	98	89.1%
Residential Services	10	100.0%	110	100.0%
Total	**28**	**93.3%**	**318**	**96.4%**

* *HSAG overread 10 cases for each BH service category.*
** *HSAG overread 11 individual data elements for each case (i.e., a denominator of 110 cases per service category).*

CCHA Region 7: Strengths

CCHA Region 7's EDV documentation described the development of its EDV tools and instructions, reviewer training, reviewers' professional experience, and data abstraction reliability testing. Additionally, CCHA Region 7 described its implementation of CAPs, training, or education for low-scoring providers so as to address deficiencies identified during the EDV. HSAG's over-read results agreed completely with CCHA Region 7's EDV results for the Prevention/Early Intervention Services and Residential Services.

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to RAE 411 EDV

HSAG's over-read findings suggest a high level of confidence that CCHA Region 7's EDV results accurately reflect its encounter data quality. However, CCHA Region 7's self-reported EDV results demonstrated a moderately high level of encounter data accuracy, with the exception of the *Units* data element, when compared to the corresponding medical records. As such, results from HSAG's FY 2019–2020 RAE over-read suggest opportunities for CCHA Region 7 to consider internal processes for ongoing encounter data monitoring, as well as training to ensure clarity on BH service coding accuracy among providers.

Validation of Network Adequacy

CCHA Region 7: Strengths

During FY 2019–2020, CCHA participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used CCHA's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the RAEs' quarterly network adequacy reports. Table 3-98 summarizes HSAG's geoaccess analysis results by county classification for CCHA, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no RAE met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the RAEs are working to address.

Table 3-98—CCHA Region 7's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	14	10	71.4%	14	12	85.7%	14	12	85.7%
Primary Care Time/Distance	14	8	23.2%	26	8	8.8%	20	8	2.1%
Behavioral Health Time/Distance	14	6	51.2%	26	6	68.6%	20	6	71.3%
Facilities Time/Distance	14	3	7.1%	26	3	0.0%	20	3	0.0%

CCHA Region 7: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

CCHA's network included no practitioners attributed to the Gynecology (Mid-Level) or the Pediatric Primary Care Provider (Mid-Level) network categories. Further, CCHA reported no facilities for the Acute Care Hospitals network category. Consequently, CCHA failed to meet the time/distance network standards for those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required standard for CCHA's members.

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for CCHA's data values for provider type, specialty, and credentials. As such, HSAG recommends that CCHA continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

MCO Capitation Initiative—Denver Health Medical Plan

Assessment of Compliance With Medicaid Managed Care Regulations

Denver Health Medical Plan (DHMP) Overall Evaluation

Table 3-99 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 2019–2020.

Table 3-99—Summary of DHMP Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	30	30	29	1	0	0	97%
Standard II—Access and Availability	15	15	13	2	0	0	87%
Standard VI—Grievance and Appeal Systems	35	35	29	6	0	0	83%
Totals	**80**	**80**	**71**	**9**	**0**	**0**	**89%***

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

Table 3-100 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-100—Summary of DHMP Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	52	44	8	38	85%
Grievances	60	51	51	0	9	100%
Appeals	60	50	41	9	10	82%
Totals	**210**	**153**	**136**	**17**	**57**	**89%***

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

DHMP: Strengths

DHMP's UM policies, procedures, and supporting documentation provided evidence that DHMP ensured services were furnished that were sufficient to meet members' needs. DHMP's documents used accurate definitions and included criteria for medical necessity. DHMP's medical staff members reviewed requests for authorizations when needed. NABD letters and extension templates included all required content. Software systems were able to automatically alert reviewers so that time frames for the review of requests and mailing the NABD were upheld. Policies and claims procedures included accurate definitions for "emergency services," "emergency conditions," and "post-stabilization services." In addition, policies described appropriate claims processing for emergency and post-stabilization services.

Denver Health and Hospital Authority (DHHA) was DHMP's primary source of practitioners to serve its Medicaid members. DHMP used geoaccess reports to analyze network adequacy. Network Management Committee minutes provided evidence that DHMP used the geoaccess reports to determine adequacy of geographical access and timeliness of service provision. DHMP produced supporting plans and reports to depict accessibility and adaptive equipment. DHMP's policies and procedures described family planning services and out-of-network options for Medicaid members. DHMP contracted with MedImpact as its pharmacy benefit manager and most DHHA clinic sites also offered on-site pharmacies. DHMP used data analysis to monitor member and provider languages spoken, member language preferences, and ethnicity reported to determine the sufficiency of the network's cultural competency. The member handbook and provider directory included accurate information regarding language, translation, and adaptive services.

Grievance and appeal policies and procedures were comprehensive and largely accurate concerning the requirements. Of the records reviewed, 100 percent demonstrated compliance with procedural requirements. Record review also demonstrated that All-Med Healthcare Management external physicians reviewed all initial adverse benefit determinations and that DHMP medical directors and/or Considine & Associates reviewed appeal decisions. Appeal and grievance information contained in member appeal resolution letters was mostly accurate and the provider manual included an extensive description of DHMP's grievance and appeal policies and procedures.

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

Standard I—Coverage and Authorization of Services

While NABD letters included all required content areas, there were some inaccuracies. DHMP was required to clarify the date an appeal must be filed (60 days from the date of the NABD letter) and the time frame for requesting continuation of services during an appeal (10 days from the date of NABD, or before the intended date of the action). DHMP was also required to remove the statement describing the duration of the continued benefits, and to clarify that a SFH must be requested within 120 days of the appeal resolution letter (not of the NABD).

Standard II—Access and Availability

Although DHMP engaged in regular data analysis of the network, these reports did not include evidence regarding monitoring to ensure that members are scheduled for non-urgent symptomatic care within seven days of request or an outpatient follow-up appointment within seven days after an inpatient hospitalization discharge. DHMP was required to develop a mechanism to track compliance with these timely access standards. Additionally, DHMP did not have a mechanism to monitor its contracted organizational providers for compliance with timely access standards and was required to develop such a mechanism as well as CAPs for providers who do not meet standards.

Standard VI—Grievance and Appeal Systems

While DHMP included mostly accurate information in policies, procedures, and documentation, HSAG found some inaccuracies. DHMP was required to ensure that:

- The NABD offers members assistance with completion of appeals forms and procedures.
- Appeal resolution letters are written in member-friendly language.
- Appeal resolution letters omit references to the appeal process as a potential next step (as the appeal has already occurred).
- Member materials include accurate information regarding requesting continuation of benefits (within 10 days following the date of the NABD or before the intended effective date of the NABD).
- The provider manual contains adequate and accurate information regarding:
  - Filing grievances (at any time).
  - Filing appeals, including that a verbal appeal establishes the date of filing and the time frame for resolving the appeal.
- Continuation of services during an appeal or SFH.

DHMP was also required to remove extraneous information from the provider manual related to appeals regarding filing "related documents."

DHMP: Trended Performance for Compliance With Regulations

Table 3-101—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 (2016–2017, 2019–2020)*	**94%**	**97%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**92%**	**87%**

Standard and Applicable Review Years	DHMP Average—Previous Review	DHMP Average—Most Recent Review
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 Systems (2017–2018, 2019–2020)*	**86%**	**83%**
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 2019–2020.*

Trended scores over the past two review cycles indicates that DHMP improved performance in 5 of the 11 standards, one of which was reviewed in FY 2019–2020. In FY 2019–2020, DHMP's performance in Standard I—Coverage and Authorization of Services improved slightly (less than 10 percentage points) by 3 percentage points and Standard II—Access and Availability and Standard VI—Grievance and Appeal Systems both decreased slightly by five and three percentage points respectively. The most significant decline in performance in the most recent year the standard was reviewed when compared to the previous review, was Standard IX—Subcontracts and Delegation which decreased from 100 percent to zero percent compliance. Followed by a substantial (10 percentage points or more) decrease of 22 percentage points in Standard III—Coordination and Continuity of Care and a 20 percentage point decrease in Standard VII—Provider Participation and Program Integrity. DHMP maintained 100 percent compliance with Standard IV—Member Rights and Protections. The most substantial improvements in performance when compared to the previous year the standard was reviewed were Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services which increased by 24 percentage points, followed by a 13 percentage point improvement in Standard V—Member Information. Slight increases were noted for Standard VIII—Credentialing and Recredentialing and Standard X—Quality Assessment and Performance Improvement. HSAG cautions that, over the three-year cycle, and between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the Compliance Monitoring results over review cycles. HSAG recommends that DHMP continue efforts to achieve full compliance with regulations as demonstrated in previous review cycles and focus on coming into compliance for Standards scoring below 90 percent compliance.

HEDIS Measure Rates and Validation

DHMP: Information Systems Standards Review

According to the 2020 HEDIS Compliance Audit Report, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO'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 3-102 shows the performance measure results for DHMP for HEDIS 2018 through HEDIS 2020, along with the percentile ranking for each HEDIS 2020 rate.

Table 3-102—Performance Measure Results for DHMP

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 2	68.27%	67.97%	69.65%	25th–49th
Combination 3	65.94%	64.72%	66.67%	25th–49th
Combination 4	64.23%	64.60%	66.35%	25th–49th
Combination 5	58.09%	56.73%	57.78%	25th–49th
Combination 6	43.39%	45.13%	48.03%	75th–89th
Combination 7	56.77%	56.61%	57.63%	25th–49th
Combination 8	42.53%	45.07%	48.03%	75th–89th
Combination 9	39.50%	40.69%	42.85%	75th–89th
Combination 10	38.80%	40.63%	42.85%	75th–89th
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	75.69%	76.89%	78.06%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	47.30%	49.46%	50.47%	≥90th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	9.12%	7.08%	4.84%	<10th
Six or More Visits	4.39%	52.28%	55.57%	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	60.91%	63.59%	64.53%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	36.33%	41.29%	40.10%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	16.75%	21.89%	25.11%^	<10th
Counseling for Nutrition—Total	5.97%	7.45%	9.16%	<10th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Counseling for Physical Activity—Total	1.36%	5.90%	8.08%	<10th
Access to Care				
Prenatal and Postpartum Care[2]				
Timeliness of Prenatal Care	—	—	84.53%	—
Postpartum Care	—	—	66.50%	—
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	86.84%	88.52%	89.11%	<10th
Ages 25 Months to 6 Years	72.12%	75.09%	74.46%	<10th
Ages 7 to 11 Years	75.53%	80.08%	80.05%	<10th
Ages 12 to 19 Years	75.43%	80.30%	79.19%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	55.19%	53.89%	55.30%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Total	66.68%	69.58%	72.91%^	≥90th
Breast Cancer Screening				
Breast Cancer Screening	50.65%	46.48%	46.01%	<10th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	43.03%	43.07%	45.58%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.14%	0.00%	0.04%	≥90th
Adult BMI Assessment				
Adult BMI Assessment	83.25%	81.44%	80.35%	10th–24th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	54.88%	54.20%	57.19%	75th–89th
Effective Continuation Phase Treatment	33.52%	33.96%	37.69%	50th–74th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	37.40%	39.69%	41.35%	25th–49th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics[2]				
Blood Glucose Testing—Total	—	—	NA	—
Cholesterol Testing—Total	—	—	NA	—
Blood Glucose and Cholesterol Testing—Total	NB	46.34%	NA	—

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	69.77%	46.88%	NA	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	82.16%	82.06%	83.00%	10th–24th
*HbA1c Poor Control (>9.0%)**	42.92%	40.38%	40.51%	25th–49th
HbA1c Control (<8.0%)	45.45%	47.88%	48.96%	25th–49th
Eye Exam (Retinal) Performed	46.59%	45.83%	45.70%	10th–24th
Medical Attention for Nephropathy	82.47%	81.51%	83.75%	<10th
Blood Pressure Control (<140/90 mm Hg)	64.01%	61.67%	63.49%	25th–49th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	54.64%	57.75%	61.74%	25th–49th
Statin Adherence 80%[1]	59.47%	60.63%	67.58%^	75th–89th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	75.00%	72.41%	76.14%	25th–49th
Statin Adherence 80%—Total[1]	58.33%	69.52%	64.18%	25th–49th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	69.33%	72.83%	77.62%^	75th–89th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	55.69%	50.34%	59.82%^	10th–24th
Bronchodilator	67.06%	72.21%	74.49%	10th–24th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	54.19%	58.80%	61.84%	50th–74th
Medication Compliance 75%—Total	27.75%	33.10%	36.05%	25th–49th
Asthma Medication Ratio				
Total	63.77%	46.60%	46.60%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.44%	28.57%	26.19%	25th–49th
Antibiotic Stewardship				
Appropriate Testing for Pharyngitis[2]				
Total	—	—	85.51%	—
Appropriate Treatment for Upper Respiratory Infection[2]				
Total	—	—	96.35%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[2]				
Total	—	—	79.61%	—
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.31	0.32	0.34	≥90th
Average Days Supplied per Antibiotic Script—Total	9.27	9.44	9.54	25th–49th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Average Scripts PMPY for Antibiotics of Concern—Total	0.09	0.09	0.10	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	27.52%	28.74%	28.99%	≥90th
Opioids				
Use of Opioids at High Dosage* [2]				
Use of Opioids at High Dosage	—	—	5.85%	—
Use of Opioids From Multiple Providers*				
Multiple Pharmacies	—	12.09%	6.17%^	25th–49th
Multiple Prescribers	—	18.61%	16.11%	75th–89th
Multiple Prescribers and Multiple Pharmacies	—	6.32%	4.41%	25th–49th
Risk of Continued Opioid Use*				
At Least 15 Days Covered—Total	—	—	5.40%	50th–74th
At Least 31 Days Covered—Total	—	—	2.35%	75th–89th
Pharmacotherapy for Opioid Use Disorder				
Total—Total	—	—	15.91%	—
Use of Services				
Ambulatory Care—Total				
*Emergency Department Visits—Total—Total**	41.79	43.95	45.35	75th–89th
Outpatient Visits—Total—Total	183.12	203.78	215.69	<10th
Inpatient Utilization—General Hospital/Acute Care—Total				
Discharges per 1,000 Member Months (Total Inpatient)—Total	4.58	5.06	5.79	25th–49th
Average Length of Stay (Total Inpatient)—Total	4.73	4.59	4.40	50th–74th
Discharges per 1,000 Member Months (Medicine)—Total	2.55	2.90	3.39	50th–74th
Average Length of Stay (Medicine)—Total	4.25	4.17	3.92	25th–49th
Discharges per 1,000 Member Months (Surgery)—Total	0.78	0.90	1.06	25th–49th
Average Length of Stay (Surgery)—Total	9.40	8.49	8.23	75th–89th
Discharges per 1,000 Member Months (Maternity)—Total	1.75	1.72	1.80	10th–24th
Average Length of Stay (Maternity)—Total	2.77	2.76	2.58	10th–24th
Plan All-Cause Readmissions* [2]				
Observed Readmissions—Total	—	—	13.79%	—
O/E Ratio—Total	—	—	1.26	—

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

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 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 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.

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 statistically significant improvement in performance from the previous year.

DHMP: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for DHMP (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2019):

- *Childhood Immunization Status—Combinations 6, 8, 9, and 10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Chlamydia Screening in Women—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Statin Therapy for Patients With Diabetes—Statin Adherence 80%*
- *Use of Imaging Studies for Low Back Pain*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*
- *Risk of Continued Opioid Use—At Least 31 Days Covered—Total*

For HEDIS 2020, DHMP demonstrated strength with immunizations, as evidenced by the following measure rates above the 75th percentile: *Childhood Immunization Status—Combinations 6, 8, 9, and 10* and *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*. 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* ranking above the 90th percentile. DHMP's rates for *Statin Therapy for Patients With Diabetes—Statin Adherence 80%* and *Use of Imaging Studies for Low Back Pain* showed statistically significant improvements and measured above the 75th percentile.

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

The following HEDIS 2020 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 2019):

- *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*
- *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*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*

For HEDIS 2020, DHMP 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 domain and several measures within the Preventive Screening domain (i.e., *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Adult BMI Assessment*) falling below the 25th percentile. Additionally, several measures within the Pediatric Care domain (i.e., *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Adolescent Well-Care Visits*; and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*) fell 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.

Validation of DHMP's Performance Improvement Project

Table 3-103 and Table 3-104 display the FY 2019–2020 validation findings for DHMP's *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP. During FY 2019–2020, DHMP completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by DHMP are summarized in Table 3-103.

Table 3-103—Intervention Determination Summary for the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Member does not show up for the scheduled appointment	• Education and communication to members about the importance of an adolescent well-care (AWC) visit • Communication regarding free transportation to appointment options − Potential intervention methods to be tested include: o Enlisting Webb Pediatrics patient navigators or the plan's Ambulatory Care Services (ACS) central patient navigators to call the parents/guardians of members with birthdays in the next calendar month who have not had a well-child visit in over a year to remind

Failure Modes	Potential Interventions
	them of the importance of an AWC visit and inform them of available free transportation services and tracking resulting appointments through the plan's Epic system and/or claims database o Sending mobile text messages to parents/guardians of members who are not current on their AWC to educate them on the importance of an AWC visit, how to schedule, and how to receive free transportation and track resulting appointments through Epic and/or the claims database o Creating a script for Webb Pediatrics Clinic staff members to follow when making reminder calls for scheduled appointments that will include information regarding the importance of attending an AWC appointment and questions and answers regarding free transportation options to the appointment with clinic staff members documenting both calls and results • Decisions regarding interventions will be made in consultation with Webb Pediatrics Clinic staff members, ACS analytics staff members, and through small feasibility tests
Clinic is not offering convenient appointment times (after school/work or weekends)	• When parent/guardian of member calls the appointment center, educate them about the option of scheduling an AWC visit at a school-based health center (SBHC); at Webb Pediatrics clinic and through DHMP, provide outreach and education about SBHCs including sharing with the parent/guardian the consent form for member to be seen at an SBHC • Allow for scheduling of AWC appointments via the appointment center 60 days out instead of the current 30-day scheduling limit
Clinic staff members are unable to reach parent/guardian via phone call to confirm appointment	Send e-notifications through Denver Health's Epic MyChart—a software application connected to the member's Denver Health electronic medical record that allows the member to access medical information, schedule appointments, and communicate with providers—or mobile SMS text messages to parents/guardians of members with upcoming appointments

DHMP also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-104 summarizes the intervention DHMP selected for testing.

Table 3-104—Planned Intervention for the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP

Intervention Description	Key Drivers	Failure Mode
Education and communication to members about the importance of AWC visits and free transportation to appointment options	• Member compliance with well-care visits • Transportation to visits	Member does not show up for the scheduled appointment

DHMP: Strengths

DHMP continued work on a PIP focused on increasing the rate of adolescent well-care visits among members 15 to 18 years of age. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for members to obtain an adolescent well-care visit and considered potential interventions to address identified process flaws or gaps and increase the percentage of members who receive an adolescent well-care visit. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

Summary Assessment of Opportunities for Improvement and Recommendations Related to the DHMP PIP

After initiating Module 4, DHMP had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected interventions on well-child visit rates. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Survey

Table 3-105 shows the adult Medicaid CAHPS results achieved by DHMP for FY 2017–2018 through FY 2019–2020.

Table 3-105—Adult Medicaid Top-Box Scores for DHMP

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	77.5%	71.8%	74.5% ↓
Getting Care Quickly	78.0%	74.7%	73.5% ↓
How Well Doctors Communicate	92.5%	92.0%	94.2%
Customer Service	85.7%	90.0%+	89.1%+
Rating of Personal Doctor	70.9%	66.0%	69.6%
Rating of Specialist Seen Most Often	61.4%+	70.7%+	74.1%+
Rating of All Health Care	52.2%	50.3%	55.5%
Rating of Health Plan	59.1%	56.4%	60.3%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

DHMP: Adult Medicaid Strengths

For the adult Medicaid population, HSAG found no measures in which DHMP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 or in which DHMP scored statistically significantly above the 2019 NCQA national average.

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

For the adult Medicaid population, DHMP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure. However, DHMP scored statistically significantly below the 2019 NCQA national average on two measures: *Getting Needed Care* and *Getting Care Quickly*. HSAG recommends that DHMP develop initiatives designed to improve access and timeliness of services provided.

Table 3-106 shows the child Medicaid CAHPS results achieved by DHMP for FY 2017–2018 through FY 2019–2020.

Table 3-106—Child Medicaid Top-Box Scores for DHMP

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	84.8%	78.2%	75.1%+
Getting Care Quickly	86.1%	87.2%	80.5%+ ↓
How Well Doctors Communicate	94.7%	95.5%	94.9%+
Customer Service	91.2%	86.1%+	89.0%+
Rating of Personal Doctor	86.0%	85.9%	78.8%
Rating of Specialist Seen Most Often	75.0%+	75.7%+	60.9%+
Rating of All Health Care	76.9%	73.5%	66.0%+
Rating of Health Plan	77.0%	73.2%	67.4%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

DHMP: Child Medicaid Strengths

For the child Medicaid population, HSAG found no measures in which DHMP scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 or statistically significantly above the 2019 NCQA national average.

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

For the child Medicaid population, DHMP did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure. However, DHMP scored statistically significantly below the 2019 NCQA national average on one measure, *Getting Care Quickly*. HSAG recommends that DHMP develop initiatives designed to improve timeliness of services provided.

Encounter Data Validation—DHMP 412 Audit Over-Read

FY 2019–2020 was DHMP's fifth year participating in the independent MCO EDV and subsequent over-read. DHMP validated 103 cases from each of four service categories and Table 3-107 presents DHMP's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-107—Self-Reported EDV Results by Data Element and Service Category for DHMP

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	88%	92%	91%	100%
Through Date	88%	NA	NA	NA
Primary Diagnosis Code	80%	82%	63%	85%
Primary Surgical Procedure Code	85%	NA	NA	NA
Discharge Status	89%	NA	NA	NA
Procedure Code	NA	74%	79%	83%
Procedure Code Modifier	NA	92%	86%	97%
Units	NA	87%	91%	96%

DHMP provided medical record documentation for all sampled over-read cases and Table 3-108 presents DHMP's FY 2019–2020 EDV over-read case-level and element-level accuracy rates by service category. HSAG's over-read results indicated complete agreement with DHMP's internal EDV results for 77 of the 80 sampled encounters, resulting in a 96.3 percent agreement rate. The overall agreement rate is greater than the 85.0 percent overall agreement rate from the FY 2018–2019 EDV.

Table 3-108—Percent of Cases in Total Agreement and Percent of Element Accuracy for DHMP

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	22	100.0%	132	100.0%
Outpatient	18	88.9%	90	93.3%
Professional	20	100.0%	100	100.0%
FQHC	20	95.0%	100	99.0%
Total	**80**	**96.3%**	**422**	**98.3%**

DHMP: Strengths

Overall results from HSAG's FY 2019–2020 MCO over-read continue to show improved agreement between HSAG's and DHMP's reviewers compared to the previous year; HSAG's reviewers agreed with DHMP's reviewers for 98.3 percent of the individually reviewed data elements. Additionally, HSAG's over-read results agreed completely with DHMP's EDV results for the Inpatient and Professional encounters. Finally, DHMP's 412 internal EDV results show a higher level of service coding accuracy among FQHC encounters compared to the other validated service categories.

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

HSAG's over-read findings suggest a high level of confidence that DHMP's EDV results accurately reflect its encounter data quality. However, DHMP's self-reported EDV results demonstrated a lower level of encounter data accuracy for diagnosis and procedure codes when compared to the corresponding medical records. Additionally, DHMP's EDV documentation did not confirm whether or not DHMP implemented CAPs, training, or education for low-scoring providers to address deficiencies identified during the EDV. As such, results from HSAG's FY 2019–2020 MCO over-read suggest opportunities for DHMP to consider internal processes for ongoing encounter data monitoring, as well as training to ensure contracted providers are able to code and submit encounters that accurately reflect medical record documentation for the procedures rendered and the corresponding diagnoses.

Validation of Network Adequacy

DHMP: Strengths

During FY 2019–2020, DHMP participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used DHMP's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the Medicaid MCOs' quarterly network adequacy reports. Table 3-109 summarizes HSAG's geoaccess analysis results by county classification for DHMP, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no Medicaid MCO met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the Medicaid MCOs are working to address.

Table 3-109—DHMP's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	28	21	75.0%	28	28	100%	28	28	100%
Primary Care Time/Distance	14	8	58.5%	27	8	11.2%	13	8	1.4%
Behavioral Health Time/Distance	14	20	51.5%	27	20	17.0%	13	20	31.1%
Facilities Time/Distance	14	2	28.6%	27	2	50.0%	13	2	50.0%

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

DHMP's failure to meet the network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for a limited number of members (i.e., fewer than five members).

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for DHMP's data values for provider type, specialty, and credentials. As such, HSAG recommends that DHMP continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

MCO Capitation Initiative—Rocky Mountain Health Plans Medicaid Prime

Assessment of Compliance With Medicaid Managed Care Regulations

Rocky Mountain Health Plans Medicaid Prime (RMHP Prime) Overall Evaluation

Table 3-110 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 2019–2020.

Table 3-110—Summary of RMHP Prime Scores for the FY 2019–2020 Standards Reviewed

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
Standard I—Coverage and Authorization of Services	34	30	27	3	0	4	90%
Standard II—Access and Availability	16	15	16	0	0	1	100%
Standard VI—Grievance and Appeal Systems	35	35	30	5	0	0	86%
Totals	**85**	**80**	**73**	**8**	**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.*

Table 3-111 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2019–2020.

Table 3-111—Summary of RMHP Prime Scores for the FY 2019–2020 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Denials	90	58	54	4	32	93%
Grievances	60	48	46	2	12	96%
Appeals	60	55	50	5	5	91%
Totals	**210**	**161**	**150**	**11**	**49**	**93%***

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

RMHP Prime: Strengths

RMHP Prime submitted a large body of evidence to substantiate compliance with coverage and authorization services. Policies, procedures, reports, work plans, tools, manuals, and sample denial and authorization timeline extension letters illustrated a comprehensive approach for review, authorization, and denial of services. UM functions were delegated to eviCore for specific services and RMHP Prime maintained oversight of these delegated activities. Record reviews of denial records demonstrated that NABDs included required content and that staff members made efforts to call members in addition to notifying members of the denial through mail. Policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions and, through interview discussions, RMHP Prime staff members reported that claims for emergency and post-stabilization services were processed according to federal regulations.

Network capacity reports were used by RMHP Prime to ensure maintenance of a sufficient provider network to cover services for RMHP Prime members. The network included family planning and options for out-of-network providers when needed. Network capacity reports demonstrated the number of PCP and specialist providers, provider-to-member ratios, and compliance with time and distance standards. While rural access was a challenge, telemedicine was used wherever possible. Timely access standards were clearly stated in public and internal documents and RMHP Prime monitored for timely access through member surveys. Cultural competency was addressed through an array of policies and an online educational series.

Policies and procedures thoroughly defined operations for both appeals and grievances, and included accurate definitions and an explanation of the role of a designated representative. Through on-site record review, HSAG found that RMHP Prime staff members routinely followed up on orally submitted appeals to prompt the member to submit the written appeal. HSAG found on-site grievance record reviews 100 percent compliant with the following record review elements: acknowledgement letter sent within required time frame, resolution letter sent in the required time frame, resolution by a person not previously involved, and resolution letter easy to understand. RMHP Prime contracted with Optum physician advisors to ensure appropriate clinical review, with oversight maintained by RMHP Prime medical directors. HSAG found on-site appeal record reviews 100 percent compliant with the following record review elements: acknowledgement letter sent within the required time frame, resolution letter sent in the required time frame, resolution by a person not previously involved and with appropriate clinical expertise, and the resolution letter includes required content.

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

Standard I—Coverage and Authorization of Services

RMHP Prime's policies included inaccurate information regarding prior authorization time frames; RMHP Prime was required to update these documents to accurately describe the 10-calendar day time frame for making standard authorization decisions and the 14-calendar day time frame for extension of

the authorization decisions. RMHP Prime was also required to develop a mechanism to ensure required time frames are met and that the NABD includes member-friendly language.

Standard VI—Grievance and Appeal Systems

Due to one grievance decision being referred back to the member's treating provider, RMHP Prime was required to:

- Develop a mechanism to ensure that any grievance regarding clinical issues is reviewed and resolved by an RMHP Prime clinician with appropriate clinical expertise in treating the member's condition.
- Develop a mechanism to ensure that each member grievance is specifically and thoroughly addressed by RMHP Prime staff members.

HSAG found that five of the 10 member appeal letters reviewed included extensive clinical language; therefore, RMHP Prime was required to develop a mechanism to ensure member letters are written at the sixth-grade reading level.

RMHP Prime's appeal policy and procedures included inaccurate information; RMHP Prime was required to ensure that policies, procedures, and related documents clearly state:

- Continuation of services during the appeal must be requested within 10 days of the NABD, or before the intended effective date of the action, whereas the appeal may be filed within 60 days from the NABD.
- That criteria for requesting the continuation of benefits, "the original period covered by the original authorization has not expired," only applies to requesting continuation during the appeal period, not when requesting a SFH.
- That "the time period or service limits of a previously authorized service has been met" is criteria only when initially requesting continuation of benefits during an appeal, but does not apply once services have been continued and does not apply to the request for continuation during the SFH.

RMHP Prime: Trended Performance for Compliance With Regulations

Table 3-112—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 (2016–2017, 2019–2020)*	**94%**	**90%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**100%**	**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 and Applicable Review Years	RMHP Prime Average—Previous Review	RMHP Prime Average—Most Recent Review
Standard V—Member Information (2017–2018, 2018–2019)	100%	83%
Standard VI—Grievance and Appeal Systems (2017–2018, 2019–2020)*	**89%**	**86%**
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 2019–2020.*

Trended scores from the previous cycle as compared to the most recent year the standard was reviewed show ongoing full compliance with four standards: Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard VIII—Credentialing and Recredentialing, and Standard IX—Subcontracts and Delegation. Two additional standards met 100 percent compliance in the most recent year the standards were reviewed: Standard X—Quality Assessment and Performance Improvement and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance performance was maintained at 93 percent for Standard VII—Provider Participation and Program Integrity across review cycles. RMHP Prime improved performance slightly in Standard IV—Member Rights and Protections, increasing from 80 to 86 percent. In Standard V—Member Information RMHP Prime's performance decreased substantially from 100 percent compliance to 83 percent (a 17 percentage point decline) and RMHP Prime experienced slightly decreased performance in both Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems in the most recent year of review when compared to the previous year the same standard was reviewed. HSAG cautions; however, that over the three-year cycle and between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the Compliance Monitoring results over review periods. HSAG recommends that RMHP Prime continues efforts to maintain full compliance with applicable standards and focus efforts on standards in which performance was below 90 percent compliance in the most recent review period, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard VI—Grievance and Appeal Systems.

HEDIS Measure Rates and Validation

RMHP Prime: Information Systems Standards Review

According to the 2020 HEDIS Compliance Audit Report, RMHP Prime was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO'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 3-113 shows the performance measure results for RMHP Prime for HEDIS 2018 through HEDIS 2020, along with the percentile ranking for each HEDIS 2020 rate.

Table 3-113—Performance Measure Results for RMHP Prime

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 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	54.29%	NA	—
Combination 2 (Meningococcal, Tdap, HPV)	NA	14.29%	NA	—
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	NR	NA	—
Six or More Visits	NA	NR	NA	—
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	58.21%	61.90%	60.42%	<10th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	15.68%	17.66%	17.66%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	3.18%	4.37%	5.86%	<10th
Counseling for Nutrition—Total	15.55%	15.53%	20.08%	<10th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Counseling for Physical Activity—Total	0.71%	0.00%	1.26%	<10th
Access to Care				
Prenatal and Postpartum Care[2]				
Timeliness of Prenatal Care	—	—	42.00%	—
Postpartum Care	—	—	35.92%	—
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	NA	NA	NA	—
Ages 25 Months to 6 Years	87.84%	81.82%	85.71%	25th–49th
Ages 7 to 11 Years	90.36%	86.21%	88.46%	25th–49th
Ages 12 to 19 Years	91.12%	89.13%	88.76%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services				
Total	70.93%	71.84%	72.10%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Total	49.26%	46.46%	47.77%	10th–24th
Breast Cancer Screening				
Breast Cancer Screening	50.44%	50.10%	48.04%	10th–24th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	43.21%	41.93%	39.39%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	2.12%	2.86%	2.00%	10th–24th
Adult BMI Assessment				
Adult BMI Assessment	17.25%	27.74%	38.95%^	<10th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.34%	52.20%	73.71%^	≥90th
Effective Continuation Phase Treatment	34.46%	33.85%	64.85%^	≥90th
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[2]				
Blood Glucose Testing—Total	—	—	43.33%	—
Cholesterol Testing—Total	—	—	26.67%	—
Blood Glucose and Cholesterol Testing—Total	21.95%	20.00%	26.67%	10th–24th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.94%	84.59%	84.59%	10th–24th
*HbA1c Poor Control (>9.0%)**	70.68%	76.08%	76.08%	<10th
HbA1c Control (<8.0%)	25.19%	19.55%	19.55%	<10th
Eye Exam (Retinal) Performed	7.47%	50.14%	50.14%	10th–24th
Medical Attention for Nephropathy	82.98%	83.21%	83.21%	<10th
Blood Pressure Control (<140/90 mm Hg)	0.00%	8.91%	8.91%	<10th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	43.37%	46.70%	43.04%	<10th
Statin Adherence 80%[1]	57.33%	60.05%	85.57%^	≥90th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	71.96%	64.86%	57.44%	<10th
Statin Adherence 80%—Total[1]	68.38%	60.83%	92.86%^	≥90th
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	72.70%	71.67%	72.76%	50th–74th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	44.50%	40.28%	37.33%	<10th
Bronchodilator	54.13%	56.48%	54.22%	<10th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	63.25%	64.91%	82.40%^	≥90th
Medication Compliance 75%—Total	38.89%	38.60%	66.09%^	≥90th
Asthma Medication Ratio				
Total	52.07%	53.74%	48.40%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	34.87%	30.09%	29.46%	25th–49th
Antibiotic Stewardship				
Appropriate Testing for Pharyngitis[2]				
Total	—	—	73.66%	—
Appropriate Treatment for Upper Respiratory Infection[2]				
Total	—	—	88.24%	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[2]				
Total	—	—	47.83%	—
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.70	0.64	0.65	75th–89th
Average Days Supplied per Antibiotic Script—Total	9.32	9.11	18.21	<10th

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Average Scripts PMPY for Antibiotics of Concern—Total	0.28	0.25	0.25	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	39.55%	39.52%	38.88%	50th–74th
Opioids				
Use of Opioids at High Dosage* [2]				
Use of Opioids at High Dosage	—	—	8.84%	—
Use of Opioids From Multiple Providers*				
Multiple Pharmacies	—	4.22%	1.91%	≥90th
Multiple Prescribers	—	25.73%	57.73%^^	<10th
Multiple Prescribers and Multiple Pharmacies	—	2.79%	1.91%	75th–89th
Risk of Continued Opioid Use*				
At Least 15 Days Covered—Total	—	—	13.01%	10th–24th
At Least 31 Days Covered—Total	—	—	4.25%	25th–49th
Pharmacotherapy for Opioid Use Disorder				
Total—Total	—	—	54.02%	—
Use of Services				
Ambulatory Care—Total				
*Emergency Department Visits—Total—Total**	62.98	61.52	60.25	25th–49th
Outpatient Visits—Total—Total	317.25	326.38	341.87	25th–49th
Inpatient Utilization—General Hospital/Acute Care—Total				
Discharges per 1,000 Member Months (Total Inpatient)—Total	9.01	9.42	9.96	≥90th
Average Length of Stay (Total Inpatient)—Total	3.62	3.68	4.27	25th–49th
Discharges per 1,000 Member Months (Medicine)—Total	4.20	4.39	4.65	75th–89th
Average Length of Stay (Medicine)—Total	3.70	3.74	4.00	25th–49th
Discharges per 1,000 Member Months (Surgery)—Total	2.12	2.23	2.57	≥90th
Average Length of Stay (Surgery)—Total	5.39	5.26	6.81	25th–49th
Discharges per 1,000 Member Months (Maternity)—Total	2.83	2.96	2.93	50th–74th
Average Length of Stay (Maternity)—Total	2.10	2.33	2.35	<10th
Plan All-Cause Readmissions*,[2]				
Observed Readmissions—Total	—	—	9.87%	—
O/E Ratio—Total	—	—	1.02	—

**For this indicator, a lower rate indicates better performance.*
1 Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 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 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2018 or HEDIS 2019.
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR (Not Reported) indicates that the MCO did not report the measure.
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.

RMHP Prime: Strengths

The following HEDIS 2020 measure rates were determined to be high performers for RMHP Prime (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2019):

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Statin Therapy for Patients With Diabetes—Statin Adherence 80%*
- *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*

For HEDIS 2020, RMHP Prime demonstrated strength in measures related to Living With Illness, as evidenced by the following measure rates demonstrating statistically significant improvements and exceeding the 90th percentile: *Statin Therapy for Patients With Diabetes—Statin Adherence 80%*, *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*, and *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*. RMHP Prime's measure indicator rates for *Antidepressant Medication Management*, in the Mental/Behavioral Health domain, also demonstrated statistically significant improvements and exceeded the 90th percentile.

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

The following HEDIS 2020 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 2019):

- *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*
- *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—Blood Glucose and Cholesterol Testing—Total*
- *Comprehensive Diabetes Care—Hemoglobin A1c (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*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*
- *Risk of Continued Opioid Use—At Least 15 Days Covered—Total*

For HEDIS 2020, 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 Pediatric 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, chronic obstructive pulmonary disease [COPD], and asthma) and use of opioids 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 or pain.

Validation of RMHP Prime's Performance Improvement Project

Table 3-114 and Table 3-115 display the FY 2019–2020 validation findings for RMHP Prime's *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP. During FY 2019–2020, RMHP Prime completed Module 3—Intervention Determination and identified potential interventions to address high-priority subprocesses and failure modes. The failure modes and potential interventions identified by RMHP Prime are summarized in Table 3-114.

Table 3-114—Intervention Determination for the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP

Failure Modes	Potential Interventions
Member changes their mind after initially agreeing to MAT for SUD	• Use of a Comprehensive Recovery and Family Therapy (CRAFT) approach to engage family support at initial and subsequent SUD treatment visits to help increase commitment level for engaging treatment • Engage Peer Support services to meet with member initiating SUD treatment • Partner with Mind Springs, a behavioral health facility, to develop a referral and care plan for members initiating SUD treatment
Member does not show up to SUD assessment visit	• Use of a CRAFT approach to engage family support at initial and subsequent SUD treatment visits to help increase commitment level for engaging treatment • Engage Peer Support services to meet with member initiating SUD treatment • Partner with Mind Springs, a behavioral health facility, to develop a referral and care plan for members initiating SUD treatment
Member does not agree to MAT treatment for SUD	• Use of a CRAFT approach to engage family support at initial and subsequent SUD treatment visits to help increase commitment level for engaging treatment • Engage Peer Support services to meet with member initiating SUD treatment • Partner with Mind Springs, a behavioral health facility, to develop a referral and care plan for members initiating SUD treatment

RMHP Prime also initiated Module 4 in FY 2019–2020, selecting an intervention to test and developing the plan for testing through PDSA cycles. Table 3-115 summarizes the intervention RMHP Prime selected for testing.

Table 3-115—Planned Intervention for the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP

Intervention Description	Key Driver	Failure Modes
Use of a CRAFT approach to engage family support at initial and subsequent SUD treatment visits to help increase commitment level for engaging in SUD treatment	Primary care offices refer to and coordinate care with addiction specialists at community mental health centers (CMHCs) and methadone clinics	• Member changes their mind after initially agreeing to MAT for SUD • Member does not show up to SUD assessment visit • Member does not agree to MAT treatment for SUD

RMHP Prime: Strengths

RMHP Prime continued work on a PIP focused on increasing the percentage of members who receive effective pharmacotherapy for SUD treatment. The health plan passed Module 3 and achieved all validation criteria for this module of the PIP. The health plan identified and analyzed opportunities for improving the process for engaging members diagnosed with SUDs in medication-assisted treatment (MAT) and considered potential interventions to address identified process flaws or gaps and increase the percentage of members diagnosed with SUD who initiate MAT within 60 days of diagnosis. The health plan also successfully initiated Module 4 for the PIP by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. The health plan was originally scheduled to continue testing interventions through the end of the FY; however, due to the COVID-19 pandemic, the PIP was closed out early.

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

After initiating Module 4, RMHP Prime had the opportunity to carry out the intervention testing plan, conducting PDSA cycles, to determine the effectiveness and impact of the selected intervention on engagement in effective pharmacotherapy for SUD treatment. HSAG provided the following recommendations as guidance for successful intervention evaluation and assessment of improvement throughout the duration of the project:

- When planning a test of change, clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the project goal.
- Consistently use approved measure definitions, and data collection and calculation methods, for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- When reporting the final PIP conclusions, accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.

CAHPS Survey—RMHP Prime

Table 3-116 shows the adult Medicaid CAHPS results achieved by RMHP Prime for FY 2017–2018 through FY 2019–2020.

Table 3-116—Adult Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	82.5%	84.2%	84.5%
Getting Care Quickly	85.8%	82.6%	83.1%
How Well Doctors Communicate	92.2%	95.1%	93.4%
Customer Service	88.9%+	93.8%+	94.7%+ ↑
Rating of Personal Doctor	68.7%	74.4%	75.1% ↑
Rating of Specialist Seen Most Often	64.5%	69.6%	66.7%+
Rating of All Health Care	61.4%	64.3%	58.6%
Rating of Health Plan	56.5%	69.1%	68.3% ↑

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly above the 2019 NCQA national average.*

RMHP Prime: Adult Medicaid Strengths

For the adult Medicaid population, RMHP Prime did not score statistically significantly higher in FY 2019–2020 than in FY 2018–2019 on any measure. However, RMHP Prime scored statistically significantly above the 2019 NCQA national average on three measures: *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

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

For the adult Medicaid population, RMHP Prime did not score statistically significantly lower in FY 2019–2020 than in FY 2018–2019 on any measure. In addition, RMHP Prime did not score statistically significantly below the 2019 NCQA national average on any measure. While member experience scores for RMHP Prime's adult Medicaid population have fluctuated, either increasing or decreasing slightly, across the years, the *Rating of All Health Care* measure score decreased more than 5 percentage points in FY 2019–2020 than in FY 2018–2019 and remained RMHP Prime's lowest performing measure across the two years. 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 3-117 shows the child Medicaid CAHPS results achieved by RMHP Prime for FY 2017–2018 through FY 2019–2020.

Table 3-117—Child Medicaid Top-Box Scores for RMHP Prime

Measure	FY 2017–2018 Score	FY 2018–2019 Score	FY 2019–2020 Score
Getting Needed Care	89.8%+	91.5%+	NA
Getting Care Quickly	95.3%+	88.4%+	NA
How Well Doctors Communicate	96.9%+	89.6%+	NA
Customer Service	89.3%+	85.7%+	NA
Shared Decision Making	92.1%+	93.2%+	NA
Rating of Personal Doctor	87.5%+	71.7%+	NA
Rating of Specialist Seen Most Often	74.1%+	75.0%+	NA
Rating of All Health Care	63.0%+	68.8%+	NA
Rating of Health Plan	68.5%+	71.4%+	NA

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.

NA indicates that RMHP Prime was not required to submit child Medicaid CAHPS data for reporting purposes in FY 2019–2020; therefore, results are not available.

Encounter Data Validation—RMHP Prime 412 Audit Over-Read

FY 2019–2020 was RMHP Prime's second year participating in the independent MCO EDV and subsequent over-read. RMHP Prime validated 103 cases from each of four service categories and Table 3-118 presents RMHP Prime's self-reported encounter data service coding accuracy results by service category and validated data element.

Table 3-118—Self-Reported EDV Results by Data Element and Service Category for RMHP Prime

Data Element	Inpatient	Outpatient	Professional	FQHC
Date of Service	90%	68%	75%	74%
Through Date	91%	NA	NA	NA
Primary Diagnosis Code	90%	59%	74%	67%
Primary Surgical Procedure Code	90%	NA	NA	NA
Discharge Status	91%	NA	NA	NA
Procedure Code	NA	50%	63%	55%
Procedure Code Modifier	NA	50%	73%	67%
Units	NA	42%	74%	73%

RMHP Prime provided medical record documentation for all sampled over-read cases and Table 3-119 presents RMHP Prime's FY 2019–2020 EDV over-read case-level and element-level accuracy rates by service category. HSAG's over-read results indicated complete agreement with RMHP Prime's internal EDV results for 70 of the 80 sampled encounters, resulting in an 87.5 percent agreement rate. The overall agreement rate is greater than the 72.5 percent overall agreement rate from the FY 2018–2019 EDV.

Table 3-119—Percent of Cases in Total Agreement and Percent of Element Accuracy for RMHP Prime

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	100.0%	120	100.0%
Outpatient	20	80.0%	100	94.0%
Professional	20	95.0%	100	95.0%
FQHC	20	75.0%	100	93.0%
Total	**80**	**87.5%**	**420**	**95.7%**

RMHP Prime: Strengths

Overall results from HSAG's FY 2019–2020 MCO over-read continue to show improved agreement between HSAG's and RMHP Prime's reviewers compared to the previous year; HSAG's reviewers agreed with RMHP Prime's reviewers for 95.7 percent of the individually reviewed data elements. Additionally, HSAG's over-read results agreed completely with RMHP Prime's EDV results for the Inpatient encounters. Finally, RMHP Prime's 412 internal EDV results show a high level of service coding accuracy among Inpatient encounters.

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

HSAG's over-read findings suggest a moderate level of confidence that RMHP Prime's EDV results accurately reflect its encounter data quality. However, RMHP Prime's self-reported EDV results demonstrated a low level of encounter data accuracy for ambulatory (i.e., non-Inpatient) service categories when compared to the corresponding medical records. RMHP Prime's internal audit response file submission did not initially 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 EDV documentation did not confirm whether or not RMHP Prime implemented CAPs, training, or education for low-scoring providers to address deficiencies identified during the EDV. As such, results from HSAG's FY 2019–2020 MCO over-read suggest opportunities for RMHP Prime to consider internal processes for ongoing encounter data monitoring, as well as training to ensure contracted providers are able to code and submit ambulatory (i.e., non-Inpatient) encounters that accurately reflect medical record documentation and services rendered.

Validation of Network Adequacy

RMHP Prime: Strengths

During FY 2019–2020, RMHP Prime participated in the iterative development of the standardized quarterly network adequacy reporting template. HSAG then used RMHP Prime's network data to conduct geoaccess analyses as a baseline to support the EQRO's future validation of the Medicaid MCOs' quarterly network adequacy reports. Table 3-120 summarizes HSAG's geoaccess analysis results by county classification for RMHP Prime, including the count of provider ratio standards and time/distance standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met. While no Medicaid MCO met 100 percent of the provider ratio contract requirements across all network standards and county classifications, this was mostly attributable to data anomalies that the Department and the Medicaid MCOs are working to address.

Table 3-120—RMHP Prime's Provider Ratio and Time/Distance Results by County Classification

Measure Results	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
Provider Ratio	28	26	92.9%	28	26	92.9%	28	26	92.9%
Primary Care Time/Distance	12	8	85.6%	23	8	78.2%	10	8	75.0%
Behavioral Health Time/Distance	12	20	80.9%	23	20	60.3%	10	20	66.9%
Facilities Time/Distance	12	2	62.5%	23	2	84.8%	10	2	100%

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

RMHP Prime reported no practitioners for the Gynecology (Mid-Level) and Pediatric Ophthalmology network categories. Consequently, RMHP Prime failed to meet those network categories and standards. Failure to meet the network category access standards was largely attributable to the closest network locations being outside the required travel time or distance standards for a limited number of members residing in these counties (i.e., fewer than 10 members).

HSAG's network data review identified varying levels of missingness for network category assignments, as well as spelling variations and/or use of special characters for RMHP Prime's data values for provider type, specialty, and credentials. As such, HSAG recommends that RMHP Prime continue to assess available data values in its network data systems and standardize available data value options and network category attribution criteria.

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

Table 4-1—Statewide Results for MCO Capitation Initiative Standards

Standard and Applicable Review Years	DHMP	RMHP Prime	Statewide Average
Standard I—Coverage and Authorization of Services (2019–2020)	**97%**	**90%**	**94%**
Standard II—Access and Availability (2019–2020)	**87%**	**100%**	**94%**
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 Systems (2019–2020)	**83%**	**86%**	**86%**
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 2019–2020.

**Effective FY 2018–2019, DHMP and RMHP Prime's previous contracts were discontinued and were recontracted as MCO capitation initiatives within the RAE, thereby resetting the rotating three-year cycle of standards.*

Table 4-2—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 (2019–2020)	**90%**	**97%**	**80%**	**97%**	**80%**	**83%**	**87%**	**88%**
Standard II—Access and Availability (2019–2020)	**100%**	**94%**	**100%**	**94%**	**100%**	**94%**	**94%**	**97%**
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 Systems (2019–2020)	**86%**	**77%**	**80%**	**83%**	**83%**	**71%**	**74%**	**79%**
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 2019–2020.
**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 three standards reviewed in FY 2019–2020, the Medicaid health plans demonstrated compliance in many areas. Most (five or more) Medicaid health plans statewide—both RAEs and MCOs:

- Used clinical criteria consistently for medical necessity when making authorization determinations and UM departments ensured interrater reliability between UM reviewers.
- Maintained a panel of diverse medical reviewers, enabling clinically appropriate authorization decisions.
- Ensured that staff members who had not previously been involved with the case reviewed the appeals.
- Provided authorization decisions regarding covered outpatient drugs within 24 hours of request.
- Defined, processed, and paid emergency services and post-stabilization services per federal regulations.
- Maintained an adequate network of providers for delivery of covered services.
- Used a variety of tools and resources to monitor provider network adequacy.
- Assessed providers for timely appointment standards.
- Provided for out-of-network second opinions when access to needed services was not available in-network.
- Maintained policies and procedures to address the cultural competency of providers and staff members.
- Provided cultural competency training for health plan staff members and providers.
- Implemented policies, procedures, and comprehensive software systems to ensure grievances and appeals were processed according to regulations.
- Used various staff members and departments to ensure that members received assistance in filing a grievance or appeal.
- Ensured members were notified of translation services and other assistance in filing a grievance or an appeal.

For Medicaid health plans statewide—both RAEs and MCOs—the most common required actions assigned were the following:

- Send member letters (NABDs, grievances, appeals, and various extension letters) according to timeliness standards.
- Clearly address the member's issue (i.e., complaint reason for grievances, denial reason for NABDs).
- Ensure member-friendly language, at or below the 6th grade reading level, in member letters such as NABDs and grievance and appeal resolutions.

- Update member and provider materials to ensure accurate information about continuation of benefits criteria and timelines for continuing services during appeals and SFHs.
- Ensure member letters include accurate information regarding appeals and SFHs.
- Develop more robust mechanisms for monitoring and surveying providers to ensure timely access to services and implement CAPs for providers not in compliance.

Validation of Performance Measures

Performance Measure Validation—RAEs

Statewide Results

Information Systems Standards Review

HSAG evaluated the Department's accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. All measures were calculated by the Department using data submitted by the RAEs. The measures came from multiple sources, including claims/encounter and enrollment/eligibility data. For the current reporting period, HSAG determined that the data collected and reported by the Department followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

In Table 4-3, plan-specific and statewide weighted averages are presented for the seven RAEs for MY 2018–2019. Cells shaded green indicate performance met or exceeded the MY 2018–2019 performance goal (as determined by the Department). 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 goal are shaded green.

Table 4-3—Statewide Performance Measure Results for RAEs

Performance Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	49.58%	46.40%	47.75%	47.93%	43.54%	45.81%	55.01%	47.64%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	58.18%	64.31%	58.76%	74.36%	63.56%	69.45%	72.90%	65.43%

Performance Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Statewide Average
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	27.75%	38.33%	27.83%	46.03%	37.22%	35.25%	37.01%	34.98%
Follow-Up After a Positive Depression Screen	44.87%	50.00%	43.51%	42.98%	32.20%	52.56%	59.18%	50.16%
Behavioral Health Screening or Assessment for Children in the Foster Care System	13.29%	15.76%	12.05%	24.93%	17.20%	13.59%	19.47%	16.86%

Cells shaded green indicate the rate met or exceeded the MY 2018–2019 goal.

Statewide Conclusions and Recommendations

During this measurement period, none of the statewide averages met the goal. Additionally, only one RAE, CCHA Region 7, exceeded the goal for any measure; it exceeded the goal for *Follow-Up After a Positive Depression Screen* and *Engagement in Outpatient Substance Use Disorder (SUD) Treatment*.

HSAG recommends the RAEs include the results of analyses for the measures listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) and/or initiative(s) is the RAE considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented above, the RAEs should, at a minimum, include the following information related to identified initiatives and interventions.

1. Assigned team members' roles and responsibilities to support the related initiatives (including RAE leadership).
2. A description of how the RAE has identified and used, and will continue to identify and use, the voice of the customer in its design and prioritization of the associated interventions and initiatives.

3. Baseline measures and measure frequency, target goals, and the timeline for achievement of the goals.
4. Methods to evaluate intervention effectiveness and how the RAE will use both positive and negative results as part of lessons learned.

HEDIS Measure Rates and Validation—MCO Capitation Initiative

Statewide Results

Information Systems Standards Review

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 4-4, plan-specific and Colorado Medicaid weighted averages are presented for the MCO capitation initiative MCOs for HEDIS 2020. 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 4-4—MCO Capitation Initiative and Statewide Results

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	84.53%	42.00%	62.81%
Postpartum Care	66.50%	35.92%	50.88%
Adults' Access to Preventive/Ambulatory Health Services			
Total	55.30%	72.10%	63.01%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Preventive Screening			
Chlamydia Screening in Women			
Total	72.91%	47.77%	64.39%
Breast Cancer Screening			
Breast Cancer Screening	46.01%	48.04%	47.09%
Cervical Cancer Screening			
Cervical Cancer Screening	45.58%	39.39%	42.52%
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.04%	2.00%	0.30%
Adult BMI Assessment			
Adult BMI Assessment	80.35%	38.95%	59.16%
Mental/Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	57.19%	73.71%	65.91%
Effective Continuation Phase Treatment	37.69%	64.85%	52.03%
Living With Illness			
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	70.21%
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	83.00%	84.59%	83.74%
*HbA1c Poor Control (>9.0%)**	40.51%	76.08%	56.95%
HbA1c Control (<8.0%)	48.96%	19.55%	35.37%
Eye Exam (Retinal) Performed	45.70%	50.14%	47.75%
Medical Attention for Nephropathy	83.75%	83.21%	83.50%
Blood Pressure Control (<140/90 mm Hg)	63.49%	8.91%	38.27%
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	61.74%	43.04%	53.27%
Statin Adherence 80%	67.58%	85.57%	74.16%
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	76.14%	57.44%	66.31%
Statin Adherence 80%—Total	64.18%	92.86%	77.24%
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	77.62%	72.76%	75.08%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	59.82%	37.33%	50.88%
Bronchodilator	74.49%	54.22%	66.43%

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Medication Management for People With Asthma			
Medication Compliance 50%—Total	61.84%	82.40%	69.66%
Medication Compliance 75%—Total	36.05%	66.09%	47.47%
Asthma Medication Ratio			
Total	46.60%	48.40%	47.31%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.19%	29.46%	28.12%
Antibiotic Stewardship			
Appropriate Testing for Pharyngitis			
Total	85.51%	73.66%	81.53%
Appropriate Treatment for Upper Respiratory Infection			
Total	96.35%	88.24%	94.30%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	79.61%	47.83%	63.56%
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics—Total	0.34	0.65	0.43
Average Days Supplied per Antibiotic Script—Total	9.54	18.21	13.48
Average Scripts PMPY for Antibiotics of Concern—Total	0.10	0.25	0.14
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	28.99%	38.88%	33.48%
Opioids			
Use of Opioids at High Dosage*			
Use of Opioids at High Dosage	5.85%	8.84%	7.54%
Use of Opioids From Multiple Providers*			
Multiple Pharmacies	6.17%	1.91%	3.73%
Multiple Prescribers	16.11%	57.73%	39.96%
Multiple Prescribers and Multiple Pharmacies	4.41%	1.91%	2.98%
Risk of Continued Opioid Use*			
At Least 15 Days Covered—Total	5.40%	13.01%	9.53%
At Least 31 Days Covered—Total	2.35%	4.25%	3.38%
Pharmacotherapy for Opioid Use Disorder			
Total—Total	15.91%	54.02%	38.67%
Use of Services			
Ambulatory Care—Total			
*Emergency Department Visits—Total—Total**	45.35	60.25	49.97
Outpatient Visits—Total—Total	215.69	341.87	254.83

Performance Measure	DHMP	RMHP Prime	Statewide Weighted Average
Inpatient Utilization—General Hospital/Acute Care—Total			
Discharges per 1,000 Member Months (Total Inpatient)—Total	5.79	9.96	7.08
Average Length of Stay (Total Inpatient)—Total	4.40	4.27	5.00
Discharges per 1,000 Member Months (Medicine)—Total	3.39	4.65	3.78
Average Length of Stay (Medicine)—Total	3.92	4.00	3.95
Discharges per 1,000 Member Months (Surgery)—Total	1.06	2.57	1.53
Average Length of Stay (Surgery)—Total	8.23	6.81	7.49
Discharges per 1,000 Member Months (Maternity)—Total	1.80	2.93	2.21
Average Length of Stay (Maternity)—Total	2.58	2.35	2.47
Plan All-Cause Readmissions*			
Observed Readmissions—Total	13.79%	9.87%	11.54%
O/E Ratio—Total	1.26	1.02	1.13

**For this indicator, 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 2020 measure rates were determined to be high performers for the MCO capitation initiative statewide weighted average (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2019 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2019):

- *Childhood Immunization Status—Combination 6, Combination 8, Combination 9, and Combination 10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*
- *Statin Therapy for Patients With Diabetes—Statin Adherence 80%*
- *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total*
- *Use of Opioids From Multiple Providers—Multiple Pharmacies*

The following HEDIS 2020 measure rates were determined to be low performers for the MCO 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 2019):

- *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*
- *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—Hemoglobin A1c (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*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator*
- *Asthma Medication Ratio*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*

Based on performance measure results, HSAG recommends that the Department and the MCOs conduct a root cause analysis of the 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 consider identifying an intervention with the ability to reach and impact the highest number of members (i.e., high impact area), then work with providers and members, as applicable to the intervention, to improve member access, which will subsequently increase performance in these measure rates.

Related to substantially low performance in the Living With Illness domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to perform root cause analysis to determine the reason these measures continue to have low rates (e.g., is there a focus or a dedicated intervention approach to identifying and resolving potential barriers to filling prescriptions, or the need for community outreach and education on side effects or alternatives to certain medication therapies) 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 continues to recommend 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.[4-1]

Related to low statewide scores in the Opioids domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to identify and monitor prescribing practices for opioids to treat chronic pain. Guidelines for prescribing opioids for chronic pain include improving communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improving the safety and effectiveness of pain treatment, and reducing the risks associated with long-term opioid therapy.[4-2]

[4-1] 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: Sept 14, 2020.

[4-2] *Guideline for Prescribing Opioids for Chronic Pain.* Available at: https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf. Accessed on: Sept 14, 2020.

Validation of Performance Improvement Projects

Statewide Results

Table 4-5 shows the FY 2019–2020 statewide PIP results for the RAEs.

Table 4-5—FY 2019–2020 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 3 and Initiated Module 4*	NA*
	BH	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
Region 2—Northeast Health Partners				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 3—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 4—Health Colorado, Inc.				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 5—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
Region 6—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 7—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2019–2020 validation cycle.*

During FY 2019–2020, the RAEs continued rapid-cycle PIPs that were initiated in FY 2018–2019, focusing on topics approved by the Department. The PIPs addressed the following topic areas:

1. Well-child visits
2. Adolescent well-care visits
3. Adult well-care visits
4. Referral from primary care to behavioral healthcare following a positive depression screening
5. Substance use disorder treatment

The PIPs were scheduled to continue into the next FY, to be evaluated on outcomes and receive a final validation status after completion of all five modules of the rapid-cycle PIP process and submission of final documentation for validation. Due to the COVID-19 pandemic, the Department decided to close out the PIPs at the end of FY 2019–2020, prior to the completion of the final PIP modules. The RAEs were instructed to submit a PIP close-out report and will initiate a new round of PIPs in FY 2020–2021.

During the FY 2019–2020 validation cycle, the RAEs received training and technical assistance on methods for identifying and testing interventions as part of the rapid-cycle PIP process. The RAEs submitted documentation on Module 3, and the intervention testing plan for Module 4, for a total of 16 PIPs. HSAG provided feedback to the RAEs on the initial Module 3 submissions and the RAEs revised the module documentation and resubmitted Module 3 until all criteria were achieved. The RAEs passed Module 3, achieving all validation criteria for all 16 PIPs. After passing Module 3, the RAEs initiated Module 4 by submitting a plan for testing one or more interventions. HSAG provided pre-validation feedback to the RAEs on the intervention testing plans. After receiving HSAG's pre-validation feedback, the RAEs began testing interventions through PDSA cycles as part of Module 4. Module 4 activities were paused after March 2020, when the Department allowed the RAEs to close out the PIPs early in response to competing priorities and resource limitations related to the COVID-19 pandemic.

Statewide Conclusions and Recommendations Related to Validation of PIPs

The FY 2019–2020 validation findings for all 16 PIPs suggested that all RAEs used robust quality improvement methods to identify appropriate interventions to address the Department-approved PIP topics and developed plans to test the effectiveness of these interventions through PDSA cycles. The RAEs used process mapping and FMEAs to examine processes related to the PIP topics, identify and prioritize failures or gaps in these processes, and determine appropriate interventions to address high-priority process failures. HSAG recommended the following as the health plans initiated PDSA cycles to test interventions for Module 4 of the PIPs:

- To ensure a methodologically sound intervention testing methodology, health plans should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the

health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.

- The key driver diagram for the PIP should be updated regularly to incorporate all interventions tested and any knowledge gained and lessons learned as health plans progresses through PDSA cycles.
- When reporting the final PIP conclusions, health plans should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and any demonstrated improvement.

PCMH CAHPS Surveys—RAEs

Statewide Results

Adult

Table 4-6 shows the adult PCMH CAHPS results for the seven RAEs and the Colorado RAE Aggregate (i.e., statewide average) for FY 2019–2020.

Table 4-6—Adult Statewide PCMH CAHPS Results for RAEs*

Measure	RMHP (RAE 1)	NHP (RAE 2)	COA (RAE 3)	HCI (RAE 4)	COA (RAE 5)	CCHA (RAE 6)	CCHA (RAE 7)	Colorado RAE Aggregate
Rating of Provider	61.1%	67.0% ↑	56.6% ↓	68.5% ↑	65.0%	58.9%	54.6% ↓	59.1%
Rating of Specialist Seen Most Often	64.5%	57.9%	65.0%	61.4%	68.4%	67.9%	61.2%	63.7%
Rating of All Health Care	58.8%	61.2%	55.0%	61.5%	59.8%	55.7%	52.1% ↓	55.8%
Rating of Health Plan	58.0%	63.7%	61.3%	66.6% ↑	66.1%	60.2%	57.6% ↓	61.3%
Getting Timely Appointments, Care, and Information	43.8% ↓	52.0%	45.7%	56.8% ↑	56.7% ↑	42.1% ↓	50.8%	44.6%
How Well Providers Communicate with Patients	74.9%	77.9% ↑	69.0% ↓	76.4%	75.7%	73.5%	68.9% ↓	71.4%

Measure	RMHP (RAE 1)	NHP (RAE 2)	COA (RAE 3)	HCI (RAE 4)	COA (RAE 5)	CCHA (RAE 6)	CCHA (RAE 7)	Colorado RAE Aggregate
Providers' Use of Information to Coordinate Patient Care	59.5%	66.9% ↑	57.6% ↓	66.0% ↑	64.2%	61.1%	53.4% ↓	58.7%
Talking with You About Taking Care of Your Own Health	48.7%	49.7%	46.9%	51.8%	47.5%	52.3% ↑	43.5% ↓	48.0%
Comprehensiveness	53.1%	50.9%	53.6%	49.3%	43.7% ↓	56.5% ↑	46.9% ↓	51.0%
Helpful, Courteous, and Respectful Office Staff	69.8%	66.7%	60.4% ↓	69.5%	73.9% ↑	65.1% ↓	73.7% ↑	68.6%
Customer Service	56.4%+	57.0%+	59.7%	62.1%	66.9%+	64.2%	65.2%	63.5%
Received Care from Provider Office During Evenings, Weekends, or Holidays	32.6%+	31.9%+	26.7%+	34.1%	24.6%+	13.1% ↓	29.2%	23.2%
Reminders about Care from Provider Office	70.3%	67.2%	70.7%	71.5%	69.4%	74.7%	69.4%	71.0%
Saw Provider Within 15 Minutes of Appointment	35.8%	45.2%	38.8%	38.1%	39.3%	33.9%	40.3%	38.0%
Receive Health Care and Mental Health Care at Same Place	56.0%	63.5%	52.5%	52.4%	57.4%	60.4%	53.2%	60.4%

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 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.*

↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Child

Table 4-7 shows the child PCMH CAHPS results for the seven RAEs and the Colorado RAE Aggregate (i.e., statewide average) for FY 2019–2020.

Table 4-7—Child Statewide PCMH CAHPS Results for RAEs*

Measure	RMHP (RAE 1)	NHP (RAE 2)	COA (RAE 3)	HCI (RAE 4)	COA (RAE 5)	CCHA (RAE 6)	CCHA (RAE 7)	Colorado RAE Aggregate
Rating of Provider	79.0%	80.5%	71.2% ↓	65.1% ↓	90.1% ↑	68.2% ↓	74.6%	71.8%
Rating of Specialist Seen Most Often	74.3%+	84.3%+	75.3%	73.6%+	70.4%+	82.3%	75.2%	78.0%
Rating of All Health Care	78.8% ↑	76.7%	73.1%	62.7% ↓	89.7% ↑	71.6%	72.8%	72.0%
Getting Timely Appointments, Care, and Information	70.3% ↑	57.9%+	48.4% ↓	56.8% ↓	74.8%+ ↑	61.5%	65.1%	57.3%
How Well Providers Communicate with Child	81.9%	82.7%+	78.5%	75.3%	85.4%+	78.3%	82.1%	79.3%
How Well Providers Communicate with Parents or Caretakers	82.4%	78.2%	78.1%	75.8% ↓	86.4% ↑	78.0%	81.8%	78.3%
Providers' Use of Information to Coordinate Patient Care	78.5% ↑	69.8%	69.4% ↓	69.6%	84.2%+ ↑	72.8%	73.1%	70.7%
Comprehensiveness—Child Development	73.5% ↑	64.9%	70.4% ↑	51.6% ↓	75.7% ↑	69.0%	66.0%	65.5%
Comprehensiveness—Child Safety and Healthy Lifestyles	66.1% ↑	60.8%	68.3% ↑	49.0% ↓	67.4% ↑	66.1% ↑	56.7% ↓	61.0%
Helpful, Courteous, and Respectful Office Staff	72.6% ↑	63.6%	59.4% ↓	64.1%	82.5% ↑	65.6%	67.5%	65.0%
Received Information on Evening, Weekend, or Holiday Care	82.9%	76.4%	80.4%	75.3% ↓	85.9% ↑	76.5%	82.4%	78.6%

Measure	RMHP (RAE 1)	NHP (RAE 2)	COA (RAE 3)	HCI (RAE 4)	COA (RAE 5)	CCHA (RAE 6)	CCHA (RAE 7)	Colorado RAE Aggregate
Received Care from Provider Office During Evenings, Weekends, or Holidays	49.7%+ ↑	9.1%+ ↓	25.4% ↓	37.9%+	49.6%+ ↑	32.5%	36.4%	33.1%
Saw Provider Within 15 Minutes of Appointment	40.8%	37.6%	31.5% ↓	30.7% ↓	48.2% ↑	40.4%	44.5% ↑	36.6%
Reminders about Child's Care from Provider Office	74.5% ↑	61.3% ↓	72.2%	53.6% ↓	73.9%	72.5%	72.9% ↑	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.

**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.*

↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Aggregate.*

↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Aggregate.*

Statewide Conclusions and Recommendations Related to PCMH CAHPS

RAE Adult Survey

Five RAE regions had scores that were statistically significantly lower than the Colorado RAE Aggregate for a total of 10 measures in areas related to access to care, timeliness of care, communication, and care coordination. HSAG recommends that the Department consider developing statewide improvement initiatives and the RAEs consider establishing performance goals designed to improve member perceptions related to these measures.

Of note, the State's three most rural RAE regions (RAE Regions 1, 2, and 4) experienced a lower number of measure scores that were statistically significantly lower than the Colorado RAE Aggregate than the State's most urban RAE regions (RAE Regions 5 and 6). RAE Region 7 experienced the greatest number of measure scores that were statistically significantly lower than the Colorado RAE Aggregate (seven measure scores). RAE Region 3, which is considered within the Denver metropolitan area, had four measure scores that were statistically significantly lower than the Colorado RAE Aggregate. 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.

The Department may also want to consider working with the health plans that received no scores significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on specific measures to develop and share best practices with other RAEs that show opportunities for improvement for the same measures.

RAE Child Survey

Five RAE regions had scores that were statistically significantly lower than the Colorado RAE Aggregate for a total of 12 measures in areas related to access to care, timeliness of care, communication, and care coordination. In addition, there was one measure (*Rating of Provider*) in which three RAE regions had statistically significantly lower scores than the Colorado RAE Aggregate. HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve parent/caretaker perceptions related to these measures.

Of note, RAE Region 4 had the greatest number of measure scores that were statistically significantly lower than the Colorado RAE Aggregate (nine measure scores). The Department may want to consider working with the health plans that received no scores significantly lower than the Colorado RAE Aggregate in FY 2019–2020 on specific measures to develop and share best practices with other RAEs that show opportunities for improvement for the same measures.

CAHPS Survey—MCO Capitation Initiative

Statewide Results

Table 4-8 shows the adult Medicaid CAHPS results achieved by DHMP and RMHP Prime for FY 2019–2020.[4-3]

Table 4-8—FY 2019–2020 Adult Medicaid CAHPS Results for MCOs

Measure	DHMP	RMHP Prime
Getting Needed Care	74.5% ↓	84.5%
Getting Care Quickly	73.5% ↓	83.1%
How Well Doctors Communicate	94.2%	93.4%
Customer Service	89.1%+	94.7%+ ↑
Rating of Personal Doctor	69.6%	75.1% ↑
Rating of Specialist Seen Most Often	74.1%+	66.7%+
Rating of All Health Care	55.5%	58.6%
Rating of Health Plan	60.3%	68.3% ↑

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.
↑ *Indicates the FY 2019–2020 score is statistically significantly above the 2019 NCQA national average.*
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

[4-3] HSAG did not combine DHMP's and RMHP Prime's CAHPS results into a statewide average due to the differences between the health plans' Medicaid populations. Therefore, a statewide average is not presented in the table.

Table 4-9 shows the child Medicaid CAHPS results achieved by DHMP for FY 2019–2020.[4-4,4-5]

Table 4-9—FY 2019–2020 Child Medicaid CAHPS Results for DHMP

Measure	DHMP
Getting Needed Care	75.1%+
Getting Care Quickly	80.5%+ ↓
How Well Doctors Communicate	94.9%+
Customer Service	89.0%+
Rating of Personal Doctor	78.8%
Rating of Specialist Seen Most Often	60.9%+
Rating of All Health Care	66.0%+
Rating of Health Plan	67.4%

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.
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

Statewide Conclusions and Recommendations Related to MCO CAHPS

HSAG identified several possible interventions that could be applied by the MCOs as appropriate to the MCOs' populations and organizational structures. To impact member perception related to getting the care they need and getting it quickly, HSAG recommends that the two MCOs 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 could 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.

[4-4] 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.
[4-5] RMHP Prime was not required to submit child Medicaid CAHPS data for reporting purposes in FY 2019–2020; therefore, the CAHPS results for RMHP Prime are not presented in the table.

ECHO Survey

Statewide Results

Adult

Table 4-10 shows the adult ECHO survey results achieved by the seven RAEs and the Colorado RAE Program (i.e., statewide average) for FY 2019–2020.[4-6]

Table 4-10—FY 2019–2020 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)	Colorado RAE Program
Rating of All Counseling or Treatment	40.6%	50.7%	41.9%	53.8%	55.1%	47.8%	39.4%+	46.4%
Getting Treatment Quickly	65.6%	65.3%	71.5%	74.0%	70.2%	65.4%	70.5%+	68.8%
How Well Clinicians Communicate	89.9%	87.2%	90.7%	93.4%	90.9%	91.9%	85.7%+	89.8%
Perceived Improvement	60.3%	60.0%	55.3%	58.3%	62.5%	64.0%	59.4%	59.9%
Amount Helped	81.4%	82.7%	79.0%	86.4%	89.8%	83.3%	76.2%+	82.5%
Cultural Competency	NA	NA	NA	NA	NA	NA	NA	69.2%+
Including Family	38.7%	45.3%	50.0%	42.6%	42.4%	49.0%	36.7%+	43.9%
Information About Self-Help or Support Groups	54.8%	49.6%	59.4%	57.9%	52.4%	62.8% ↑	40.4%+ ↓	53.7%
Information to Manage Condition	74.9%	66.5% ↓	75.6%	81.4%	85.3% ↑	78.2%	76.9%+	77.0%
Office Wait	83.9%	79.8%	87.8%	82.9%	83.2%	85.8%	85.8%+	84.5%
Patient Feels He or She Could Refuse Treatment	87.9%	76.1%	78.8%	74.4%	74.4%	79.1%	79.6%+	78.8%
Privacy	94.7%	94.5%	96.4%	94.9%	92.2%	97.1%	93.4%+	94.7%
Support from Family and Friends	66.8%	62.5%	63.6%	57.6%	57.5%	68.1%	60.1%	62.5%

[4-6] The RAE results were case-mix adjusted to account for disparities in respondents' demographics for comparability among the RAEs. Due to case-mix adjustment, the results of the seven RAEs may be different than the results in Section 3 of this report.

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Colorado RAE Program
Told About Medication Side Effects	72.0%+	71.6%+	75.4%+	71.1%+	78.1%+	75.9%+	74.4%+	74.6%
Improved Functioning	52.5%	52.5%	53.2%	48.3%	51.6%	53.1%	50.4%	52.0%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Program.*
↓ *Indicates the FY 2019–2020 score is statistically significantly lower than the Colorado RAE Program.*

Child

Table 4-11 shows the child ECHO survey results achieved by the seven RAEs and the Colorado RAE Program (i.e., statewide average) for FY 2019–2020.[4-7]

Table 4-11—FY 2019–2020 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)	Colorado RAE Program
Rating of All Counseling or Treatment	43.6%	39.2%+	45.9%	46.7%+	41.6%+	44.4%	47.3%	44.7%
Getting Treatment Quickly	63.9%	63.0%+	61.2%	70.2%	78.9%+ ↑	65.1%	72.9%	66.2%
How Well Clinicians Communicate	88.7%	83.5%+	90.1%	84.6%+	90.9%+	87.3%	89.3%	88.1%
Perceived Improvement	68.4%	69.0%	67.5%	68.6%	76.9%+	67.8%	61.9%	68.6%
Amount Helped	76.3%	72.4%+	71.7%	71.8%+	85.3%+	73.9%	76.6%	75.2%
Child Had Someone to Talk To	75.1%	75.5%+	65.7%	72.7%+	82.3%+	72.3%	76.6%	73.4%
Cultural Competency	NA	NA	NA	NA	NA	NA	NA	71.8%+
Information to Manage Condition	73.8%	72.6%+	70.4%	68.9%+	79.0%+	67.6%	75.6%	70.9%
Office Wait	90.0%	84.3%+	87.8%	85.8%+	91.8%+	90.7%	91.5%	89.7%
Privacy	96.5%	100.0%+ ↑	92.2%	95.8%+	91.6%+	94.9%	92.4%	94.7%

[4-7] The RAE results were case-mix adjusted to account for disparities in respondents' demographics for comparability among the RAEs. Due to case-mix adjustment, the results of the seven RAEs may be different than the results in Section 3 of this report.

Measure	RMHP (Region 1)	NHP (Region 2)	COA (Region 3)	HCI (Region 4)	COA (Region 5)	CCHA (Region 6)	CCHA (Region 7)	Colorado RAE Program
Respondent Feels He or She Could Refuse Treatment for Their Child	90.8%	85.4%+	85.5%	81.5%+	83.5%+	91.2%	89.8%	88.8%
Support from Family and Friends	68.6%	75.6%	71.2%	75.3%	76.7%+	66.7%	66.2%	69.7%
Told About Medication Side Effects	92.7%+	88.0%+	81.7%+	71.0%+	86.5%+	84.1%+	81.6%+	84.3%
Improved Functioning	58.9%	57.3%	62.4%	57.4%	66.6%+	60.7%	49.0%	60.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
Results based on fewer than 30 respondents were suppressed and are noted as "NA" (Not Applicable).
↑ *Indicates the FY 2019–2020 score is statistically significantly higher than the Colorado RAE Program.*

Statewide Conclusions and Recommendations Related to ECHO Surveys

All measures (except *Office Wait*) within the adult and child ECHO surveys addressed quality. In addition, *Information About Self-Help or Support Groups*, *Information to Manage Condition*, *Improved Functioning*, and *Child Had Someone To Talk To* addressed access; *Getting Treatment Quickly* addressed timeliness; and *Office Wait* addressed both access and timeliness.

The adult and child Colorado RAE Program scores are calculated as weighted averages, with each RAE's eligible population acting as the weight.

RAE Adult Survey

COA Region 5 scored statistically significantly higher and NHP scored statistically significantly lower than the Colorado RAE Program for one measure, *Information to Manage Condition*. CCHA Region 6 scored statistically significantly higher and CCHA Region 7 scored statistically significantly lower than the Colorado RAE Program for one measure, *Information About Self-Help or Support Groups*.

HSAG recommends that the Department consider developing statewide improvement initiatives designed to improve member perceptions related to the measures that scored statistically significantly lower than the Colorado RAE Program.

RAE Child Survey

NHP scored statistically significantly higher than the Colorado RAE Program for one measure, *Privacy*. COA Region 5 scored statistically significantly higher than the Colorado RAE Program for one measure, *Getting Treatment Quickly*.

None of the RAEs scored statistically significantly lower than the Colorado RAE Program for any measure; however, COA Region 3 and CCHA Region 6 had the most measures (nine) that scored lower than the Colorado RAE Program. The rest of the RAE regions had between three and eight measure rates that were lower than the Colorado RAE Program. HSAG determined no particular trend or pattern related to this. HSAG recommends that the Department work with the RAEs that had the least measures with lower scores than the Colorado RAE Program to develop and share best practices with the other RAEs.

Encounter Data Validation—RAE 411 Audit Over-Read

Statewide Results

Table 4-12 presents the RAEs' self-reported BH encounter data service coding accuracy results by service category and validated data element.

Table 4-12—RAEs' Aggregated, Self-Reported EDV Results by Data Element and BH Service Category*

Data Element	Prevention/Early Intervention Services	Club House or Drop-In Center Services	Residential Services	Aggregate Results
Procedure Code	59.1%	44.4%	74.2%	61.0%
Diagnosis Code	73.8%	74.7%	90.5%	81.5%
Place of Service	70.1%	78.3%	84.0%	79.4%
Service Program Category	66.9%	50.5%	85.8%	69.5%
Units	76.0%	73.2%	85.0%	79.9%
Start Date	78.0%	79.0%	88.8%	83.8%
End Date	78.0%	79.0%	88.0%	83.6%
Appropriate Population	78.1%	79.4%	92.7%	85.3%
Duration	77.5%	78.8%	90.8%	84.3%
Allow Mode of Delivery	74.8%	79.1%	92.5%	84.0%
Staff Requirement	77.1%	76.7%	90.7%	83.4%

** Each service category has a denominator of 959 total cases.*

Table 4-13 presents, by BH service category, the number and percent of cases in which HSAG's over-read results agreed with the RAEs' aggregated EDV results for the composite *Validation Elements*, as well as the number and percent of cases in which HSAG's over-read results agreed with the RAEs' aggregated EDV results for each of the validated data elements. Each data element was overread for 70 cases for each service category.

Table 4-13—Statewide Aggregated Encounter Over-Read Agreement Results for RAEs by BH Service Category

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	64	91.4%	733	95.2%
Club House or Drop-In Center Services	63	90.0%	729	94.7%
Residential Services	65	92.9%	757	98.3%
Total	**192**	**91.4%**	**2,219**	**96.1%**

* *HSAG overread 70 cases for each BH service category among all RAEs.*
** *HSAG overread 11 individual data elements for each case (i.e., a denominator of 770 cases per service category among all RAEs).*

Statewide Conclusions and Recommendations Related to RAE 411 Over-Read

FY 2019–2020 is the first year in which the RAEs have used a MRR to validate BH encounter data under the Department's guidance, and the EDV results provide a baseline from which the RAEs and the Department can monitor quality improvement within the RAEs' BH encounter data. The RAEs' 411 EDV results and HSAG's subsequent over-read findings support opportunities for improvement in the RAEs' oversight of data submissions from their BH providers. HSAG's over-read results suggest a high level of confidence that the RAEs' independent validation findings accurately reflect their encounter data quality. However, the RAEs' independent validation findings reflect targeted opportunities for RAEs to implement provider education and training on the USCS manuals and service coding accuracy, especially pertaining to coding accuracy for BH procedure codes. Additionally, given the resource-intensive nature of MRR, the RAEs should consider internal processes for ongoing encounter data monitoring and use the annual EDV study with the Department as a focused mechanism for measuring quality improvement.

Encounter Data Validation—MCO 412 Audit Over-Read

Statewide Results

Table 4-14 presents the MCOs' self-reported encounter data service coding accuracy results, aggregated for both MCOs by service category and validated data element.

Table 4-14—MCOs' Aggregated, Self-Reported EDV Results by Data Element and Service Category*

Data Element	Inpatient Encounters	Outpatient Encounters	Professional Encounters	FQHC Encounters	Aggregate Results
Date of Service	89.3%	80.1%	83.0%	86.9%	84.8%
Through Date	89.8%	NA	NA	NA	89.8%
Primary Diagnosis Code	85.0%	70.4%	68.3%	76.2%	75.0%
Primary Surgical Procedure Code	87.7%	NA	NA	NA	87.7%
Discharge Status	90.3%	NA	NA	NA	90.3%
Procedure Code	NA	61.9%	70.9%	68.9%	67.3%
Procedure Code Modifier	NA	74.3%	79.6%	83.4%	79.3%
Units	NA	64.5%	82.5%	84.4%	77.3%

** Each service category has a modified denominator based on the MCO's 412 Service Coding Accuracy Report Summary.*

Overall, results from HSAG's FY 2019–2020 MCO 412 audit over-read showed that HSAG's reviewers agreed with the MCOs' reviewers for 91.9 percent of the over-read cases and 97.0 percent of individual encounter data elements.[4-8]

Table 4-15 shows the percentage of cases in which HSAG's reviewers agreed with the MCOs' reviewers' results (i.e., case-level and element-level accuracy rates) by service category.

Table 4-15—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	42	100.0%	252	100.0%
Outpatient	38	84.2%	190	93.7%
Professional	40	97.5%	200	97.5%

[4-8] HSAG reported over-read results to the Department; however, each MCO submitted feedback to the Department indicating disagreement with selected findings in HSAG's MCO-specific EDV over-read reports.

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
FQHC	40	85.0%	200	96.0%
Total	**160**	**91.9%**	**842**	**97.0%**

Statewide Conclusions and Recommendations Related to MCO Over-Read

The current over-read results show improved agreement between HSAG's reviewers and each MCO's reviewers compared to the previous year. HSAG's over-read results suggest a moderately high level of confidence that the MCOs' independent validation findings accurately reflect their encounter data quality. However, the MCOs' independent validation findings reflect targeted opportunities to implement provider education and training on service coding accuracy, especially pertaining to coding accuracy for diagnosis and procedure codes in ambulatory care (i.e., non-Inpatient) settings.

Additionally, HSAG's desk review findings suggest continued opportunities for the MCOs to improve their internal EDV documentation to offer examples of specific instructions, reviewer training materials, and/or information on corrective action processes implemented among providers as a result of the EDV findings. Given the resource-intensive nature of MRR, the MCOs should consider internal processes for ongoing encounter data monitoring and use the annual EDV study with the Department as a focused mechanism for measuring quality improvement.

Validation of Network Adequacy

Statewide Results

In addition to collaborating with the Department to develop and implement standardized quarterly network adequacy reporting templates, HSAG used network crosswalk files developed during FY 2018–2019 to calculate standard, health plan-specific geospatial analyses as a baseline for future validation of network adequacy. The geoaccess calculation results highlight the importance of using consistent network categories and geoaccess analysis methods across health plans to systematically assess the health plans' compliance with network standards.

Overall, neither Medicaid MCO met all network standards across all counties in each county designation. In general, failure to meet the contract standards was largely attributable to the closest network locations being outside the required standard. However, both Medicaid MCOs were responsible for only a small number of members (i.e., fewer than 30 members) residing in counties in which the network access standards were not met. Among the specific network categories, RMHP Prime reported no Gynecology (Mid-Level) practitioners or Pediatric Ophthalmology practitioners for its members. However, both Medicaid MCOs reported an adequate number of primary care practitioners (i.e., Adult

and Pediatric Primary Care Provider, Gynecology, Family Practitioner) and physical health specialists for adults (i.e., Adult General Surgery, Adult Cardiology) across each county type.

Likewise, overall, no RAE met all network standards across all counties in each county designation. In general, failure to meet the contract standards was largely attributable to the closest network locations being outside the required standard. Except for RMHP Prime, no RAE reported practitioners in the Pediatric Primary Care (Mid-Level) network category. No RAEs reported Gynecology (Mid-Level) practitioners across the county designations, except CCHA Region 6, in its urban counties. However, RAEs reported numbers of primary care practitioners (i.e., Adult and Pediatric Primary Care Provider, Family Practitioner) and behavioral health practitioners (i.e., Adult and Pediatric Mental Health Provider, Adult and Pediatric Substance Use Disorder Provider) across each county type.

While no health plan met all network contract standards, the contract requirement for the health plan to meet each network standard for 100 percent of its members presents a potential barrier to health plans meeting the contract standards for areas in which practitioners are physically unavailable. For example, a health plan may have 99 percent of members in an urban county residing within the required time or distance of at least two primary care providers; however, the health plan would fail to meet the network standard for the county because less than 100 percent of members resided within the required travel time or driving distance. HSAG's use of consistent calculation methods allows the Department to use the FY 2019–2020 geoaccess analysis results to identify instances in which a health plan's failure to meet network contract standards may be attributed to one or more of the following scenarios:

- Data concerns (e.g., the health plan failed to include practitioners in its network calculations reported to the Department or data submissions to HSAG)
- Network deficiencies (e.g., no practitioners are available and/or willing to contract with the health plan in a given county)
- A limited number of members residing outside the contract standard (e.g., rural or frontier areas with a limited number of specialty providers)

Statewide Conclusions and Recommendations Related to Network Adequacy

The FY 2019–2020 NAV findings highlight the importance of consistent network category attribution as a foundation from which to assess whether health plans' lack of compliance with selected network standards may stem from data-related concerns versus a lack of available network locations. In developing and implementing standardized network adequacy templates and supporting documentation for the health plans' quarterly reporting, the FY 2019–2020 NAV study established a foundation from which the Department can standardize its process for requiring and reviewing health plans' requests for exemptions to the network contract standards, ensuring comprehensive access to care for all Medicaid members.

Based on the FY 2019–2020 NAV results and conclusions, HSAG offers the following recommendations to the Department to improve network adequacy data and oversight of the health plans' compliance with network adequacy contract requirements:

- The Department made significant progress during FY 2019–2020 in developing and implementing quarterly network adequacy reporting materials that are standardized within and across health plan types. The Department should continue to refine and automate the quarterly network adequacy reporting process to reduce duplication of reporting and oversight efforts for the Department and the health plans, and to facilitate routine NAV by an external entity.
- HSAG's network data review identified varying levels of missingness within the health plans' network category assignments, as well as spelling variations and/or use of special characters in the data values for provider type, specialty, and credentials.
  - The health plans should continue to assess available data values in their network data systems and standardize available data value options and network category attribution using the network category crosswalk supplied by the Department for quarterly network adequacy reporting.
  - The Department should incorporate data verification processes into the quarterly network adequacy report reviews. Specifically, the health plans' quarterly network data should be cross-referenced against the network crosswalk categories to identify instances in which health plans may have misaligned or failed to attribute required network categories (e.g., ensure that RAEs' data include acute care hospitals and psychiatric residential treatment facilities).
- The Department should review the network categories for which health plans failed to meet the time/distance standards, and request that the health plans confirm whether failure to meet the time/distance network access standard(s) resulted from concerns with the health plan's network category data attributions, a lack of network locations for the specific geographic area, or the health plan's inability to contract with available network locations in the geographic area.
  - Future NAV analyses should evaluate the extent to which health plans have requested network standards exemptions, including the use of telemedicine, from the Department for network categories in which network locations may not be physically available or willing to contract with the health plan.
  - To help address scenarios in which a health plan's failure to meet the network access standards may be related to a potential lack of network locations, the Department should consider comparing each health plan's network data to the Department's interChange data on network locations contracted with the Department to serve Health First Colorado or members (i.e., a saturation analysis) to determine the extent to which each health plan is contracted with available network locations.
- The Department should consider conducting an independent network directory review to verify that the health plans' publicly available network data accurately represent the network data supplied to members and used for geoaccess analyses.
- As the time/distance results represent the potential geographic distribution of contracted network locations and may not directly reflect network availability at any point in time, the Department should consider using appointment availability surveys to evaluate health plans' compliance with contract standards for access to care. HSAG also recommends incorporating encounter data to

assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate network availability.

- In addition to assessing the number, distribution, and availability of the health plans' network locations, the Department should review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care. Survey results and grievance and appeals data can then be used to evaluate the degree to which members are satisfied with the care they have received and the extent to which unsatisfactory care may be related to a health plan's lack of compliance with network standards.

5. Assessment of Health Plans' Follow-Up on FY 2018–2019 Recommendations

Region 1—Rocky Mountain Health Plans

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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.

For Standard IV—Member Rights and Protections, 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.

For Standard V—Member Information, 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).

RMHP submitted its initial CAP proposal on May 20, 2019. Following Department approval, RMHP successfully completed implementation of all planned interventions on October 4, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, RMHP initiated the PH care PIP, *Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18*. HSAG recommended 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.

For FY 2018–2019, RMHP initiated the BH care PIP, *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*. HSAG recommended 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.

In FY 2019–2020, RMHP passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that RMHP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. RMHP also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, RMHP reported engaging in the following quality improvement initiatives:

- RMHP promotes "Destination RMHP," a website containing a series of podcasts hosted by RMHP's Practice Transformation team. These podcasts include interviews with healthcare professionals with tips about improving communication and building patient relationships.
- RMHP continues to contact new members through the Welcome Call process and periodically updates the Welcome Call script based on feedback received through audits and from members.
- RMHP analyzes Service Form reports to identify and address any increase in volumes.
- RMHP sends a Spanish version of the "Getting Started Guide" to new members who indicate Spanish is their primary language. A language field was added to packets to assist with gathering this information.
- RMHP follows up with members who provide negative responses during Net Promoter Score (NPS) calls. The follow-up includes a phone outreach by an Advocate4Me staff member. In addition, a designated customer advocate reviews complaints and contacts members to address concerns.
- RMHP provides an educational video series for providers produced by the Practice Transformation team in partnership with the RMHP Chief Medical Officer (CMO) available via YouTube.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, RMHP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. RMHP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 2—Northeast Health Partners

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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.

For Standard III—Coordination and Continuity of Care, NHP had one required action, 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.

NHP submitted its initial CAP proposal on June 27, 2019. Following Department approval, NHP successfully completed implementation of all planned interventions on December 16, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, NHP initiated the PH care PIP, *Increasing Well Checks for Adult Members 21–64 Years of Age*. HSAG recommended 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.

For FY 2018–2019, NHP initiated the BH care PIP, *Increasing Mental Healthcare Services After a Positive Depression Screening*. The health plan lacked historical data to address some Module 1 and Module 2 validation criteria during FY 2018–2019 and, therefore, received a *Conditional Pass* for these modules. The health plan was instructed to resubmit Module 1 and Module 2 in FY 2019–2020, once

historical data had been collected for a complete 12-month period, so that HSAG could complete the final validation of Module 1 and Module 2. HSAG recommended 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.

In FY 2019–2020, NHP passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that NHP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. NHP also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. These recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

For the BH care PIP, NHP also addressed the recommendations related to setting the SMART Aim goal and designing the SMART Aim goal data collection methodology. In FY 2019–2020, the health plan resubmitted Module 1 and Module 2 for the PIP, updating the documentation to include data from a complete 12-month period. With the resubmissions, the health plan fully addressed the recommendations and met all validation criteria for these modules.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, NHP focused on the following performance areas that fell statistically significantly below the Colorado RAE Aggregate: timely appointments, weekend/evening availability with the provider, and reminders about care from the provider's office. Therefore, NHP reported engaging in the following quality improvement initiatives:

- NHP is working to incorporate the CAHPS survey results into its annual quality plan, with specific survey results being the focal point of greater regional conversation and collaboration. NHP intends to facilitate conversation in its regional quality committee to understand significant improvements that have occurred for certain providers over the year and share those best practices with other providers. From this, NHP will develop resources for providers and members that can be shared through the region and maintained on its website.
- NHP implemented an online scheduling process to address the measures with lower scores.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, NHP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. NHP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 3—Colorado Access

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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.

For Standard V—Member Information, COA Region 3 had one required action, to ensure that information on its website includes updated and correct information regarding appeals procedures.

COA Region 3 also had one required action for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services and 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.

COA Region 3 submitted its initial CAP proposal on June 3, 2019. Following Department approval, COA Region 3 successfully completed implementation of all planned interventions on September 30, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, COA Region 3 initiated the PH care PIP, *Well-Child Visits for Members 10–14 Years of Age*. HSAG recommended 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.

For FY 2018–2019, COA Region 3 initiated the BH care PIP, *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*. HSAG recommended 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.

In FY 2019–2020, COA Region 3 passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that COA Region 3 addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. COA Region 3 also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, COA Region 3 reported engaging in the following quality improvement initiatives:

- COA Region 3 implemented two programs within the customer service department that focus on continuous monitoring of customer service quality and identify areas of improvement. The Quality Monitoring Program, an ongoing program, scores and monitors customer service representatives (CSRs) to identify areas of improvement based on the program guidelines. Additionally, COA Region 3 invests in a NPS, a short survey, to monitor member satisfaction with the service they received from COA Region 3 CSRs. Along with these programs, CSRs participate in a four-week training program that includes a comprehensive review of member benefits and department workflows, training on all applicable systems, and trainees take mock and live calls in the training environment before they are released to the floor.

- COA Region 3 initiated a satisfaction survey for members who call customer service to monitor the members' experience with access, timeliness, and quality of care provided by COA Region 3-contracted providers. Results from the survey will be analyzed to identify key drivers for customer satisfaction and opportunities for improvement.
- COA Region 3 will resume several planned interventions/strategies involving providers and members when the COVID-19 crisis decreases in severity.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, COA Region 3 participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. COA Region 3 continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 4—Health Colorado, Inc.

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections and Standard V—Member Information.

For Standard III—Coordination and Continuity of Care, HCI was required to:

- Implement mechanisms to ensure that the electronic care coordination tool used by each accountable care coordination 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.

For Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services, HCI was required to complete the process of developing and executing an onboarding plan with each Healthy Communities contractor in the region.

HCI submitted its initial CAP proposal on June 27, 2019. Following Department approval, HCI successfully completed implementation of all planned interventions on January 6, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, HCI initiated the PH care PIP, *Increasing Well Checks for Adult Members 21–64 Years of Age*. HSAG recommended 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.

For FY 2018–2019, HCI initiated the BH care PIP, *Increasing Mental Healthcare Services After a Positive Depression Screening*. The health plan lacked historical data to address some Module 1 and Module 2 validation criteria during FY 2018–2019 and, therefore, received a *Conditional Pass* for these modules. The health plan was instructed to resubmit Module 1 and Module 2 in FY 2019–2020, once historical data had been collected for a complete 12-month period, so that HSAG could complete the final validation of Module 1 and Module 2. HSAG recommended 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.

In FY 2019–2020, HCI passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that HCI addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. HCI also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. These recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

For the BH care PIP, HCI also addressed the recommendations related to setting the SMART Aim goal and designing the SMART Aim goal data collection methodology. In FY 2019–2020, the health plan resubmitted Module 1 and Module 2 for the PIP, updating the documentation to include data from a complete 12-month period. With the resubmissions, the health plan fully addressed the recommendations and met all validation criteria for these modules.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, HCI focused its attention on improving the results to survey questions surrounding timely access for children, as seen through the following:

- HCI met with Valley Wide Health Systems to address these results and any possible interventions. Beginning in May 2020 and continuing every six months, Valley Wide Health Systems clinics are contacted via telephone to inquire about appointment availability. Results of the access to care calls will continue to be shared with Valley Wide Health Systems for internal use to generate process improvement on future CAHPS surveys.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, HCI participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. HCI continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 5—Colorado Access

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections.

For Standard III—Coordination and Continuity of Care, 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.

For Standard V—Member Information, COA Region 5 was required to ensure that information on its website includes updated and correct information regarding appeals procedures.

For Standard IX—Early and Periodic Screening, Diagnostic, and Treatment Services, 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.

COA Region 5 submitted its initial CAP proposal on June 13, 2019. Following Department approval, COA Region 5 successfully completed implementation of all planned interventions on March 12, 2020.

Validation of Performance Improvement Projects

For FY 2018–2019, COA Region 5 initiated the PH care PIP, *Well-Child Visits for Members 10–14 Years of Age*. HSAG recommended 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.

For FY 2018–2019, COA Region 5 initiated the BH care PIP, *Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*. HSAG recommended 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.

In FY 2019–2020, COA Region 5 passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that COA Region 5 addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. COA Region 5 also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, COA Region 5 reported engaging in the following quality improvement initiatives:

- COA Region 5 implemented two programs within the customer service department that focus on continuous monitoring of customer service quality and identify areas of improvement. The Quality Monitoring Program, an ongoing program, scores and monitors CSRs to identify areas of improvement based on the program guidelines. Additionally, COA Region 5 invests in a NPS, a short survey, to monitor member satisfaction with the service they received from COA Region 5 CSRs. Along with these programs, CSRs participate in a four-week training program that includes a comprehensive review of member benefits and department workflows, training on all applicable systems, and trainees take mock and live calls in the training environment before they are released to the floor.
- COA Region 5 initiated a satisfaction survey for members who call customer service to monitor the members' experience with access, timeliness, and quality of care provided by COA Region 5-contracted providers. Results from the survey will be analyzed to identify key drivers for customer satisfaction and opportunities for improvement.
- COA Region 5 will resume several planned interventions/strategies involving providers and members when the COVID-19 crisis decreases in severity.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, COA Region 5 participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. COA Region 5 continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 6—Colorado Community Health Alliance

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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. For the remaining two standards, HSAG found two required actions for Standard V—Member Information and two for Standard IX—Early and Periodic Screening, Diagnostic, and Treatment Services. 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.
- 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.

CCHA Region 6 submitted its initial CAP proposal on July 26, 2019. Following Department approval, CCHA Region 6 successfully completed implementation of all planned interventions on December 2, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, CCHA Region 6 initiated the PH care PIP, *Well-Care Visits for Children Ages 15–18 Years of Age*. HSAG recommended 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.

For FY 2018–2019, CCHA Region 6 initiated the BH care PIP, *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*. The health plan lacked historical data to address some Module 1 and Module 2 validation criteria during FY 2018–2019 and, therefore, received a *Conditional Pass* for these modules. The health plan was instructed to resubmit Module 1 and Module 2 in FY 2019–2020, once historical data had been collected for a complete 12-month period, so that HSAG could complete the final validation of Module 1 and Module 2. HSAG recommended 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.

In FY 2019–2020, CCHA Region 6 passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that CCHA Region 6 addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. CCHA Region 6 also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. These recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

For the BH care PIP, CCHA Region 6 also addressed the recommendations related to setting the SMART Aim goal and designing the SMART Aim goal data collection methodology. In FY 2019–2020, the health plan resubmitted Module 1 and Module 2 for the PIP, updating the documentation to include data from a complete 12-month period. With the resubmissions, the health plan fully addressed the recommendations and met all validation criteria for these modules.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, CCHA Region 6 started improvement efforts around categories with the lowest scores among the surveyed practices, which included access to care and coordination of medical care for both pediatrics and adults, and patient-centered communication for pediatrics, through the following:

- CCHA Region 6 practice transformation coaches (PTCs) will work with their quality improvement teams to identify and implement interventions for the practices.
- To improve access to care, CCHA Region 6 PTCs will track the third next available appointments quarterly to measure how many days it takes for members to get an appointment for needed care. The workflows, cycle times, and staff members of practices outside of contract standards will be reviewed for improvement.
- To improve patient-centered communication, CCHA Region 6 PTCs will encourage practices to implement Patient and Family Advisory Councils (PFACs), in alignment with Alternative Payment Model (APM) initiatives. PFACs will be used to review materials and gain feedback on how to effectively communicate with members and their families.
- To improve the coordination of medical care, CCHA Region 6 PTCs are working with practices on improving/creating workflows for referrals to specialists to ensure that PCMPs receive follow-up information from the specialist.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, CCHA Region 6 participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. CCHA Region 6 continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Region 7—Colorado Community Health Alliance

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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. For the remaining two standards, HSAG found two required actions for Standard V—Member Information and two for Standard IX—Early and Periodic Screening, Diagnostic, and Treatment Services. 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.
- 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.

CCHA Region 7 submitted its initial CAP proposal on July 26, 2019. Following Department approval, CCHA Region 7 successfully completed implementation of all planned interventions on December 2, 2019.

Validation of Performance Improvement Projects

For FY 2018–2019, CCHA Region 7 initiated the PH care PIP, *Well-Care Visits for Children Ages 15–18 Years of Age*. HSAG recommended 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.

For FY 2018–2019, CCHA Region 7 initiated the BH care PIP, *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*. The health plan lacked historical data to address some Module 1 and Module 2 validation criteria during FY 2018–2019 and, therefore, received a *Conditional Pass* for these modules. The health plan was instructed to resubmit Module 1 and Module 2 in FY 2019–2020, once historical data had been collected for a complete 12-month period, so that HSAG could complete the final validation of Module 1 and Module 2. HSAG recommended 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.

In FY 2019–2020, CCHA Region 7 passed Module 3 and achieved all validation criteria for this module for both PIPs. The Module 3 validation findings suggest that CCHA Region 7 addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. CCHA Region 7 also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIPs did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. These recommendations applied to Module 4 and Module 5 of the PIPs, which were not scheduled to be completed or validated during FY 2019–2020.

For the BH care PIP, CCHA Region 7 also addressed the recommendations related to setting the SMART Aim goal and designing the SMART Aim goal data collection methodology. In FY 2019–2020, the health plan resubmitted Module 1 and Module 2 for the PIP, updating the documentation to include data from a complete 12-month period. With the resubmissions, the health plan fully addressed the recommendations and met all validation criteria for these modules.

Surveys (PCMH CAHPS and ECHO Survey)

To improve member perceptions related to FY 2018–2019 PCMH CAHPS and ECHO results, CCHA Region 7 started improvement efforts around categories with the lowest scores among the surveyed practices, which included coordination of medical care for adults and patient-centered communication for both adults and pediatrics, through the following:

- CCHA Region 7 PTCs will work with their quality improvement teams to identify and implement interventions for the practices.
- To improve patient-centered communication, CCHA Region 7 PTCs will encourage practices to implement PFACs, in alignment with APM initiatives. PFACs will be used to review materials and gain feedback on how to effectively communicate with members and their families.
- To improve the coordination of medical care, CCHA Region 7 PTCs are working with practices on improving/creating workflows for referrals to specialists to ensure that PCMPs receive follow-up information from the specialist.

Encounter Data Validation

Due to FY 2018–2019 being the first year of the RAE contract, the 411 EDV was not conducted and, therefore, this section is not applicable to the RAEs.

Validation of Network Adequacy

During FY 2019–2020, CCHA Region 7 participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. CCHA Region 7 continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Denver Health Medical Plan

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections.

For Standard III—Coordination and Continuity of Care, 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.

For Standard V—Member Information, 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.

HSAG also identified one required action for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services, in which 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 submitted its initial CAP proposal on June 13, 2019. Following Department approval, DHMP successfully completed implementation of all planned interventions on March 12, 2020.

HEDIS Measure Rates and Validation

To improve its HEDIS rates from last year, DHMP decided to focus on the following interventions:

- DHMP maintained and expanded active partnership and collaboration in quality improvement work group activities with Ambulatory Care Services (ACS) on several quality improvement interventions in chronic disease management, prevention, screening, and annual visits. Workgroups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated behavioral health, transitions of care, immunizations, and the ambulatory care Quality Improvement Committee (QIC).
- DHMP continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS scores.
- DHMP continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores.
- For the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, the DHMP quality improvement department tracks the number of members due for their diabetic eye exam in addition to those members who received an exam each month. This dashboard also tracks the number of calls Eye Clinic care navigators complete monthly and this information is then shared with the Eye Clinic staff members. The creation of a new SharePoint site in 2019 has improved DHMP's ability to target members for outreach and track success rates of their efforts.
- For the *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Childhood Immunization Status*; and *Immunizations for Adolescents* measures, DHMP sent out Healthy Hero Birthday Cards for members 19 and under. The birthday cards are intended to provide visit reminders as well as prepare and educate children and parents on what will happen at upcoming well-child visits. DHMP also conducted outreach calls for well-child and adolescent well-care visits. In addition, DHMP used SBHCs to provide a variety of services such as well-child visits, sports physicals, immunizations, chronic disease management, and primary care and behavioral healthcare services.
- For the *Breast Cancer Screening* measure, DHMP sent out monthly mammogram mailers to members due for mammography. The mailer includes information on scheduling an appointment as well as a calendar for the women's mobile clinic.
- For the *Medication Management for People With Asthma* and *Asthma Medication Ratio* measures, DHMP had its Asthma Work Group (AWG) and registered nurse line utilize a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. In addition, the DHMP pharmacy team has directed more focus on the need to refill asthma controller medications on a consistent basis and will begin utilizing a pharmacy vendor tracking system in FY 2020–2021 to streamline this process.
- In the Access to Care domain, DHMP introduced several strategies to reduce the wait list, including an improved new patient workflow for the appointment center, the hiring and placement of providers in key locations, collaboration between the appointment center and clinics to fill open appointment slots, and adjusted provider panel sizes. In addition, they renovated the adult behavioral health facilities and increased the number of beds and living space for patients. DHMP

also doubled capacity in the ACUTE Center for Eating Disorders, allowing increased available treatment for these severely ill patients, and has begun offering state of the art therapies and advanced treatments for people suffering from non-healing wounds at the Wound Care Center.

- DHMP implemented focused member outreach to facilitate care transitions when acuity of need was identified.
- DHMP collaborated with ACS care coordination to increase assessment of members for gaps in care and problem solving to achieve a more comprehensive member approach to care and services.
- DHMP continued a pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization.
- DHMP developed and implemented enhanced patient education materials specific to chronic disease states.
- DHMP conducted and reviewed the provider satisfaction survey and incorporated data from ACS electronic medical records into supplemental files used for HEDIS reporting.
- DHMP maintained reporting of quality of care concerns (QOCCs) and facilitated process improvements as identified during the QOCC review process.
- DHMP developed clinical practice guidelines to cover the lifespan from infancy to geriatric.
- DHMP streamlined the clinical and preventive guidelines review and is updating the process.
- DHMP increased physician involvement in the development of clinical practice guidelines.
- DHMP continued development, review, and revision of policies and procedures annually through electronic tracking through the organization's transition to an updated system, PolicyStat.
- DHMP maintained physician involvement within the Quality Management Committee (QMC) structure.

Validation of Performance Improvement Projects

For FY 2018–2019, DHMP initiated the PIP, *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*. HSAG recommended 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.

In FY 2019–2020, DHMP passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that DHMP addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. DHMP also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Survey

To follow up on recommendations related to FY 2018–2019 CAHPS, DHMP reported engaging in the following quality improvement initiatives:

- DHMP improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores.
- DHMP increased member support outreach through ACS initiatives to follow up on gaps in care and preventive health screenings.
- DHMP focused on member outreach for facilitating care transitions.
- DHMP developed and implemented enhanced patient education materials specific to chronic diseases.
- DHMP uses the DHHA system to provide greater appointment availability by expanding capacity, provider communication, hours of operation, and specialty services.
- DHMP uses the Health Plan Customer Service Team to perform sample audits of calls for bimonthly discussion and provide real-time training for staff members regarding member service call quality improvement.
- DHMP worked with the member services department to develop a work plan that outlines the processes to effectively track the reasons members stated for not getting the help or information they needed to assist in identifying process improvement and staff training opportunities.
- DHMP works collaboratively with ACS clinics, providers, committees, and DHHA to perform a quality review of cases regularly and improve the referral process.
- DHMP performs a health needs assessment (HNA) of all new members. The results of the HNA are communicated to the care coordination team, who directly follows up with the member to provide general information, resources, and support.
- DHMP built a risk stratification tool to monitor, analyze, and target members' specific health conditions, needs, and issues and directly provide education and resources.

Encounter Data Validation (412 Audit Over-Read)

Results from the FY 2018–2019 412 EDV were used for a Quality Improvement Project (QUIP) follow-up activity in FY 2019–2020. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failures were then ranked in terms of priority and ability to impact data quality and DHMP developed targeted interventions to address high-priority failure modes. Over the course of three months, DHMP monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Despite these efforts, only half of DHMP's encounter data scores showed an increase in accuracy. HSAG recommended DHMP continue barrier analysis and explore alternative interventions while continuing to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

Validation of Network Adequacy

During FY 2019–2020, DHMP participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. DHMP continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

Rocky Mountain Health Plans Medicaid Prime

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2018–2019 (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), 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.

For Standard IV—Member Rights and Protections, 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.

HSAG identified three required actions for Standard V—Member Information. 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 submitted its initial CAP proposal on May 20, 2019. Following Department approval, RMHP Prime successfully completed implementation of all planned interventions on October 4, 2019.

HEDIS Measure Rates and Validation

To improve its HEDIS rates from last year, RMHP Prime decided to focus on the following interventions:

- For the *Adult BMI Assessment* measure, RMHP Prime sent member educational brochures that include encouragement of yearly preventive services for women ages 40 to 65 and include the recommendation for a BMI screening. RMHP Prime also used a Wellness that Rewards Program, which is an educational and incentive mailing brochure through which members are eligible to receive a gift card upon completion of their blood pressure plan with their provider, which includes a BMI assessment. In addition, RMHP Prime did practice level performance improvement work related to the *Adult BMI Assessment* measure. It would document BMI and, if outside of normal parameters, a follow-up plan is documented.

- For the *Breast Cancer Screening* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of breast cancer screening. RMHP Prime also sent member educational brochures that include encouragement of yearly preventive services for women ages 40 to 65 and include the recommendation for breast cancer screening. In addition, RMHP Prime sent a Provider Gap Report in the fall of 2019 to providers listing members who were missing breast cancer screening for collaboration for completion of breast cancer screenings.
- For the *Cervical Cancer Screening* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of cervical cancer screening. RMHP Prime also sent member educational brochures that include encouragement of yearly preventive services for women ages 40 to 65 and include the recommendation for cervical cancer screening. In addition, RMHP Prime sent a Winter Provider Newsletter article that included education to increase provider knowledge about the importance of cervical cancer screening including education on HEDIS measure documentation.
- For the *Child Immunization Status* measure, RMHP Prime sent out a New Baby Packet, which is an educational brochure that is mailed after birth and includes recommended well-child visit schedules for immunizations. RMHP Prime also sent out Child's First Birthday cards, which are educational brochures mailed at 12 months age and include education about why to immunize, how immunizations work, what happens if the child is not immunized, and a typical immunization schedule from the Center for Disease Control (CDC). RMHP Prime also sent additional brochures on birthdays and included immunization reminders.
- For the *Comprehensive Diabetes Care* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of their diabetes health exams with their providers. RMHP Prime also deployed a chronic disease management program for diabetes. The purpose of the disease management program was to connect members to a PCP if the member did not have a medical home, identify gaps in care, address social determinants of health needs, and provide care coordination. In additional, RMHP Prime conducted a phone outreach call campaign in the fall of 2019 to outreach to members with diabetes and encourage the completion of all recommended diabetic screenings.
- For the *Immunizations for Adolescents* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of a wellness visit, including immunizations for meningococcal meningitis and influenza.
- For the *Prenatal and Postpartum Care* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of a postpartum visit. RMHP Prime also deployed three pregnancy programs for members: Prenatal, High-risk Management, and Post-Partum Follow-up. These programs range from various screeners and services offered to ensure proper obstetric care, reducing complications, preventing unnecessary emergency department (ED) visits, and addressing any social determinants of health needs.
- For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, RMHP Prime used a Wellness that Rewards Program in which the members are eligible to receive a gift card upon completion of a wellness visit, including BMI calculation and discussion of eating habits and physical activity. RMHP Prime also sent out a Fall

Provider Newsletter, which included an article that discussed education specific to adolescent and well-child visit documentation.

- For the *Medication Management for People With Asthma* and *Asthma Medication Ratio* measures, RMHP Prime deployed a chronic disease program for asthma. The purpose of the disease management program was to connect members to a PCP if they did not have a medical home, identify gaps in care, address social determinants of health needs, and provide care coordination.

Validation of Performance Improvement Projects

For FY 2018–2019, RMHP Prime initiated the PIP, *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*. HSAG recommended 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.

In FY 2019–2020, RMHP Prime passed Module 3 and achieved all validation criteria for this module for the PIP. The Module 3 validation findings suggest that RMHP Prime addressed the FY 2018–2019 recommendations related to completing a process map, identifying and prioritizing failure modes, and developing interventions to address high-priority failure modes. RMHP Prime also initiated Module 4 and made a prediction as part of the *Plan* step for the first PDSA testing cycle. The PIP did not progress to the point of addressing the remaining recommendations related to tracking intervention evaluation measures, refining interventions based on evaluation results, and updating the key driver diagram, during FY 2019–2020. The remaining recommendations applied to Module 4 and Module 5 of the PIP, which were not scheduled to be completed or validated during FY 2019–2020.

CAHPS Survey

To follow up on recommendations related to FY 2018–2019 CAHPS, RMHP Prime reported engaging in the following quality improvement initiatives:

- RMHP Prime promoted "Destination RMHP," a website containing a series of podcasts hosted by RMHP's Practice Transformation team. These podcasts include interviews with healthcare professionals with tips about improving communication and building patient relationships.
- RMHP Prime provides an educational video series for providers produced by the Practice Transformation team in partnership with the RMHP CMO available via YouTube.

Encounter Data Validation (412 Audit Over-Read)

Results from the FY 2018–2019 412 EDV were used for a QUIP follow-up activity in FY 2019–2020. Data elements that scored below 90 percent accuracy were analyzed to better understand failure modes within the provider and RAE systems. These failures were then ranked in terms of priority and ability to impact data quality and RMHP Prime developed targeted interventions to address high-priority failure modes. Over the course of three months, RMHP Prime monitored the accuracy of coding and submitted a final report with overall findings regarding the success of the interventions. Through these efforts, 17 out of the 19 encounter data types showed an increase in accurate scores. RMHP Prime's QUIP successfully used enhanced communication strategies to increase provider compliance with submitting medical records and also showed effective training approaches. HSAG recommended RMHP Prime continue to work with providers on refresher trainings, ongoing audits, and implementing CAPs as needed.

Validation of Network Adequacy

During FY 2019–2020, RMHP Prime participated in the iterative process led by HSAG and the Department to develop and implement standardized quarterly network adequacy reporting templates and network data submission materials. RMHP Prime continues to fully participate in quarterly NAV activities, beginning with the FY 2020–2021 quarterly network adequacy report and network data submission to the Department in July 2020.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix A. MCO Capitation Initiative Administrative and Hybrid Rates

Table A-1 shows DHMP's rates for HEDIS 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2020 hybrid rate.

Table A-1—HEDIS 2020 Administrative and Hybrid Performance Measure Results for DHMP

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
Childhood Immunization Status			
Combination 2	69.65%	70.56%	25th–49th
Combination 3	66.67%	67.15%	25th–49th
Combination 4	66.35%	67.15%	25th–49th
Combination 5	57.78%	59.61%	25th–49th
Combination 6	48.03%	49.15%	75th–89th
Combination 7	57.63%	59.61%	50th–74th
Combination 8	48.03%	49.15%	75th–89th
Combination 9	42.85%	43.80%	75th–89th
Combination 10	42.85%	43.80%	75th–89th
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	84.53%	91.73%	—
Postpartum Care	66.50%	77.62%	—
Preventive Screening			
Adult BMI Assessment			
Adult BMI Assessment	80.35%	92.46%	50th–74th
Living With Illness			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	83.00%	84.43%	10th–24th
*HbA1c Poor Control (>9.0%)**	40.51%	33.58%	50th–74th
HbA1c Control (<8.0%)	48.96%	55.47%	50th–74th

**For this indicator, a lower rate indicates better performance.*
— Indicates that NCQA recommended a break in trending; therefore, comparisons to benchmarks are not performed.

Table A-2 shows RMHP Prime's rates for HEDIS 2020 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2020 hybrid rate.

Table A-2—HEDIS 2020 Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measure	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
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	60.42%	77.08%	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	5.86%	89.41%	75th–89th
Counseling for Nutrition—Total	20.08%	83.47%	75th–89th
Counseling for Physical Activity—Total	1.26%	77.12%	75th–89th
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	42.00%	95.38%	—
Postpartum Care	35.92%	84.43%	—
Preventive Screening			
Cervical Cancer Screening			
Cervical Cancer Screening	39.39%	59.85%	25th–49th
Adult BMI Assessment			
Adult BMI Assessment	38.95%	97.50%	≥90th
Living With Illness			
Comprehensive Diabetes Care			
Hemoglobin A1c (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 indicator, a lower rate indicates better performance.*
— Indicates that NCQA recommended a break in trending; therefore, comparisons to benchmarks are not performed.